### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 91PN

## ${\bf MEDICARE/MEDICAID\ CERTIFICATION\ AND\ TRANSMITTAL}$

	PARI	I - IO BE COM	PLETED BY I	HE STATI	E SURVEY AGENCY	Facil	ity ID: 00235
MEDICARE/MEDICAID PROVIDER N     (L1) 245546  2.STATE VENDOR OR MEDICAID NO.	0.	3. NAME AND ADD (L3) MISSION NU (L4) 3401 EAST M	URSING HOME		ARD		7 (L8)  2. Recertification  4. CHOW
(L2) <b>121742900</b>		(L5) PLYMOUTH	I, MN		(L6) <b>55441</b>	5. Validation	6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)	NERSHIP	7. PROVIDER/SUB	PPLIER CATEGORY	Y 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit  8. Full Survey After Comple	9. Other aint
6. DATE OF SURVEY <b>08/10</b> /8. ACCREDITATION STATUS:	<b>2016</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR ENDING DA	TE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:				
From (a): To (b):		X A. In Complian Program Re Compliance	quirements Based On:		And/Or Approved Waivers Of The2. Technical Personnel3. 24 Hour RN	6. Scope of Services 7. Medical Director	Limit
12.Total Facility Beds	<b>97</b> (L18)	1. A	acceptable POC		4. 7-Day RN (Rural SNF)	_	
13.Total Certified Beds	<b>97</b> (L17)		pliance with Program and/or Applied Waiv		5. Life Safety Code  * Code: A*	9. Beds/Room (L12)	
14. LTC CERTIFIED BED BREAKDOWN		I			15. FACILITY MEETS		
18 SNF 18/19 SNF 97	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMARK Mandatory DOPNA is	`		· · · · · · · · · · · · · · · · · · ·	effectiv	ze 08/10/2016		
17. SURVEYOR SIGNATURE	3 01100011 7 0 0	Date :	Tobolilaca		18. STATE SURVEY AGENCY AP	PROVAL	Date:
Jennifer Bahr,	HFE NE II		08/10/2016		Kate JohnsTon, Pr		08/31/2016
				(L19)	<u> </u>		(L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	EGIONAL	OFFICE OR SINGLE STAT	'E AGENCY	
DETERMINATION OF ELIGIBILITY      1. Facility is Eligible to Part      2. Facility is not Eligible	icipate (L21)		IPLIANCE WITH C	IVIL	Statement of Financi     Ownership/Control I     Both of the Above:	ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-15	13)
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2	24. LTC AGREEME	ENT	26. TERMINATION ACTION:	(L30)	)
OF PARTICIPATION 02/01/1991	BEGINNING	DATE	ENDING DATE	E	VOLUNTARY 00 01-Merger, Closure	<u>INVOLUNTARY</u> 05-Fail to Meet F	_
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursemen	nt 06-Fail to Meet A	greement
25. LTC EXTENSION DATE:	27. ALTERNATIVI				03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider State	us Change
(L27)	B. Rescind Sus	pension Date:	(L44)			00-Active	
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION ( 07/26/2016	OF APPROVAL DAT	ГЕ	Posted 09/13/2016 Co.		
	(L32)	07/20/2010		(L33)	DETERMINATION APPRO	VAL	



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245546 August 31, 2016

Mr. Timothy Meyer, Administrator Mission Nursing Home 3401 East Medicine Lake Boulevard Plymouth, MN 55441

Dear Mr. Meyer:

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 August 10, 2016 the above facility is certified for or recommended for:

97 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 97 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.

Mission Nursing Home August 31, 2016 Page 2

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered July 20, 2016

Mr. Timothy Meyer, Administrator Mission Nursing Home 3401 East Medicine Lake Boulevard Plymouth, MN 55441

RE: Project Number S5546026

Dear Mr. Meyer:

On June 6, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an extended survey, completed on May 17, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On July 18, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on May 17, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 14, 2016. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our extended survey, completed on May 17, 2016.

However, compliance with the health deficiencies issued pursuant to the May 17, 2016 extended survey has not yet been verified. The most serious health deficiencies in your facility at the time of the extended survey were found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

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

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 17, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new

admissions is effective August 17, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 17, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Mission Nursing Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 17, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

### **APPEAL RIGHTS**

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

### Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644

> Washington, D.C. 20201 (202) 565-9462

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 17, 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc</a> idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail #7015 0640 0003 5695 6283 August 31, 2016

Mr. Timothy Meyer, Administrator Mission Nursing Home 3401 East Medicine Lake Boulevard Plymouth, MN 55441

RE: Project Number S5546026

Dear Mr. Meyer:

On June 6, 2016, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective June 27, 2016. (42 CFR 488.422)

On July 20, 2016, this office informed you that the Centers for Medicare and Medicaid Services (CMS) concurred with the following enforcement remedies being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective August 17, 2016. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on May 17, 2016. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On August 10, 2016, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on May 17, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 10, 2016. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on May 17, 2016, as of August 10, 2016.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective August 10, 2016.

However, as we notified you in our letter of June 6, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), as a result of the extended survey your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 17, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of July 20, 2016:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective August 17, 2016 be rescinded as of August 10, 2016. (42 CFR 488.417 (b))

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

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,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

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Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

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P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
245546 <sub>Y1</sub>	A. Building B. Wing	Y2	8/10/2016	Y3
NAME OF FACILITY MISSION NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441		

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).

ITE	М	DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix	F0246	Correction	ID Prefix F0248		Correction	ID Prefix	F0250		Correction
Reg.#	483.15(e)(1)	Completed	Reg. #	(f)(1)	Completed	Reg.#	483.15(g)(1)		Completed
LSC		07/28/2016	LSC	(	08/01/2016	LSC			05/18/2016
ID Prefix	F0278	Correction	ID Prefix F0312		Correction	ID Prefix	F0323		Correction
Reg.#	483.20(g) - (j)	Completed	Reg. #	(a)(3)	Completed	Reg. #	483.25(h)		Completed
LSC		08/01/2016	LSC	(	08/01/2016	LSC			08/05/2016
ID Prefix	F0325	Correction	ID Prefix F0334	. (	Correction	ID Prefix	F0406		Correction
Reg.#	483.25(i)	Completed	Reg. #	(n)	Completed	Reg.#	483.45(a)		Completed
LSC		06/27/2016	LSC	(	07/27/2016	LSC			08/10/2016
ID Prefix	F0441	Correction	ID Prefix F0490		Correction	ID Prefix	F0493		Correction
Reg.#	483.65	Completed	Reg. #		Completed	Reg.#	483.75(d)(1)-(2)		Completed
LSC		07/29/2016	LSC	(	07/01/2016	LSC			05/20/2016
ID Prefix	F0496	Correction	ID Prefix F0497	. (	Correction	ID Prefix	F0501		Correction
Reg.#	483.75(e)(5)-(7)	Completed	Reg. #	(e)(8)	Completed	Reg.#	483.75(i)		Completed
LSC		07/25/2016	LSC	(	07/29/2016	LSC			07/21/2016
REVIEWE STATE AC		REVIEWED BY (INITIALS) PK/KJ	DATE 08/31/2016	SIGNATURE OF SUR		209		DATE 08/1	0/2016
REVIEWE CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE	TITLE				DATE	

### POST-CERTIFICATION REVISIT REPORT

		PU31	-CERTIFI	CATIO	N KEVISII KI	EPURI		
PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 245546  PROVIDER / SUPPLIER / CLIA / A. Building B. Wing			TRUCTION				DATE (	OF REVISIT
245546	CATION NUMBER	D Wing					<sub>Y2</sub> 8/10/20	016 <sub>Y3</sub>
NAME OF	EACILITY	11 1			STREET ADDRESS, CIT	TV STATE ZID CODE	12	
	I NURSING HON	<b>1</b> ⊏			3401 EAST MEDICINE L			
WIIOGIOIN	1101011101101	/IL			PLYMOUTH, MN 55441	7 WE BOOLE VI W.		
					1			
program, corrected provision	to show those d I and the date su	by a qualified State surveyor eficiencies previously report ch corrective action was a identification prefix code p	orted on the CMS ccomplished. Ea	-2567, Staten ach deficiency	nent of Deficiencies and should be fully identified	d Plan of Correction, the dusing either the regular	at have been ulation or LSC	
ITEI	M	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix	F0520	Correction						
Reg.#	483.75(o)(1)	Completed						
LSC		05/27/2016						
			1					
REVIEWE STATE AG		REVIEWED BY (INITIALS)	DATE	SIGNATUR	RE OF SURVEYOR		DATE	
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
<b>FOLLOW</b> ( 5/17/2016	JP TO SURVEY CO		ECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF CORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?  YES N					

		POST	-CERTIFIC	CATION RE	EVISIT RI	EPORT			
PROVIDER / SUPPLIER / CL	.IA / MUL	TIPLE CONS	STRUCTION					DATE OF R	EVISIT
IDENTIFICATION NUMBER	Ь м	•	- MAIN BUILDING	G 01				7/18/2016	
245546	<sub>Y1</sub> B. W	ing					Y2	7/10/2010	Y3
NAME OF FACILITY				STRE	ET ADDRESS, CIT	Y, STATE, ZIP CODE			
MISSION NURSING HOM	1E			3401 E	EAST MEDICINE L	AKE BOULEVARD			
				PLYM	OUTH, MN 55441				
This report is completed by program, to show those do corrected and the date surprovision number and the the survey report form).	eficiencies pre ch corrective a	viously repaction was a	orted on the CMS- accomplished. Ea	-2567, Statement of ch deficiency should	Deficiencies and be fully identifie	d Plan of Correction, to deduce the reg	hat have t julation or	LSC	
ITEM		DATE	ITEM		DATE	ITEM		ı	DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix	Co	rrection	ID Prefix		Correction	ID Prefix		C	orrection

				STA	ATE FO	RM: REV	ISIT F	REPORT				
	R / SUPPLIER / CI CATION NUMBER		MULTIPLE CONS <sup>*</sup> A. Building	TRUCTION								F REVISIT
00235		Y1	B. Wing							Y2	8/10/20	16 <sub>Y3</sub>
NAME OF	FACILITY						STREE	T ADDRESS, CIT	Y, STATE, ZIF	CODE		
MISSION	NURSING HO	ΜE			3401 EAST MEDICINE LAKE BOULEVARD							
							PLYMO	UTH, MN 55441				
corrective	e action was acc	omplished	I. Each deficienc	y should be	fully ide	entified usir	ig eithei	the regulation	or LSC prov	and the date such ision number and nent on the survey	the	
ITEI	VI		DATE	ITEM				DATE	ITEM			DATE
Y4			Y5	Y4				Y5	Y4			Y5
ID Prefix	20190		Correction	ID Prefix	20255			Correction	ID Prefix	20300		Correction
Reg. #	MN Rule 4658.00	060 B.	Completed	Reg.#	MN Rule	e 4658.0070		Completed	Reg. #	MN Rule 4658.010	5	Completed
LSC			08/01/2016	LSC				08/01/2016	LSC			08/01/2016
ID Prefix	20302		Correction	ID Prefix	20550	1050.0100		Correction	ID Prefix	20830		Correction
Reg. #	MN State Statute 144.6503		Completed	Reg. #	Subp. 4	e 4658.0400		Completed	Reg. #	MN Rule 4658.052 Subp. 1		Completed
LSC			08/01/2016	LSC				08/01/2016	LSC			08/01/2016
ID Prefix	20850		Correction	ID Prefix	20920			Correction	ID Prefix	21230		Correction
Reg. #	MN Rule 4658.05	520	Completed	Reg.#		e 4658.0525		Completed	Reg.#	MN Rule 4658.070	0	Completed
LSC	Subp. 2 D		08/01/2016	LSC	Subp. 6	В		08/01/2016	LSC	Subp. 2 B		08/01/2016
			-									00/01/2010
ID Prefix	21375		Correction	ID Prefix	21426			Correction	ID Prefix	21435		Correction
Reg.#	MN Rule 4658.08 Subp. 1	300	Completed	Reg. #	MN St. S Subd. 3	Statute 144A	04	Completed	Reg.#	MN Rule 4658.090 Subp. 1	0	Completed
LSC			08/01/2016	LSC				08/01/2016	LSC			08/01/2016
.D.D. 6			0 "					0 "				0 "
ID Prefix	21495 MN Rule 4658.10	005	Correction	ID Prefix	21510 MN Bul	e 4658.1200		Correction	ID Prefix			Correction
Reg. #	Subp. 5		Completed	Reg. #	Subp. 2			Completed	Reg.#			Completed
LSC			08/01/2016	LSC				08/01/2016	LSC			
REVIEWE	D BY	REVIEW	ED BY	DATE		SIGNATUR	E OF SL	JRVEYOR	<u> </u>		DATE	
STATE AG		(INITIALS		08/31/2	2016					10/2016		
REVIEWE CMS RO	D BY	REVIEW		DATE		TITLE					DATE	

Page 1 of 1 EVENT ID: 91PN12

YES NO

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

5/17/2016

FOLLOWUP TO SURVEY COMPLETED ON

### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 91PN

## MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PAR	T I - TO BE COMPLETED BY T	HE STAT	E SURVEY AGENCY	Facility ID: 00235	
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245546  2.STATE VENDOR OR MEDICAID NO.     (L2) 121742900	(L1) 245546 (L3) MISSION NURSING HOME (TATE VENDOR OR MEDICAID NO. (L4) 3401 EAST MEDICINE LAKE BOULEVARD				
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGOR 01 Hospital 05 HHA	Y 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other  8. Full Survey After Complaint	
6. DATE OF SURVEY <b>05/17/2016</b> (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited	02 SNF/NF/Dual 06 PRTF 03 SNF/NF/Distinct 07 X-Ray 04 SNF 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31	
11LTC PERIOD OF CERTIFICATION From (a): To (b):  12. Total Facility Beds 97 (L18) 13. Total Certified Beds 97 (L17)	10.THE FACILITY IS CERTIFIED AS:  X A. In Compliance With  Program Requirements  Compliance Based On:  _X_1. Acceptable POC  B. Not in Compliance with Program  Requirements and/or Applied Waiv	n	And/Or Approved Waivers Of The  2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code	Following Requirements:	
14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF 19 SNF  97  (L37) (L38) (L39)	ICF IID (L42) (L43)	reis.	* Code: A1*  15. FACILITY MEETS  1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE S  Mandatory DOPNA is effective 0  17. SURVEYOR SIGNATURE  Annette Truebenbach, HFE NI	08/17/2016.  Date:	(L19)	18. STATE SURVEY AGENCY API		
PART II - TO  19. DETERMINATION OF ELIGIBILITY  1. Facility is Eligible to Participate 2. Facility is not Eligible  (L21)	20. COMPLIANCE WITH CRIGHTS ACT:		21. 1. Statement of Financi		
22. ORIGINAL DATE  OF PARTICIPATION  02/01/1991  (L24)  (L41)			26. TERMINATION ACTION:  VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemer 03-Risk of Involuntary Termination	05-Fail to Meet Health/Safety	
25. LTC EXTENSION DATE:  27. ALTERNATIV  A. Suspension  (L27)  B. Rescind Sus	of Admissions: (L44)		04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active	
28. TERMINATION DATE: 29	0. INTERMEDIARY/CARRIER NO.	(L31)	30. REMARKS		
31. RO RECEIPT OF CMS-1539 32 (L32)	2. DETERMINATION OF APPROVAL DA	TE (L33)	Posted 07/26/2016 Co.  DETERMINATION APPRO	VAL	



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 6139 June 22, 2016

Mr. Timothy Meyer, Administrator Mission Nursing Home 3401 East Medicine Lake Boulevard Plymouth, Minnesota 55441

RE: Project Number S5546026, H5546050

Dear Mr. Meyer:

On May 17, 2016, an extended survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the May 17, 2016 extended survey the Minnesota Department of Health completed an investigation of complaint number H5546050 that was found to be unsubstantiated.

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

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

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

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

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to

resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

### REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on May 17, 2016, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

#### DEPARTMENT CONTACT

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

Pam Kerssen, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Phone: (218) 308-2129

Fax: (218) 308-2122

### NO OPPORTUNITY TO CORRECT - REMEDIES

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

this Department is imposing the following remedy:

• State Monitoring effective June 27, 2016. (42 CFR 488.422)

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

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

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

### SUBSTANDARD QUALITY OF CARE

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

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Mission Nursing Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 17, 2016. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

### **APPEAL RIGHTS**

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of

care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <a href="https://dab.efile.hhs.gov">https://dab.efile.hhs.gov</a> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

### Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

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

### PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

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

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

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

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

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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

If substantial compliance with the regulations is not verified by August 17, 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 November 17, 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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Submitted June 6, 2016

Mr. Timothy Meyer, Administrator Mission Nursing Home 3401 East Medicine Lake Boulevard Plymouth, Minnesota 55441

RE: Project Number S5546026, H5546050

Dear Mr. Meyer:

On May 17, 2016, an extended survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered. In addition, at the time of the May 17, 2016 extended survey the Minnesota Department of Health completed an investigation of complaint number H5546050 that was found to be unsubstantiated.

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

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

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

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

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate

jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

### REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on May 17, 2016, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

### **DEPARTMENT CONTACT**

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

Pam Kerssen, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Phone: (218) 308-2129

Fax: (218) 308-2122

### **NO OPPORTUNITY TO CORRECT - REMEDIES**

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

this Department is imposing the following remedy:

• State Monitoring effective June 11, 2016. (42 CFR 488.422)

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

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

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

### **SUBSTANDARD QUALITY OF CARE**

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

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Mission Nursing Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 17, 2016. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

### **APPEAL RIGHTS**

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of

care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

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

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

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

### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by August 17, 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 November 17, 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:

Mr. Tom Linhoff, Supervisor Health Care Fire Inspections State Fire Marshal Division

Email: <a href="mailto:tom.linhoff@state.mn.us">tom.linhoff@state.mn.us</a> Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

PRINTED: 06/06/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT AND PLAN OI	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION .	(X3) DATE SURVEY COMPLETED	
		245546	B. WING			0.5	/17/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	71772010
MISSION	NURSING HOME			3.	401 EAST MEDICINE LAKE BOULEVARD		
				P	LYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	as your allegation of of Department's accepta enrolled in ePOC, you at the bottom of the first form. Your electronic be used as verification.  Upon receipt of an accon-site revisit of your validate that substanti regulations has been your verification.  A survey was conduct Department of Health The survey resulted in (IJ) at F323 related to to comprehensively as appropriate interventic alcohol use and lack or residents were intoxic high potential for harm 7/1/15, when it was ic extremely elevated broclinical symptoms with intervention. The IJ was 2:30 p.m. when the fainterventions including safety, implementing/einterventions, educating policies/procedures.  An extended survey we minnesota Department through 5/17/16.	correction (POC) will serve compliance upon the ance. Because you are or signature is not required rest page of the CMS-2567 submission of the POC will not compliance.  ceptable electronic POC, an facility may be conducted to all compliance with the attained in accordance with the attained in accordance with the facility's failed response assess and develop ons related to unsafe of monitoring when atted, which resulted in the nor death. The IJ began on lentified R51 had an eathalyzer reading and nout appropriate as removed on 5/17/16, at cility implemented assessing the residents' enforcing appropriate and sout appropriate as removed by the tof Health on 5/12/16	Jan	ooo b	Mission Nursing Home objects to and disagrees with both the findings of not compliance and the level of deficience cited. We do not believe that the conat Mission constitute "actual harm". This Credible Allegation of Compliance has been prepared & time submitted. Submission of this Credib Allegation of compliance is not a legal admission that a deficiency exists or the Statement of Deficiency were concited, and is also not to be construed a admission against interest of the facility Administrator or any employees, agenother individuals who draft or may be discussed in the Credible Allegation of Compliance. In addition, preparation submission of the Credible Allegation Compliance doe not constitute an admission or agreement of any kind by facility of the truth of any facts alleged the correctness of any conclusions set in this allegation by the survey agency Accordingly, we are submitting this Compliance solely becaustate and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Sment of deficiencies as a condition to participate in the Medicare & Medical Assistance programs. The submission Credible Allegation of Compliance within time frame should not be considered.	on- y ditions ely le le lhat rectly ss an ty, it's of  to of y the d or forth redible use ion se state- of the th lered	
AHORATORY	JIKECTOR'S OKTPROVIDER/S	UPPLIER BEPRESENTATIVES SIGNATURE		1	TITLE	$\sim$	(X6) DATE

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

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

Event ID: 91PN11

Facility ID: 00235

If continuation sheet Page 1 of 93

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	COM			SURVEY LETED
		245546	B. WING_			05/	17/2016
	ROVIDER OR SUPPLIER			34	REET ADDRESS, CITY, STATE, ZIP CODE 101 EAST MEDICINE LAKE BOULEVARD LYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000 F 246 SS=D	483.15(e)(1) REASOI OF NEEDS/PREFER A resident has the rig services in the facility accommodations of ir	ertification survey an laint H5546050 was not to be substantiated. NABLE ACCOMMODATION ENCES  ht to reside and receive with reasonable and when the health or safety of	F 2		or construed as agreement with the alle of non-compliance or admissions by the facility.  It is the policy of this facility to provide resident with reasonable accommodation meet their individual needs and preference their individual needs and preference assure continued compliance the formula plan has been put into place:  1. Develop Preference Assessment Rest to care including shaving/facial hair. I will be done immediately.  2. Current residents will be assessed on before 7/29/2016. New admissions will	ne le each ons to ences. illowing lated R38	7/13/2016
	by: Based on observation review, the facility fall facial hair for 1 of 2 rechoices.  Findings include: R38 was admitted to quarterly minimum daidentified R38 had maintenance for the facility of the facilit	nore, R38's MDS identified ner's disease, receiving quiring extensive physical			be assessed.  3. Nurse Manager will ensure care pre observation is completed with each ad MDS, and provide information on care assignment sheets.  4. DON or designee will audit assessment compliance, reflection to care plan, assignment sheets, and report findings Audit outcomes will be reported to the committee by 7/21/2016 for review for compliance and/or development of an plan for further issues.  Responsible: Nurse Manager, DON	mission & plan & nent to QA. c QA	<sup>5</sup> 7/21/2016
	care deficit in ADL's r with grooming. It furth "Encourage to wash	equiring one staff to assist ner specified for staff to his face and hands.". The cify any preferences in the					:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245546	B, WING_			05/	17/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 3401 EAST MEDICINE LAKE E PLYMOUTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 246	Continued From page 2		F 2	46			
		uded an admission photo in white and gray mustache.					
	in his wheelchair. Wh	n. R38 was observed sitting ite hairs, approximately 1/8" id on his upper lip and leks.					
	the same white hairs scattered on both che	eks. The stubble was					
	approximately the same as the day before.  On 5/11/16 at 8:24 a.m. family member (F)-A expressed concerns that R38 was not being shaved often enough. F-A further thought that R38 was only receiving assistance with shaving once a week. F-A stated that shaving was very important to R38, who had been "the most particular person you can imagine" regarding shaving. FA-1 went on to state that shaving "was a huge thing for him." F-A stated R38 always kept his mustache in his younger years and would "not feel good" about the mustache being shaved.						
	sitting in his wheelcha cart. R38 continued to his upper lip and chee	m. R38 was again observed air, waiting by a medication o have white facial hair on eks. The hair on R38's upper nger than when observed 5.					
	sitting in wheelchair e room. His hair appeal combed. R38 stated l	.m. R38 was observed sating breakfast in the dining red wet and had been he had had a bath that air on his upper lip and roximately 1/4" long.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  3		(3) DATE SURVEY COMPLETED	
		245546	B. WING		05/	/17/2016	
ļ	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 246	and shaving assistant and the facility nursing shaving was the respondent of the facility nursing shaving was the respondent use as well. It refused offers to shave that morning. NA-M resource, some resident some would say "go reday at 11:29 a.m. R38 wheelchair looking out clean shaven, including R38 was stated he did "a mustache I like."  On 5/13/16, at 1:39 a. (LPN)-B stated R38 wand facility staff and we residents were shaved stated nursing staff we needed it because the LPN-B further stated it.	a.m. nursing assistant ceived grooming, bathing, be from the hospice aides grassistants. NA-M stated possibility of the facility of the facility of the facility of there was a floor razor for NA-M stated R38 at there was a floor razor for NA-M stated R38 never e and NA-M shaved him exported that shaving was a ts would say yes or no, light ahead." Later that same to was observed sitting in his to the window. His face was not the window. His face was not like having a beard but the window in the window in the window. His face was not like having a beard but m. licensed practical nurse was shaved by both hospice went on to state that most dievery third day. LPN-B build shave a resident if they are would "see it [facial hair]."	F 24				
F 248 SS=D	was suppose to be a dincluded in grooming. assessment regarding not a resident wanted 483.15(f)(1) ACTIVITI INTERESTS/NEEDS	LPN-A was unaware of any facial hair and whether or to keep a mustache. ES MEET	F 24	8			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN			(X3) DATE SURVEY COMPLETED	
		245546	B. WING_			05/1	17/2016
MISSION NURS		ATEMENT OF DEFICIENCIES	ID	34	REET ADDRESS, CITY, STATE, ZIP CODE 101 EAST MEDICINE LAKE BOULEVARD LYMOUTH, MN 55441 PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	×	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE
of a the the of 6 for the of 6	comprehensive a physical, mental, each resident.  Is REQUIREMENT ased on observation in the facility fail ivities for 1 of 3 reivities.  Is care plan date gnoses included scheimer's disease, imonary disease (MDS) date were cognitive implemental facility in the groups of people to the facility in the groups of people to the groups of groups of groups of groups of groups of groups and groups of	to meet, in accordance with ssessment, the interests and and psychosocial well-being  T is not met as evidenced on, interview, and document ed to provide meaningful sidents (R16) reviewed for  d 4/14/16, indicated R16's indicated R16's indicated R16 had airment. It also indicated mportant to listen to music, agazines to read, to do things e, and important to go in air. A quarterly MDS dated 8 was independent with coted staff to invite and tend upcoming programs of vised sporting events, socials A Therapeutic Recreation d 5/15/15, indicated some of ed smoking, cards, Bingo, espapers, music, and dated 5/16, indicated some of dated	F2		Mission strives to meet the interests; phy mental and psychosocial needs of each oresident through structured activity programs. The Director re-educated staff on the imp of documenting resident being offered programs, attendance and refusals. This completed through review of job descrip department policies including basic facil policy "Steps to follow each time when ra program" dated 2/14.  TR Director established a computerized program for attendance for the activities whole house with every five (5) day intehighlighted. That is to ensure that each rais seen at least one time within that 5 day period, preferably more. TR staff continumnitor whether residents are active or participants in programs and whether the refuse programs.  R16's refusal and /or attendance was not documented. However, in June, R16 refused 16 programs, regularly attended monitored smoking program and also we the barber, attended a reading group and social. In May R16 refused 18 programs regularly attended monitored smoking p interacted with staff & peers 2 times, ar participated in traveling program one times and the program one times are participated in traveling program one times.	of the rams. Solutions & ity running for the ray resident by runsive to bassive by the first total a solutions, and	6/30/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245546	B. WING	. WING		05/17/2016	
NAME OF PROVIDER OR SUPPLIER  MISSION NURSING HOME  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			aı	STREET ADDRESS, CITY, STATE, ZIP CODE  3401 EAST MEDICINE LAKE BOULEVARD  PLYMOUTH, MN 55441  ID PROVIDER'S PLAN OF CORRECTION (X5)			
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A, BUILDING	E CONSTRUCTION	(X3) DATE : COMPL	
		245546	B. WING		05/	17/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 250	practicable physical, well-being of each results with the facility fail related social service alcohol, to ensure constablished facility prodischarge planning for R51) reviewed for alcoholate planning for R51) reviewed for alcoholate with chemically of the initial care confer interdisciplinary treat is appropriate for the acknowledged if results approp	mental, and psychosocial sident.  is not met as evidenced in, interview, and document led to provide medically s for residents who abuse insistent implementation of otocols and/or to assist with or 2 of 3 residents (R11 and othor use and other in 12:50 p.m. the or (SSD) stated part of her dependent residents is ory. The SSD stated during	F 250	Revised alcohol drug use policy to incluce consequences of alcohol use on LOA, minclude breathalyzing, room searches- (a states that any room may be searched if is suspected of having alcohol), person searches, adjusting monitoring level. Refusal to submit to a breathalyzer, in-house alcohol consumption (outside Gazebo program) or returning from an I intoxicated will trigger a resident's curr of parameters (restrictions) to the next blevel based on their individual circumstan alcohol related infraction will trigge moving up one or more monitoring lever one week and then will be re-evaluated IDT will evaluate and monitor all alcoholincidents at each morning meeting to empolicy is being adhered to.  Responsible Director of Social Service Quality assurance committee review at meeting and on-going.	nay now anyone  of the LOA ent set nigher ances. r els for by IDT. ol related asure (DSS)	5/18/16

	OF DEFICIENCIES . F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245546	B. WING			05	/17/2016
	ROVIDER OR SUPPLIER NURSING HOME			3.	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 250	non-Alzheimer's deme cognitive communicate cirrhosis of liver, and a MDS also identified R behavioral symptoms and rejection of care.  R11's behavioral symptoms and episodes of impaid decision making, notir was in a verbally aggranother resident which physical aggression. "about not going out in alcohol or take drugs a in with him." The CAA direction or guidance is behaviors.  R11's medical record I assessment related to R11's medical record I Drug Use policy. The finite his own responsible particular alteration in communication of the pendence. It also is out 'for a few drinks'. I encouraging sobriety, initiated 12/11/11), privinget along with roomman physical and verbal agalso indicated R11 was due to alcohol or drug	anded diabetes mellitus, entia, anxiety, depression, ion deficit, alcoholic alcohol dependence. The 11 exhibited other not directed toward others, otom Care Area atted 7/2/15, identified R11 red judgment and poor ing an episode in which he essive altercation with a lead to threatening and He also has been warned to the community to drink and/or bring anything back a documentation lacked any in dealing with these acked a comprehensive safety of alcohol use.  acked a signed Alcohol and face sheet identified R11 as arty.  4/8/16, identified a cognition related to alcohol dentified a history of going interventions included: Level I monitoring (date vate room due to inability to ates, and identifying igression. The care plan is at moderate risk for falls	F		Selected residents (R51, R11, will sign revised alcohol policy. Current resident guardians will also be signing the updated by 8/1/2016.  Responsible: DSS  Develop individualized resident alcohologian of care for R51, R11, (on-going risterinking with their diagnosis, praising frompliance, breathalyze upon return to search upon every return to the facility) Responsible: DON, Nurse Managers, DR51: Goal: will comply with MNH alcoholicy through next review.  Ensure R51 has no containers in his when going down for Gazebo program. Follow Intoxication/Impairment Assess: Tool and care track indicated as needed. Praise R51 for compliance with alcohol Remind R51 about the rules r/t alcohol is out of the Gazebo program.  Room check random and when suspicional coholopossession.  Search R51 upon reentry into building. I looking in socks.  When intoxicated encourage R51 to dring and Gatorade, eat food and rest.  Ongoing monitoring for seizure activity history of alcohol withdrawal related se	related lks of facility, SS sohol seelchair ment policies in and in of facilude lk water d/t	5/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245546	B. WING		05/17/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVAR PLYMOUTH, MN 55441	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 250	orthostatic blood prestacked specific intervuse.  The facility provided Listing by Room date identified as a Level information provided  On 5/16/16, at 10:01 director (SSD) was a level information for I was unsure why R11 Resident Classificatic [R11] "is a Level I, ar Everyone knows this R11's Fall/Safety Ris Assessment dated 3 had a current issue van extensive history cirrhosis of the liver, alcohol-induced persassessment indicate confrontational with especially if drinking Review of R11's programs of R11's program of R11's program. I don't have facility's Gazebo Alcohysician approved,	a Resident Classification d 4/18/16. R11 was I (which contradicted on the care plan).  a.m. the social service sked about the conflicting R11. The SSD stated she was a Level II on the on Listing. The SSD stated, and has been since 9/23/12.  ks Evaluation and /7/16, failed to indicate R11 with alcohol and/or drug use, of alcoholism, alcoholic drunkenness, and isting dementia. The d "occasionally resident is staff and other residents, alcohol."  gress notes dated 4/22/15 ntified the following incidents:  n. R11 went for a walk at ned at 9:10 p.m. Refused, "I'm not on the Gazebo we to do that anymore." (The ohol Program [A program run allows residents to drink a set amount of alcohol a specific area of the building	F 2	R11: Goal: R11 will allow Int Impairment Assessment Tool of through next review Breathalyzer on any return to feel Follow Intoxication/Impairment Tool protocol when alcohol us suspected.  Observe for and document any alcohol use per Intoxication/Impairment Tool.  Ongoing education regarding alcohol consumption on health Random room search and for see possession of alcohol.  Search for any alcohol upon respect to include checking soon When R11 is intoxicated encoordinated intake, food intake a	when indicated Cacility. Int Assessment It is known or It is symptoms of Inpairment It isks of continued It and safety. It is suspicion of It is in the facility. It is in the facility in the facility. It is in the facility in the f

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:			A. BUILD		(X3) DATE SURVEY COMPLETED		
		245546	B. WING				05/17/2016
	ROVIDER OR SUPPLIER NURSING HOME			340	EET ADDRESS, CITY, STATE, ZIP CODE I EAST MEDICINE LAKE BOULEVARD MOUTH, MN 55441		00/1//2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X6) COMPLETION DATE
F 250	- 5/23/15, at 3:50 a.i agitated, jumping fro times not making se his room 5/23/15, at 9:45 a.r staff in a "foul langua shared with dietary s. The documentation around room do not bottles/containers." - 5/24/15, at 3:30 a.r was observed blocki the door monitoring syelling racial slurs to "physically harm the toward staff in a three and was informed if the police would be cand returned at 10:00 teeth, and leaning or informed the police would be continued the police would be contin	m. R11 exited his room, om one subject to another, at nse, talking about drinking in m. R11 had been speaking to age". It also noted R11 staff he had been drinking. Included: "In a brief glance see any alcohol  in. identified at 9:50 p.m. R11 ng the door entrance, with staff outside. R11 began staff and threatening to door monitor." R11 walked atening manner, swearing, ne physically harmed staff, called. R11 went to his room, 5 p.m. cursing, gritting his in the nursing station. He was would be called if he didn't	F:	250	DEFICIENCY)		
	"extremely blood shot [twice] and appeared - 6/17/15, at 12:00 p. a verbal altercation wescorted out of the distribution threaten the peer, mand attempted to get The note indicated Risuspected he had be "Did he laugh at me, of him." A corresponding the subsection of the subsection	so noted R11's eyes were t." R11 was checked on x 2 to have calmed down.  m. R11 confronted and had yith a peer, and when being ining room, began to aking the motion of a fist, back in the dining room. 11 had slurred speech and en drinking. R11 stated, I'm gonna knock the shit out ding incident report dated ed, but lacked any additional					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245546	B. WING		05/	17/2016
	NURSING HOME		3.	TREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST MEDICINE LAKE BOULEVARD LYMOUTH, MN 55441		
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F 250	discussed recent be informed he could re building unless in the indicated if the reside cooperate with the preathalyzer and if sent to the hospital to assist. He stated certainly did not was behaviors. Finally he given a notice to dis incidents, he respondanyway" and when could not give an aindiated the administed the administer everything one final verified he understoresident had asked a place to go if give - 6/19/15, at 9:30 a entry) identified R1 given notice to leave - 7/5/15, at 5:36 p.r. with a peer, threater from each other.  - 7/7/15, at 7:46 p.r. altercation with a pyelling and cursing - 7/10/15, at 3:12 pabdominal pain, and indicated in the country of the countr	m. the SSD and administrator ehaviors with R11, and he was not drink in or out of the see gazebo program. The notes dent gets intoxicated he has to hourses when they ask for a he doesn't comply he will be and/or the police will be called at that he understood and in the police called due to his ne was told that he will be scharge if there are any more inded with "I am leaving soon asked where he was going he newer. The documentation strator had reiterated I time and the resident had bod. A couple of hours later the whether if they would find him and a discharge notice.  In. (documented as a late 1 was told that he would be re if his behaviors continued.  In. R11 had a verbal altercation whing to "beat each other up." and until the peers walked away  In. R11 was in a verbal eer, entering peer's room, at peer.  In. R11 complained of an abdominal x-ray was and, "Don't send them in my	F 250	Revise the Resident Monitoring (Leve to include initial placement at a level individual circumstances may warrant change and how staff will be notified changes. Greater restriction (monitorioccur for non-compliance, lesser restr (monitoring) for compliance with the Responsible: SSD	IV, a level of ng) will ictions	5/18/2016

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245546	B. WING			05	/17/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 3401 EAST MEDICINE LAKE BO PLYMOUTH, MN 55441	•	1 00.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	AN OF CORRECTION TE ACTION SHOULD BE D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 250	issues to staff. He the became agitated.  - 9/4/15, at 4:32 p.m. appeared to be drunk administrator entered breathalyzer. When as last night or this morni speech was somewharead 0.204, and a rete 0.203. "This writer an reminded him of a dist that he understood that happened again he we leave. He said that he writer then informed him made for the Glennworesidential facility for chomeless men and wo planning could begin. this."  - 9/8/15, at 10:22 p.m. near the door in his ro but refused breathalyz assessment. Residen police I am already in incident report comple "possibly" give resider discharge.  - 9/9/15, at 5:44 p.m. Sappeared drunk. SSD R11's room. R11 refusinformed if he did not othe same as saying the	R11 was complaining about en began cursing and staff reported to nurse R11. The SSD and R11's room with the sked if he had been drinking ng, R11 denied it. His t slurred. Breathalyzer st of the breathalyzer was d Administrator then cussion in which he stated at if an incident like this buld be given a notice to be remembered this. This im that a referral would be od, (wethouse) [a hronically alcoholic and simen], so that discharge He stated understanding of R11 was found on the floor om. He appeared drunk er and vital sign t stated "don't call the grouble." Corresponding ted, identified plan to t a 30 day notice to	F2	250			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245546	B. WING		05/17/2016	
	ROVIDER OR SUPPLIER		34	TREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST MEDICINE LAKE BOULEVARD LYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 250	Continued From page	e 12	F 250			
	p.m. and returned at 0.105.	m. R11 left facility at 8:30 9:50 p.m. Breathalyzer read				
	p.m 9:35 pm. Brea	o.m. R11 went out from 5:45 hthalyzer read 0.162.				
		n. R11 had a verbal ekeeping. A corresponding eted on 10/31/15 lacked any		·		
	- 11/7/15, at 7:27 p.m returning at 7:11 p.m	n. R11 went out at 6:50 p.m., Breathalyzer read 0.022.				
		n. R11 left at 8:00 p.m., and Breathalyzer read 0.077.				
	station asking for me refused. He became cursing". Staff attem	a.m. R11 to the nurses edication he had previously be very upset and began pted to talk with R11, but he walked off to his room.				
		m. R11 out of the building ) p.m. Breathalyzer was				
	- 11/19/15, at 10:54 and breathalyzer rea	p.m. R11 out of the building ad 0.06 upon return.				
	DON stated breatha limit, and she would monitoring. The DOI and would expect he been notified of any	n 5/11/16, at 4:21 p.m. the lyzer was below the legal n't expect any increased N stated she was not notified, erself or the SSD to have incident involving drinking of ould expect an incident report				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245546	B. WING		**************************************		05	/17/2016
	ROVIDER OR SUPPLIER NURSING HOME		•	3401 EAS	DDRESS, CITY, STATE, ZIP CODE T MEDIGINE LAKE BOULEVARD ITH, MN 55441			,200
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	E	(X5) COMPLETION DATE
	completed.  - 12/24/15, at 5:30 p.r cans of beer in his roo it down the drain where cursing, slammed the foot.  On 5/11/16, at 4:21 p. breathalyzer was done room search revealed was notified of this indurther symptoms, and minute checks. Further aggressive, but he was alcohol.  - 3/29/16, at 9:13 p.m. p.m. and returned at 9 being down by the lake was 0.143.  - 4/13/16, at 9:06 p.m. refused breathalyzer under the complete of th	m. R11 was found with two om, observed to be dumping in staff entered. R11 began cabinet door shut with his im. the DON stated no is. The DON also stated a no further alcohol, and she sident. There were no if she would not expect 15 is. The DON stated R11 was a also aggressive without in R11 left the facility at 6:20 is 20 p.m. R11 reported it. and breathalyzer reading in R11 left the facility at 2:05 is 39 p.m. Breathalyzer read to his room.  In the SSD stated R11 was igram because he didn't overified that on 5/7/16 when ding was so high, R11 had	F	250				

OCIVICATION OF WILLIAM OF THE STREET OF THE		(A3) MIII	TIDI E /	(X3) DATE SURVEY			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILD		CONSTRUCTION	COMPL	
			TI, BOILD				
		245546	B. WNG			05/1	7/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				34	01 EAST MEDICINE LAKE BOULEVARD		
MISSION	NURSING HOME			PL	YMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 250	report and 15 minute completed.  R11's Social Service: 3/10/16, identified "H term memory deficits selective memory. He judgement." The note also be verbally aggrespecially when they He does not want an knocking. He has epoutside of the buildin has. Social Service withrough 1 to 1 visits interventions as need.  During interview with original plan for R11 wethouse [a residential alcoholic and homeled However, he was not has a colostomy, and independent with the there was a concern shared bathrooms. In home was not an apas he requires no skippendent setting, current plan in place.  The SSD stated on R51 remained adam drink, and that a reatting nursing home we	s Review notes dated le does display some short is some of which could be e has episodes of impaired es also included, "He can ressive towards staff want him to do something. I want him to do something. I wone in his room even after pisodes of drinking inside or ing and then denying that he will remain actively involved and behavior management ded."  In the SSD, she stated the was to discharge him to a tial facility for chronically less men and women]. It accepted there because he did even though he is e cares of his colostomy, I from the wethouse about The SSD verified the nursing propriate placement for R11, iilled care, and stated she had noe him to go to a more I but stated there was no	F	250			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	•	245546	B. WING			05	/17/2016
	ROVIDER OR SUPPLIER NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP C 3401 EAST MEDICINE LAKE BOULE PLYMOUTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
	R51's quarterly MDS or resident had modified skills for daily decision symptoms not directed required the use of a vincluded hypertension disorder/epilepsy, and R51's CAA dated 11/3 acute alcohol intoxicat weakness, depression poor coordination, poor impairment. It also ideincluding disruptive, lo room "especially after The CAA noted impair transitions, and difficul balance as well as agit mobility. The CAA lack guidance in dealing with not have a comprehen the safe use of alcohol R51's medical record in to participate in the Ga 8/7/15. However, there and Drug Use policy. TR51 as his own response R51's care plan dated care performance deficalso identified R51 had related to being wheeld alcohol with the Gazeb care indicated both lon problems, and poor judentified R51 had problems.	dated 4/28/16, identified the independence in cognitive in making, behavioral distorated to toward others, and wheelchair. Diagnoses, diabetes mellitus, seizure depression.  1/15, identified diagnoses of ion/withdrawal, physical, limited range of motion, or balance, and visual ntified behavior problems ud talking in the dining Gazebo/alcohol program." ed balance during ty maintaining sitting tation and decreased any direction or the these behaviors. R51 did sive assessment related to .  Included a signed contract zebo program dated e was not a signed Alcohol The face sheet identified isible party.  4/27/16, identified a self sit related to alcohol use. It is a potential risk for falls chair bound, and the use of o program. The plan of g and short term memory legement and decision dependence. The care alteration in mood and	F	250			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245546	B. WING			05/	7/2016
NAME OF PROVIDER OR SUPPLIER  MISSION NURSING HOME		•	3	TREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441		·
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
remind of the rules at program. The care pl alcohol monitoring let. The Resident Classif form, dated 4/18/16, Review of R51's prog 5/15/16, identified the A Physician Progress identified "Patient has returned from the hos intoxication. Patient consume controlled a facility."  - On 7/1/15, at 6:47 president (R51) was deprogram. "Client more pressure upon wakin Given meal tray and water. Blood pressure Physician notified and blood pressure every encourage fluids. Of identified resident let and returned at 1:05 breathalyzer was 0.2 whiskey in his room, liquor cabinet. An incomplete in the incident on 7 instructed to not dring evidence their Gazel On 5/11/16, at 3:02 press up like this who	al. Interventions included to round the gazebo/ alcohol an failed to identify R51's vel.  Tication Listing By Room identified R51 as a Level III.  Typess notes from 4/28/15 - e following:  So Note for R51 dated 6/2/15, as remained stable since he spital in February for alcohol continues to smoke and amount of alcohol here at the common outside the Gazebo intored closely". Blooding is 75/54 and heart rate 75. drank 300 ml (milliliters) of	F	250			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245546	B. WING			05	5/17/2016
	ROVIDER OR SUPPLIER  NURSING HOME			3	STREET ADDRESS, CITY, STATE, ZIP CODE 1401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	-	(X5) COMPLETION DATE
F 250	are sent to the hospital are sent to the hospital are sent to the hospital and been seen by the note indicated R51 is smoke when he wants or anyone else."  On 7/2/15, at 1:59 p. was on a three day suprogram.  A Physician Progress identified the chief contintoxication. It noted reading of 0.258, and to be low at 87/56, with note indicated during if the resident had stated someone and had som I will do whatever I was drink and smoke. If I gwill do it. I am not hurtified when I drink, so I shound it will do whatever to allowed to sleep it off, aggressive behavior to "Patient will be off Gazdays. Nursing will cont of withdrawal."  On 7/8/15, at 1:20 p.r was restricted from the having the bottle.  On 8/6/15, at 10:11 president had left with hereturned at 3:45 p.m.,	a.m. a note indicated R51 nurse practitioner, and the an adult and can drink and be an adult and can drink and c. "He is not hurting himself a.m. a note identified R51 spension from the Gazebo  note for R51 dated 7/2/15, aplaint as alcohol esident had a breathalyzer blood pressure was noted an a retake at 75/54. The anterview with the physician d, "I am fine, I went out with and the drinks. I am an adult and ant. I am here because I can et the opportunity again, I and myself or anyone else and be left alone." The and included, ebo program for three inue to monitor for any sign  m. the notes indicated R51 agazebo program due to	F	250			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245546	B. WING			05/1	17/2016
	ROVIDER OR SUPPLIER			34	TREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST MEDICINE LAKE BOULEVARD LYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 250	be monitored." It was refused the breathaly assessments. The regazebo policy was for a 8/17/15, at 3:51 p.m. Gazebo program in a p.m., attempting to ta documentation indicated to stop the resident, but returned at approxima paper bag, and a bott indicated staff had tal resident was verbally record lacked evident followed.  On 5/11/16, at 3:02 palcohol was taken from cabinet. A Code B (a controlled, where all was called since R54 threatening her. Whe was intoxicated, slurr at this time was 0.330 was running low. The called, and instructed encourage fluids, and decline.	a also documented R51 had zer as well as other cord lacked evidence the llowed.  . resident left after the taxi at approximately 3:13 ke a peer with him. The ted the SSD had attempted but he'd left anyway and had ately 3:46 p.m. with a brown le of alcohol in it. The notes ken the bag, and the abusive toward staff. The ce the Gazebo policy was  .m. the DON stated the m R54 and locked up in a behavior that cannot be available staff come to help) was following the staff and in the nurse went in, R54 ing his words. Breathalyzer 5, and his blood pressure e on call physician was a staff to monitor resident, if to call back if there was a	F	250			
	examined by a regist approximately 7:25 p intoxicated, fatigued, Breathalyzer was 0.3 and 86/54. Physician to monitor resident a back with a decline.	0 p.m. noted resident was ered nurse in his room at .m. He was "clearly and slurring his words." 136. Blood pressure 94/59 notified and orders received and encourage fluids. Call At 10:00 p.m. blood pressure ited at this time to be more					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245546	B. WING			05/17/2016	
	ROVIDER OR SUPPLIER NURSING HOME			STREET ADDRESS, CITY, STATE, ZI 3401 EAST MEDICINE LAKE BOU PLYMOUTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 250	awake, not slurring we The record lacked evi was followed.  - On 8/18/15, at 2:57 at 12:15 a.m. staff attern and resident was increasing language. Noted staff on resident every one  A Physician Progress identified a review of the where resident returned breathalyzer of 0.33. signs were now normal baseline. During interestable and the was "are cannot allow him to be facility. He was also as Gazebo program for 3 intoxicated." The progreducation and no orderincreased monitoring we Then note indicated numonitor for any signs of the facility via taxi at all was met at the door by alcohol bottles, and breaking Gazebo tome.  On 5/11/16, at 3:02 p.r. liked to go out and drinverified the Gazebo pooutside the program we	a.m. noted at approximately pted to obtain vital signs, easingly agitated, using foul obtaining frequent checks to two hours for safety.  Note dated 8/21/15, ne incident [dated 8/17/15] and to the facility and had a The note indicated the vital all and resident is back to his view with the physician, agry that the social workering his own 'Booze' into the nagry that he will be off the days since he got himself ress note identified no reswere provided for when R51 was intoxicated. It is incompared to proximately 6:00 p.m. and of the SSD. He turned in his eathalyzer was 0.141.  If by the SSD he will not be orrow.	F	250			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
		245546	B. WING_			5/17/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3401 EAST MEDICINE LAKE BOULEVA PLYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 250	Continued From page	∋ 20	F 2	250		
	had refused to showed had been informed he Gazebo program, so angry.  On 11/5/15, at 11:24 returned at 5:35 p.m. with his brother [left a indicated he was druibeing searched. The Gazebo policy having.  On 5/11/16, at 3:02 p should have been and the gazebo contract.  On 12/4/15, at 10:2 R51 had gone out at 6:00 p.m. a call had being under supervisibeen sent to the hos dated 12/4/15, indicated the host dated 12/4/15, indicated 12/4/1	A p.m. identified R51 had from going out on a visit at 12:05 p.m.] The note of				

PRINTED: 06/06/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRI	UCTION			E SURVEY IPLETED
		245546	B. WING		·		05	5/17/2016
	ROVIDER OR SUPPLIER			3401 EAST	DRESS, CITY, STATE, ZIP COD MEDICINE LAKE BOULEVA "H, MN 55441		<u>, 00</u>	11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
	had called the facility incident. The SSD als to eat, and the restaur liquor store. The SSD restaurant and gone to the liquor store had supplice, reporting some stated the facility did report. The DON state to take R51 to the hos return to the facility after fused the breathalyz said R51 had been de police and hospital to a calmed him down and The DON stated no also available from the hospital to increased monitoring, expectation that increased monitoring, expectation that increased monitoring he was not to be for the gazebo. The SS lunch, or he would not gazebo program and a serious lately because  - On 12/5/15, at 1:47 prindicated R51 had not Gazebo for breaking red (drinking alcohol outsice).	m. the DON stated dispatch regarding the 12/4/15 or stated R51 had gone out rant was across from a stated R51 had left the or the liquor store. Staff at absequently called the sone intoxicated. The SSD not have a copy of the police of she'd instructed dispatch pital for evaluation. Upon the resix hours, R51 had the return his alcohol. Staff had R51 returned to his room. Cohol levels or reports were pital. There was no record tacted for any orders of The DON confirmed her used monitoring would be an incident report. The DON costed a note on his door the disturbed unless it was SD stated R51 had to eat be able to attend the idded, "He is taking it more it is important to him."  Im. documentation been allowed to attend the ules yesterday [12/4/15] the Gazebo program).  Im. notes indicated R51	F	250				
	program until re-evalua							

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3401 EAST MEDICINE LAKE BOULEVARD  PLYMOUTH, MN 55441   (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAC REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION DATE
MISSION NURSING HOME  3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
(X4) ID SUMMARY STATEMENT OF THE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
DEFICIENCY)	
F 250 Continued From page 22 F 250	
When interviewed on 5/11/16, at 3:02 p.m. the SSD stated at that time R51 had been restricted from the Gazebo program for one day, which she verified did not correlate with the Gazebo Alcohol Program Contract which directed a one week violation for drinking outside of the gazebo program.  A Psychology Progress Note dated 2/16/16, identified R51 had been treated for depressed mood and alcohol use disorder. "Patient is now want [sic?] to control drinking program. He has not had any acute binge episodes that I am aware of recently." Previous visit with psychology was dated 11/17/15.  - On 1/10/16, at 1:44 p.m. notes indicated R51 quickly returned from the Gazebo program after receiving ice from staff. There was a covered coffee cup noted behind the resident. R51 was asked if staff could check the cup, and after R51 stated "yes" it was noted to smell of alcohol. The cup was taken, and the resident chased staff around the front lobby. The note indicated the SSD had been notified and R51 was restricted from the Gazebo policy was followed, which directed a one week violation for drinking outside of the Gazebo policy was followed, which directed a one week violation for drinking outside of the Gazebo program.  - On 2/3/16, at 4:53 p.m. R51's quarterly note identified when he participated in programs after the gazebo program, he was noted to be talking inappropriately/making sexual comments.  - On 2/29/16, at 7:32 a.m. R51's quarterly to take a Keppra level drawn, and became verbally	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245546	B. WING	h		05/17/2016	
	ROVIDER OR SUPPLIER  NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
F 250	aggressive with the prindicated R51 had constomping his feet and be awakened for anyth program.  On 5/11/16, at 3:02 p.r a history of only wantin Gazebo program, statin needed to eat lunch be program, and had bee SSD stated there had gazebo program for refrom behaviors of yellin his room to offer service.  On 3/13/16, 12:19 p.r been yelling at staff in administer insulin, and door indicated to never gazebo program.  On 3/13/16, at 9:41 p had again stated staff is the Gazebo program.  On 3/14/16, at 2:49 a be offered insulin prior indicated R51 had state WAKE MEONLY WA  On 3/31/16, at 5:45 p for gait training due to a attempting to be seen at the constant of the program of the program of the constant of the program	me to nursing station later, yelling he did not want to hing but the Gazebo  m. the SSD stated R51 had ng to be awakened for the ing he'd been informed he efore attending the n compliant with this. The been no restriction from the fusing therapy/services, or ng at staff when they enterces.  m. notes indicated R51 had his room for waking him to had stated the sign on his r wake him except for the  m. notes indicated R51 should only wake him for  m. resident was noted to	F2	250			
		gency. I only want to be					

	GRATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE (X2) MULTIPLE (X2) MULTIPLE (X3) PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE (X6) PROVIDER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/S		CONSTRUCTION (X3) DATE SURVEY COMPLETED				
		245546	B. WING			05/1	17/2016
	ROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 250	Continued From page	e 24	F:	250			
	- On 5/6/16, at 8:55 p be awakened for any	.m. R51 requested to never thing but the Gazebo.					
	and stated he had be year and a half, and I program ever since. I to this nursing home and smoke." R51 stathe program, but was specified. "I didn't re sign to participate." I alcohol was purchase locked up. "I have be occasions, when I drawe." R51 stated whad only been restrict drink on outings anyreto take me on outings.	a.m. R51 was interviewed en at the facility for about a had been part of the Gazebo He said he'd agreed to come "because I was able to drink ted he signed a contract for not exactly sure what it ad it thoroughly. I had to Further, R51 stated the ed by the SSD, and it was en restricted on one or two ank more than I should hen he was hospitalized, he sted for 1-2 days. "I don't more. I have nobody locally s. I would if I could." The but "I am probably gonna"					
	program on 5/11/16, residents need to as evaluated by the interest of the series of th						
	The facility's undated Use, identified: "Put	d policy Alcohol and Drug pose: A primary mission of					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(	(X3) DATE SURVEY COMPLETED	
		245546	B. WNG			05/	17/2016
	PROVIDER OR SUPPLIER  NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP C 3401 EAST MEDICINE LAKE BOULE PLYMOUTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIAT		(X5) COMPLETION DATE
	Mission Nursing Home residents who are christed the efforts of residents facility also recognizes relapse or continue to This policy is adopted use of alcohol and dru and healthy environme supporting and encour the policy included:  1. Mission Nursing Home efforts at sobriety and assistance at all times  2. In order to participathe resident will be assand the behavior mans  3. The use or possess building is not permitte searches are conducted alcohol in the building.  4. Inappropriate behavior alcohol will not be all addressed according to management policy.  An undated facility policindicated "violent, crim behavior in public will resident in public will facility." Examples of seasault (including three also identified other in affecting the health, sa resident and/or the con allowed. "Residents when the sidents were seasoned."	e is to provide care to conically chemically couraging and supporting at to maintain sobriety, the se that some persons will use alcohol and drugs. To provide guidelines on the gray with the goals of a safe cent in mind, while also raging sobriety." In addition the will support any and all is available to give you the in the Gazebo program, researed by therapy, nursing, reagement committee. The did also not alcohol in the did. Random room and to ensure there is no the facility behavior.  To titled Behavior Policy, inal or inappropriate sexual not be tolerated by Mission onts who engage in such the discharged from the use lock behavior included ats of assault). The policy appropriate behavior in fety, or welfare of the normality would not be no engage in such behavior at the behavior twice will	F	250			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S COMPL	
		245546	B. WING		05/1	7/2016
	PROVIDER OR SUPPLIER I NURSING HOME	,	3	TREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 256	such behavior included 483.20(g) - (j) ASSES ACCURACY/COORD The assessment must resident's status.  A registered nurse meach assessment wit participation of health A registered nurse massessment is completed in the complete and willfully and knowing false statement in a subject to a civil more \$1,000 for each asses willfully and knowing to certify a material aresident assessment.  Clinical disagreemer material and false statement in the complete assessment.  Clinical disagreemer material and false statement in the complete assessment.  This REQUIREMEN by:  Based on interview	ed self-endangerment.  SSMENT DINATION/CERTIFIED  st accurately reflect the  ust conduct or coordinate the the appropriate of professionals.  ust sign and certify that the eted.  completes a portion of the of and certify the accuracy of sessment.  Medicaid, an individual who by certifies a material and resident assessment is sey penalty of not more than sesment; or an individual who by causes another individual and false statement in a is subject to a civil money than \$5,000 for each  at does not constitute a stement.  T is not met as evidenced and document review, the are 1 of 1 residents (R66) was	F 250		urately  n  ct  II  eviewed  nce	8/1/2016

I A. BOILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
245546 B. WNG		05/47/0040		
NULL OF DESCRIPTION OF COLUMN	DRESS, CITY, STATE, ZIP CODE	05/17/2016		
MISSION NURSING HOME 3401 EAST	MEDICINE LAKE BOULEVARD H, MN 55441			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
F 278  Continued From page 27 Preadmission Screening and Resident Review.  Findings include:  R66's admission Minimum Data Set (MDS) dated 3/10/16, incorrectly identified R66's requirement for a Level II Preadmission Screening and Resident Review (PASRR) for residents with a mental illness, mental retardation or related illness. The MDS indicated that R66 had not been assessed for a Level II PASRR, and the MDS should have indicated the resident had been screened for a Level II PASRR.  R66's Evaluative Report Level II Preadmission Screening for Persons with Mental Retardation or Related Conditions indicated R66 was evaluated on 8/8/14. R66's proposed date of admission to the facility was 2/3/11. The Level II PASRR was completed by Hennepin County and indicated R66 had mental retardation and R6's medical needs required nursing facility services. The Level II PASRR further indicated "This person does require active treatment. The local agency assures that all active treatment needs have been specified in this person's individual service plan and will be met while this person resides in the nursing facility."  When interviewed on 5/13/16, at 10:27 a.m. the director of nursing (DON) stated that it appeared there was an error in documentation, on the MDS and it should have been documented as yes. The DON further stated that individualized services were not provided according to the the Level II PASRR as the facility did not have the Individualized service plan (ISP) from the county agency. If the MDS had been coded correctly the county could have been contacted for the ISP, so				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245546	B. WNG		05/17/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MISSION	NURSING HOME		- 1	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		N
F 278 F 312 SS=D	the facility could prov 483.25(a)(3) ADL CA DEPENDENT RESID A resident who is una daily living receives the maintain good nutritic and oral hygiene.  This REQUIREMENT by: Based on observation review, the facility fail assistance with shaving 38) who required assiliving.  Findings include: R38 was admitted to quarterly Minimum D 2/16/16, identified R3 impairment. Further in him as having Alzheithospice care, and reassistance with personal R38's care plan date having a self care destaff to assist with grifurther specified for shis face and hands."	ide the needed services. RE PROVIDED FOR ENTS  ble to carry out activities of the necessary services to the necessary services (R is the necessary services of the necessary services (R is the necessary services of the necessary services to the necessar	F 278		ctivities ces to ersonal an has d & care d and ate on care and form de all assure heets ed. QA	
	R38's face sheet inc	luded an admission photo in				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245546	B. WING			05	/17/2016
	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441	1	2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 312	which R38 had a thick On 5/9/16, at 7:00 p.m in his wheelchair. Whi (inch) long, were note scattered on both che On 5/10/16, at 11:33 a with the same white his cattered on both cheapproximately the sam On 5/11/16 at 8:24 a.m concerns that R38 warenough. F-A further the receiving assistance with F-A stated that shaving R38, who had been "the you can imagine" regains on to state that shavin him." FA-1 stated R38 in his younger years a about the mustache be on 5/11/16, at 7:14 a.m sitting in his wheelchaic cart. R38 continued to his upper lip and cheeks was lor on 5/9/16.  On 5/12/16, at 7:43 a.m sitting in wheelchair earoom. His hair appear R38 stated he had had	a white and gray mustache.  In. R38 was observed sitting the hairs, approximately 1/8" don his upper lip and eks.  In. R38 was observed elies on his upper lip and eks.  In. R38 was observed elies on his upper lip and eks. The stubble was the as the day before.  In., family member (F)-A had as not being shaved often ought that R38 was only with shaving once a week. It is not being shaved often ought shaving. FA-1 went go was very important to the most particular person riding shaving. FA-1 went go was a huge thing for always kept his mustache and would "not feel good" eling shaved.  In. R38 was again observed r, waiting by a medication have white facial hair on ks. The hair on R38's upper iger than when observed  In. R38 was observed witing breakfast in the dining wet and had been combed.  In a bath that morning. The lip and cheeks was now go.	F	312			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245546	B. WING_			05/17/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 312	(NA)-M stated that R bathing, and shaving aides and the facility stated shaving was t nursing assistants, nhad his own razor ar resident use as well. refused offers to sha that morning. Later the R38 was observed s looking out the windeshaven, including the On 5/13/16, at 1:39 at (LPN)-B stated R38 and facility staff and residents were shaving the stated nursing staff wheeded it because the LPN-B further stated identified how often groomed. LPN-B vershaving with morning cares under the facility explained if the document of the document	e 30 38 received grooming, passistance from the hospice nursing assistants. NA-M he responsibility of the facility of hospice. NA-M stated R38 nd there was a floor razor for NA-M stated R38 never ve and NA-M shaved him hat same day at 11:29 a.m. itting in his wheelchair ow. His face was clean e hair on his upper lip.  a.m., licensed practical nurse was shaved by both hospice went on to state that most ed every third day. LPN-B would shave a resident if they ney would "see it [facial hair]." I residents' care plans they needed to shaved or rified nursing staff charted g cares and documented on lity document entitled "ADL ling) Care Provided." LPN-B umentation reported shaving then R38 was not shaved that  B a.m. LPN-A stated shaving a daily event and was g. LPN-A stated the facility finding electric razors at one me nursing staff did not know stric razors. LPN-A further sume nursing staff would s part of grooming but has had l-A was unaware of where sharted grooming cares.	F3	112			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245546	B. WNG_		0/	5/17/2016	
	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARI PLYMOUTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 312	ADL Care Provided sł 5/11/16 to 5/16/16. Do	neets were reviewed from ocumentation identified that	F3	12			
	R38 was shaved once on 5/15/16 with extensive assistance. All other documentation under "shaving" between that period of time identified the "activity did not occur." ADL Care Provided care sheets were requested for the previous three months. None were provided.  A facility policy entitled Resident Cares Grooming, last reviewed 4/20/06, directed staff to "Assist or supervise each resident with shaving on a daily basis."  F 323 483.25(h) FREE OF ACCIDENT						
1			F 33		nts to live in. n Nursing Hom		
SS=J	as is possible; and ead	re that the resident as free of accident hazards		are considered at risk for potent abuse.  1 . Develop Alcohol/Substance U assessment with acuity score. Responsible: DSS, DON  2.Alcohol use potential will be caplanned and revised quarterly ansignificant change at care conferences idents. Current residents care	Jse risk are d with ences on all	7/18/2016	
	by: Based on interview ar facility failed to compredevelop safety interver consumption to reduce harm to residents or ot withdrawal for 3 of 3 residents.	ntions related to alcohol the risk of significant hers, and to monitor for sidents (R11, R51, R54) nsume alcohol, become ere not being medically and in an immediate		be updated to include individualial alcohol use potential, intervention determined by the assessment.  3. All residents will have complet by 7/22/2016. Residents with alcoholic incidents over the last six (6) morpriority.  Responsible: Social Workers  New assessment tool will be revious QA committee meeting.  Repsonsible: Nurse Managers, D	zed ns as ed assessments cohol related nths will be ewed at next	8/5/2016	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245546	B. WING_			05/1	7/2016
		ATEMENT OF DEFICIENCIES			101 EAST MEDICINE LAKE BOULEVARD LYMOUTH, MN 55441 PROVIDER'S PLAN OF CORRECTION	I (X5) BE COMPLETION	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	Κ	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
F 323	R51 had an extremely reading and clinical stappropriate intervention determined R11, R51 for significant harm distribution including comprehensimplementation of appased on facility protop.m. the facility admir (DON), and social se	rdy began on 7/1/15, when y elevated breathalyzer	F3	323	Revise alcohol drug use policy to include consequences of alcohol use on LOA, in include breathalyzing, room searches, p searches, adjusting monitoring level. R to submit to a breathalyzer, in-house ale consumption (outside of the Gazebo proor returning from an LOA intoxicated v trigger a resident's current set of param (restrictions) to the next higher level batheir individual circumstances. This wittrigger initiation of intoxication impairs protocol.  An alcohol related infraction will trigge	nay erson efusal cohol ogram) vill eters sed on ll ment	5/18/2016
	was removed on 5/17 noncompliance rema and severity level, wi immediate jeopardy ( The facility policy Alc identified: "Purpose: Mission Nursing Hom residents who are ch dependent. While en the efforts of resident facility also recognize relapse or continue to This policy is adopter use of alcohol and drand healthy environn supporting and encothe policy included:  1. Mission Nursing Hefforts at sobriety an assistance at all time 2. In order to particip	7/16, at 2:30 p.m., but ined at an isolated scope th actual harm that is not (Level G).  chol and Drug Use, undated, A primary mission of the is to provide care to ronically chemically couraging and supporting test to maintain sobriety, the est hat some persons will to use alcohol and drugs. It to provide guidelines on the rugs, with the goals of a safe the in mind, while also uraging sobriety." In addition the dome will support any and all d is available to give you			moving up one or more monitoring level one week and then will be re-evaluated IDT continues to review all alcohol relatincidents each week day.  Responsible Director of Social Service Quality assurance committee review at meeting  Selected residents (R51, R11, R54) will the revised alcohol policy. Current resiwill also be signing the updated policy. Responsible: DSS	els for by IDT. ated (DSS) next I sign dents	8/1/2016

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION -	(X3) DATE SURVEY COMPLETED	
		245546	B. WING		05/	/17/2016
NAME OF PROVIDER			,	STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
and the search alcohology aphysic provides and the search alcohology. An unconditional and the search alcohology aphysic provides the search allower a	e use or posses g is not permitte les are conduct in the building perpopriate behavior in the building perpopriate behavior in public will g Home. Reside or in public will "Examples of st (including three entified other in and/or the cood. "Residents wite and who repetharged from the heavior includents signed authour oundings seenable suspicion to the policy income can result in g procedures".	agement committee. sion of alcohol in the ed. Random room ed to ensure there is no	F 323	Develop individualized resident alcoholoplan of care for R51, R11, R54 (on-going risks of drinking with their dipraising for policy compliance, breathal upon return to facility, search upon ever to the facility).  Responsible: DON, Nurse Managers R51: Goal: will comply with MNH ale policy through next review.  Ensure R51 has no containers in his when going down for Gazebo program. Follow Intoxication/Impairment Assess Tool and protocal indicated as needed. Praise R51 for compliance with alcohol policies.  Remind R51 about the rules r/t alcoholout of the Gazebo program.  Room check random and when suspicional coholopossession.  Search R51 upon reentry into building. Include looking in socks.  When intoxicated encourage R51 to drinand Gatorade, eat food and rest.  Ongoing monitoring for seizure activity history of alcohol withdrawal related set.	liagnosis, lyze bry return cohol declchair sment in and on of	5/18/2016

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245546	B. WNG		05/1	17/2016
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	area, usually in the ballowed anywhere els grounds.  2. If you drink alcoho the gazebo program, room or on your perslevel 4 (cannot go our escort) and you will bas follows:  First violation = Can Second violation Third violation = 3. When you received door monitor.  4. Upon return from searched for alcohol.  5. There may be a seperson if staff suspectationals.  9. If you return from abeen drinking alcohogazebo that day.  10. If you fall, get intaggressive, and/or dibehaviors after you galcohol, you will be pthe gazebo program. In increasing restriction in increasing restriction in the program that dwith breathalyzer will serve in the program that dwith breathalyzer will serve in the gazebo so galangerous health serverses.	be done in the designated arbershop. No drinking is e in the building or on the lint the building, outside of alcohol is found in your on, you will be placed on of the building without an erestricted from the gazebo one week to we weeks off program or buy alcohol give it to the earth of your room or the that you are hiding an outing, and you have the you cannot go to the control of the gazebo and drink the total of the gazebo and drink the graph of	F 323	R11: Goal: R11 will allow Intoxication Impairment Assessment Tool when in through next review Breathalyzer on any return to facility. Follow Intoxication/Impairment Assess Tool protocol when alcohol use is known suspected. Observe for and document any symptote alcohol use per Intoxication/Impairment Assessment Tool. Ongoing education regarding risks of alcohol consumption on health and sat Random room search and for suspicion possession of alcohol. Search for any alcohol upon return to Search to include checking socks. When R11 is intoxicated encourage we Gatorade intake, food intake and rest.	dicated sment wn or oms of nt continued ety. n of facility.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245546	B. WING			05/	17/2016
	ROVIDER OR SUPPLIER . NURSING HOME			3	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	without an escort), an gazebo for two weeks  An undated facility po System, identified a le residents. The purpos keep the residents sat behaviors while out in Classification assess admission and annual was been a change in reviewed at each quar Classifications were:  Level II: A resider restrictions.  Level II: A reside around the building for the resident does not at the door monitor will gresident could be char restricted level for failing limitations of this level Level III: Resider remain within eyesight the front yard).  Level IV: Residents behavioral issues or sideficits are also in Level V: Residents on their individual floor other floor without escond and with each social ward and with each social ward and with each social ward behavioral with each social ward and ward	d will be restricted from the  dicy, Resident Monitoring system for all e of this system was to fe and prevent them from the community.  In the community.  In the reafter unless there condition. The levels were terly care conference.  In the can go out without the can sign out and walk rup to half an hour.  If return within half an hour, or out and find them. The leged to another more leged to another leged to anot	FS		R54 is currently discharged to an assiste living facility however until he was disc the following plan was put into place: R54: Goal: R54 will have no injury r/t a consumption through next review. Check belongings after each outing for a check socks as well. Document summary of each episode in notes. If impaired indicators are identified, mo closely for safety by following Intoxicat Impairment assessment. Ongoing education to R54 regarding the and risks of alcohol use with Atrial flutt Praise R54 for demonstrating alcohol pocompliance. Random room checks for alcohol. Remind R54 and visitors that alcohol make brought on the premises Remove any found alcohol and report finto DON and DSS. When R54 is intoxicated encourage water Gatorade, food intake and rest.	charged lcohol alcohol. progress nitor ion/ effects er. licy ay not	

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245546	B. WNG		05/17/	2016	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVAR PLYMOUTH, MN 55441				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE C	(X5) OMPLETION DATE	
F 323	an understanding of alcohol/drugs within pass. This included of privileges available of the provider did not consisted in the provider did not consisted, or have any refusal of the breath or frequency and ler monitoring for intoxic R11's quarterly Mining 3/8/16, identified add 3/1/02. It also identified pendence with a decision making, and depressed or hopele independent with a can active diagnoses in an active diagnoses of implementation of care R11's behavioral symptom and rejection of care R11'	all rules related to the use of the facility and when out on the use of alcohol and the when the rules were followed.  ecords indicated that ies were in place, the sistently use the leveling consistent protocol for use or alyzer, vital sign monitoring, and of clinical and safety cated residents.  mum Data Set (MDS) dated mission to the facility on fied R11 had modified cognitive skills for daily demonstrated feeling down, ass. R11 was noted to be citivities of daily living (ADLs). Cluded diabetes mellitus, mentia, anxiety, depression, ation deficit, alcoholic dalcohol dependence. The R11 exhibited other is not directed toward others, e.	F 323	Develop Intoxication/Impairment Ass Tool (to aide in determining intoxicati & appropriate protocol). Responsible- Director of Nursing (DC Medical Records (MRD) Quality assurance committee review a meeting. Create policy for using the Intoxicatio Impairment Tool (to aide in determini intoxication level & appropriate proto To be done on any resident return fror or in-house demonstrating symptoms impairment. Responsible- DON, DSS, MRD Quality Assurance committee review meeting. Medical Director informed of new po	ion level 5/ ON), at next on/ ng col). on LOA of at next	'18/2016	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245546	B. WING			O.F.	6/17/2016
	PROVIDER OR SUPPLIER  NURSING HOME			3	STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EAGH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 323	behaviors.  R11's medical record I assessment related to R11's medical record I Drug Use policy. The shis own responsible part R11's care plan dated potential alteration in dependence. It also it dependence. It also it out 'for a few drinks'. I encouraging sobriety, initiated 12/11/11), privinget along with roomma physical and verbal agalso indicated R11 was due to alcohol or drug included: independent orthostatic blood presslacked specific interveluse.  The facility provided a Listing by Room dated identified as a Level II information provided or On 5/16/16, at 10:01 a director (SSD) was asklevel information for R1 was unsure why R11 was elevel information for R1 was unsure why R11 was elevel I, and Everyone knows this."	acked a comprehensive safety of alcohol use.  acked a signed Alcohol and face sheet identified R11 as arty.  4/8/16, identified a cognition related to alcohol dentified a history of going interventions included: Level I monitoring (date vate room due to inability to ates, and identifying gression. The care plan as at moderate risk for falls use. Interventions with transfers, and observe sure monthly. The care plan intions related to alcohol  Resident Classification 4/18/16. R11 was (which contradicted in the care plan).  m. the social service (ed about the conflicting in the SSD stated she was a Level II on the intions. The SSD stated, has been since 9/23/12.	F		Revise the Resident Monitoring (Level to include initial placement at a level IV individual circumstances may warrant a change and how staff will be notified or Greater restriction (monitoring) will och non-compliance, lesser restrictions (monor compliance with the program.  Responsible: SSD  Provide staff education on the revised a policy and the Intoxication/Impairment for all staff now, with new hire and year Responsible: DON  Provide education to the nursing staff of Intoxication/impairment assessment too with new hire and yearly  Responsible: DON, Nurse Managers	V, a level f change cur for nitoring) lcohol policy rly n the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	(X3) DATE SURVEY COMPLETED			
		245546	B. WNG		05/	17/2016
	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	last 90 days. Addition on the form. The asshad a current issue wan extensive history cirrhosis of the liver, alcohol-induced persidentified with no fall assessment indicated confrontational with sespecially if drinking. The Medication Admi 4/15, identified a phyindicating if R11 went was to do a breathaly breathalyzer was refuminute checks. The othe 15 minute checks. Review of R11's progethrough 5/14/16, identified a phyindicating if R11 went was to do a breathaly breathalyzer was refuminute checks. The othe 15 minute checks. Review of R11's progethrough 5/14/16, identified a minute checks. The other section is a staffing a section of the sect	nally, no seizures were noted essment did indicate R11 with alcohol and/or drug use, of alcoholism, alcoholic drunkenness, and isting dementia. R11 was risk on this assessment. The difference of continue of con	F 323	All alcohol related incidences will be a at IDT meeting every week day. Alcohol specific related incidents will added to the quality assurance agenda including: frequency, severity, circums residents having more incidents than ocertain dates, one resident obtaining for Will be addressed at the next QA communication (including Medical Director, Pharmace Department Managers). Responsible: DSS, Admin Assistant Focused Quality Assurance Meeting so regarding alcohol incidents (policy revise held 5/17/2016. Medical Director of forwarded the new policies and protocoto meeting for review; and has sent ferometing for review; and has sent ferometing for review; and has sent ferometing for review and has sent ferometing for review.	be (report stance, thers, or others) mittee ist & cheduled view) to was ols prior edback.	5/18/2016

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245546	B. WING			05/17/2016	
	ROVIDER OR SUPPLIER NURSING HOME			34	REET ADDRESS, CITY, STATE, ZIP CODE 01 EAST MEDICINE LAKE BOULEVARD LYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDEO BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	was observed blockin the door monitoring significant yelling racial slurs to significant was informed if his the police would be cand returned at 10:05 teeth, and leaning on informed the police work was informed the police work was informed the police work was also informed the police work was informed the police work was informed the police work was informed and appeared in a verbal altercation with the authority of the direction of the direction was informed to get the suspected he had been informed to get work was completed to the work was completed in the suspected was completed to the work was completed in the suspected was suspected when the suspected was completed in the suspected was completed was completed in the suspected was completed was com	dentified at 9:50 p.m. R11 g the door entrance, with taff outside. R11 began staff and threatening to door monitor." R11 walked tening manner, swearing, e physically harmed staff, alled. R11 went to his room, p.m. cursing, gritting his the nursing station. He was ould be called if he didn't o noted R11's eyes were ." R11 was checked on x 2 to have calmed down.  In. R11 confronted and had th a peer, and when being ning room, began to king the motion of a fist, back in the dining room. In had slurred speech and an drinking. R11 stated, I'm gonna knock the shit out ling incident report dated d, but lacked any additional  I'm. the DON stated she halyzer to have been I, 15 minute checks  The SSD and administrator aviors with R11, and he was	F	323			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ŀ	IIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		245546	B. WING_		0	5/17/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 3401 EAST MEDICINE LAKE BOULEV PLYMOUTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	A S A A A S S S S S S S S S S S S S S S	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 323	police will be called to understood and certa called due to his behat that he will be given a are any more inciden leaving soon anyway was going he could in Administrator reiterat and he again said that hours later he came to he was given a disch to find a place for him responded yes.  - 6/19/15, at 9:30 a.m entry) identified R11 given notice to leave  - 7/5/15, at 5:36 p.m. with a peer, threateni Four staff intervened from each other.  - 7/7/15, at 7:46 p.m. altercation with a peer yelling and cursing at a cordinal pain, and ordered. R11 stated room, I'll kill them."  -8/20/15, at 1:24 a.m issues to staff. He the became agitated 9/4/15, at 4:32 p.m. appeared to be drun administrator entered.	co assist. He stated that he inly did not want the police aviors. Finally he was told a notice to discharge if there its, he responded with "I am "and when asked where he ot give an answer. He deverything one final time at he understood. A couple of up to this writer and said if arge notice we would have in to go and this writer.  In (documented as a late was told that he would be if his behaviors continued.  R11 had a verbal altercation ing to "beat each other up." until the peers walked away  R11 was in a verbal er, entering peer's room, it peer.  In R11 complained of an abdominal x-ray was "Don't send them in my  In R11 was complaining about then began cursing and  In staff reported to nurse R11	F	323			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245546	B. WING	-		05	/17/2016
	ROVIDER OR SUPPLIER  NURSING HOME	·		STREET ADDRESS, CITY, STATE, ZIP CO 3401 EAST MEDICINE LAKE BOULEV PLYMOUTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
F 323	last night or this morn speech was somewharead 0.204, and a rete 0.203. "This writer an reminded him of a dist that he understood that happened again he wileave. He said that he writer then informed himade for the Glennworesidential facility for chomeless men and wo planning could begin. this."  On 5/11/16, at 4:21 p. I would expect 15 minul for refusal of the breat report to be completed On 5/17/16, at 12:50 preferred to the Glennwaccepted there, due to (surgical procedure the large intestine out thro despite the fact that R cares for this. The rearesidents share a bath – 9/8/15, at 10:22 p.m. near the door in his roobut refused breathalyz assessment. Residen police I am already in the incident report comple "possibly" give resident discharge.  On 5/11/16, at 4:21 p.r.	ing, R11 denied it. His at slurred. Breathalyzer set of the breathalyzer was death Administrator then cussion in which he stated at if an incident like this build be given a notice to be remembered this. This im that a referral would be ood, (wethouse) [a hronically alcoholic and omen], so that discharge He stated understanding of the stated understanding the stated that sign the abdominal wall), and is independent in the son provided was that room.  R11 was found on the floor om. He appeared drunk er and vital sign that stated "don't call the rouble." Corresponding ted, identified plan to the all of the stated understanding the stated understanding ted, identified plan to the stated understanding ted, identified plan to the stated understanding ted.  In the DON verified no allable related to 15 minute	F	323			

AND DIAM OF CORDECTION DESCRIPTION NUMBERS		(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245546	B. WING		05/	17/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441		•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	BE	(X5) COMPLETION DATE
F 323	R11's room. R11 refu informed if he did not the same as saying the R11 continued to refure 10/19/15, at 6:15 p.m. and returned at 90.105.  - 10/23/15, at 10:19 pp.m 9:35 pm. Breaton 10/31/15 at 7:15 p.m. altercation with house incident report complifurther information.  - 11/7/15, at 7:27 p.m. returning at 7:11 p.m 11/9/15, at 9:45 p.m. returned at 8:50 p.m 11/16/15, at 12:30 a station asking for marefused. He became cursing". Staff attemprefused to listen and - 11/16/15, at 6:30 p. from 6:30 p.m 8:30 0.08.  On 5/11/16, at 4:21 p.m.	Staff reported R11 D and another staff entered used breathalyzer. He was do the breathalyzer, "it was nat he had been drinking." se, and closed his eyes.  m. R11 left facility at 8:30 9:50 p.m. Breathalyzer read  c.m. R11 went out from 5:45 thalyzer read 0.162.  m. R11 had a verbal ekeeping. A corresponding eted on 10/31/15 lacked any  m. R11 went out at 6:50 p.m., m. Breathalyzer read 0.022.  m. R11 left at 8:00 p.m., and m. R11 to the nurses edication he had previously "very upset and began of the totalk with R11, but he walked off to his room.  m. R11 out of the building p.m. Breathalyzer was  m. R11 out of the building p.m. Breathalyzer was  m. R11 out of the building p.m. Breathalyzer was	F 325	3		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL: A. BUILDI	TIPLE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED	
		245546	B. WING			05/17/2016	
	PROVIDER OR SUPPLIER  NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP 3401 EAST MEDICINE LAKE BOUL PLYMOUTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETION DATE	
F 323	- 11/19/15, at 10:54 p. and breathalyzer read  When interviewed on DON stated breathaly. limit, and she wouldn't monitoring. The DON and would expect hers been notified of any in any amount, and would completed.  - 12/24/15, at 5:30 p.m cans of beer in his roo it down the drain when cursing, slammed the foot.  On 5/11/16, at 4:21 p.m breathalyzer was done room search revealed was notified of this incifurther symptoms, and minute checks. Further aggressive, but he was alcohol.  - 3/29/16, at 9:13 p.m. p.m. and returned at 9: being down by the lake was 0.143.  - 4/13/16, at 9:06 p.m. refused breathalyzer u.	m. R11 out of the building 1 0.06 upon return.  5/11/16, at 4:21 p.m. the zer was below the legal texpect any increased stated she was not notified, self or the SSD to have cident involving drinking of dexpect an incident report  a. R11 was found with two m, observed to be dumping a staff entered. R11 began cabinet door shut with his  a. The DON stated no a. The DON also stated a no further alcohol, and she ident. There were no a she would not expect 15 ar, the DON stated R11 was a also aggressive without  R11 left the facility at 6:20 and breathalyzer reading  R11 left the building and pon return.	F	323			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245546	B. WING _		0	5/17/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	When interviewed on director of nursing (D should have been co enhanced monitoring the breathalyzer. The protocol for enhanced However, the DON si on 15 minute checks breathalyzer per his protocol for enhanced However, the DON si on 15 minute checks breathalyzer per his protocol for enhanced However, the DON si on 15 minute checks breathalyzer per his protocol for the Gazebo protocol for	a 5/11/16, at 4:21 p.m. the iON) stated incident reports impleted, as well as when there was a refusal of a DON stated there was not do rincreased monitoring. Itated R11 should have been for refusal of the physician order.  b.m. the SSD stated R11 was rogram because he didn't es, and it was his right to verified that on 5/7/16 when reading was so high, R11 had be DON was unable to interest assessment at that time addings, or increased clinical graph having been done. The all have expected an incident a checks to have been seen as Review notes dated le does display some short as some of which could be the has episodes of impaired es also included, "He can ressive towards staff want him to do something. The physical staff is some of which graph him to do something. The physical staff is some of drinking inside or the physical staff is graph him to denying that he will remain actively involved and behavior management.	F3	323			

	TATEMENT OF ND PLAN OF C		
245546 B. WNG 05/17/20			
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX		
F 323  Continued From page 45 5/16/16, at 1:10 p.m., and 5/16/16, at 3:00 p.m., R11 was asleep in bed, and did not reply when spoken to.  On 5/11/16, at 6:55 a.m. the DON reiterated that if a resident returned intoxicated, she would expect a nursing assessment to be completed, and with a breathalyzer reading of 0.256, she would expect increased monitoring to be done. She also stated R11 had a history of coming back to the facility intoxicated, but was unable to find any documentation of increased monitoring done for any of the incidents when R11 returned with signs and symptoms of intoxication and refused a breathalyzer.  R51's quarterly MDS dated 4/28/16, identified the resident had modified independence in cognitive skillis for daily decision making, behavioral symptoms not directed toward others, and required the use of a wheelchair. Diagnoses included hypertension, diabetes mellitus, seizure disorder/epilepsy, and depression.  R51's CAA dated 11/3/15, identified diagnoses of acute alcohol intoxication/withdrawal, physical weakness, depression, limited range of motion, poor coordination, poor balance, and visual impairment. It also identified behavior problems including disruptive, loud talking in the dining room "especially after Gazebo/alcohol program."  The CAA noted impaired balance during transitions, and difficulty maintaining sitting balance as well as agitation and decreased mobility. The CAA lacked any direction or guidance in dealing with these behaviors. R51 did not have a comprehensive assessment related to the safe use of alcohol.	55 FF s Coliffee a w Stock and for significant		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245546	B. WING		a	5/17/2016	
	NAME OF PROVIDER OR SUPPLIER  MISSION NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	to participate in the G 8/7/15. However, the and Drug Use policy. R51 as his own response to the also identified R51 has related to being when alcohol with the Gazacare indicated both is problems, and poor junking due to alcohol plan also identified a behavior related to a intoxication/withdraw remind of the rules a program. The care placohol monitoring leteral The Resident Classifform, dated 4/18/16, Review of R51's prog 5/15/16, identified the A Physician Prograssidentified "Patient has returned from the holintoxication. Patient consume controlled facility."  - On 7/1/15, at 6:47 resident (R51) was controlled facility."	d included a signed contract bazebo program dated ere was not a signed Alcohol. The face sheet identified onsible party.  d 4/27/16, identified a self ficit related to alcohol use. It ad a potential risk for falls elchair bound, and the use of elbo program. The plan of ong and short term memory udgement and decision of dependence. The care in alteration in mood and cute alcohol ral. Interventions included to round the gazebo/ alcohol lan failed to identify R51's vel.  fication Listing By Room identified R51 as a Level III.	F 32				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245546	B. WING	B. WING		05/17/2016	
NAME OF PROVIDER OR SUPPLIER  MISSION NURSING HOME				STREET ADDRESS, CITY, STATE, ZIF 3401 EAST MEDICINE LAKE BOUL PLYMOUTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI: TAG		CTION SHOULD BE O THE APPROPRIA		ON
F 323	water. Blood pressure Physician notified and blood pressure every encourage fluids. Oth identified resident left and returned at 1:05 p breathalyzer was 0.25 whiskey in his room, v liquor cabinet. An incident on 7/1 instructed to not drink. evidence their Gazebo On 5/11/16, at 3:02 p.mess up like this wher would be suspended f are sent to the hospital and been seen by the note indicated R51 is a smoke when he wants or anyone else."  - On 7/2/15, at 1:59 p.m. was on a three day su program.  A Physician Progress identified the chief con intoxication. It noted reading of 0.258, and it to be low at 87/56, with note indicated during it the resident had stated someone and had son I will do whatever I wad drink and smoke. If I g	at 6:30 p.m. 87/53. I orders received to check four hours and continue to the received to check four hours and continue to the received to the state at 10:35 a.m. with his niece of the received and the staff found a bottle of which was locked in the dent report was completed report was completed report was followed.  The record lacked of policy was followed.  The staff found a bottle of which was locked in the ground the ground the ground the program, they for 3 days, or a week if they all or detox."  The indicated R51 nurse practitioner, and the ground t	F3	323			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED	
		245546	B. WNG			05/17/2016	
NAME OF PROVIDER OR SUPPLIER  MISSION NURSING HOME				3	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	when I drink, so I sho nursing progress not allowed to sleep it off aggressive behavior. "Patient will be off Gadays. Nursing will corof withdrawal."  - On 7/8/15, at 1:20 p was restricted from the having the bottle.  - On 8/6/15, at 10:11 resident had left with returned at 3:45 p.m. talkative. "Social worbe monitored." It was refused the breathaly assessments. The regazebo policy was for the completed as well as incidents.  - 8/17/15, at 3:51 p.m. Gazebo program in a p.m., attempting to talcoumentation indicated staff had taresident was verball record lacked evider followed.	uld be left alone." The es indicated R51 was , there was no report of towards staff and included, izebo program for three entinue to monitor for any sign of the management of	F	323			

PRINTED: 06/06/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ 245546 B. WNG 05/17/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD MISSION NURSING HOME PLYMOUTH, MN 55441 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 49 F 323 alcohol was taken from R54 and locked up in a cabinet. A Code B (a behavior that cannot be controlled, where all available staff come to help) was called since R54 was following the staff and threatening her. When the nurse went in, R54 was intoxicated, slurring his words. Breathalyzer at this time was 0.336, and his blood pressure was running low. The on call physician was called, and instructed staff to monitor resident, encourage fluids, and to call back if there was a decline. DON stated the blood pressure was stable later. Further, DON stated there is not policy or procedure to follow and the physician does not specify a frequency of the checks. - On 8/17/15, at 11:10 p.m. noted resident was examined by a registered nurse in his room at approximately 7:25 p.m. He was "clearly intoxicated, fatigued, and slurring his words." Breathalyzer was 0.336. Blood pressure 94/59 and 86/54. Physician notified and orders received to monitor resident and encourage fluids. Call back with a decline. At 10:00 p.m. blood pressure was 146/82. Also noted at this time to be more awake, not slurring words, and drinking fluids. The record lacked evidence the Gazebo policy was followed. On 5/11/16, at 3:02 p.m., the DON stated the only documentation of checks was in the note from the nurse which indicated R54 was checked on every 1-2 hours. She would expect that an incident report and increased monitoring were completed. - On 8/18/15, at 2:57 a.m. noted at approximately 12:15 a.m. staff attempted to obtain vital signs. and resident was increasingly agitated, using foul language. Noted staff obtaining frequent checks on resident every one to two hours for safety,

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245546	B. WING			05/	17/2016
NAME OF PROVIDER OR SUPPLIER  MISSION NURSING HOME			340	REET ADDRESS, CITY, STATE, ZIP CODE 01 EAST MEDICINE LAKE BOULEVARD YMOUTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	identified a review of where resident return breathalyzer of 0.33 signs were now normal baseline. During into R51 stated he was a can not allow him to facility. He was also Gazebo program for intoxicated." The producation and no or increased monitoring Then note indicated monitor for any signs.  - On 9/28/15, at 10:3 the facility via taxi at was met at the door alcohol bottles, and Resident was informattending Gazebo to On 5/11/16, at 3:02 liked to go out and overified the Gazebo	s Note dated 8/21/15, If the incident [dated 8/17/15] Ined to the facility and had a The note indicated the vital Ineal and resident is back to his Ineal and resident is back t	F	3323	J. M. LINGTON, M. L.		
	suspension, which hassuming that he is The DON stated the available to use for She indicated an incommonitoring should has a constant of the c	would result in a one week and not been enforced in this are DON also stated, "we are going to go out and drinking." are was no assessment residents consuming alcohol. Cident report and increased ave been initiated.  33 p.m. notes indicated R51 wer the evening before, and he could not attend the					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245546	B. WING			05/17/2016	
NAME OF PROVIDER OR SUPPLIER  MISSION NURSING HOME				STREET ADDRESS, CITY, STATE 3401 EAST MEDICINE LAKE E PLYMOUTH, MN 55441	•		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFI TAG	(EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)		
F 323	Gazebo program, so angry.  - On 11/5/15, at 11:24 returned at 5:35 p.m. with his brother [left a indicated he was druit being searched. The Gazebo policy having.  On 5/11/16, at 3:02 p incident report should breathalyzer offered, completed. At that times should have been and the gazebo contract.  - On 12/4/15, at 10:26 R51 had gone out at 6:00 p.m. a call had being under supervisit been sent to the hosp dated 12/4/15, indicated ambulance. "Report to liquor store in Plymou were called. Arrives we intoxication and slurring wheelchair bound. Redetox center." Further "Patient was conversited loss of consciousness 30 seconds. Patient to Came to after 30 seconds. Patient!	A p.m. identified R51 had from going out on a visit at 12:05 p.m.] The note had and went to his room after record lacked evidence the peen implemented,  I.m. the DON stated an and enhanced monitoring the the SSD also stated there estriction for not following  B p.m. the notes indicated fiz:05 p.m. At approximately een received about the at a local liquor store, and on of the police. R51 had ital. The hospital visit note ed R51 had arrived via the patient was outside a the with intoxication. Police with appearance of the gwords. Patient is prortedly lives at Mission or information included, and in room when he had a on the cart lasting about unresponsive to sternal rub, ands and started yelling at note from this visit increasing agitation; or his belongings and to be	F	323			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245546	B. WNG			05/	17/2016
	ROVIDER OR SUPPLIER			34	REET ADDRESS, CITY, STATE, ZIP CODE 101 EAST MEDICINE LAKE BOULEVARD LYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page On 5/11/16, at 3:02 p had called the facility incident. The SSD als to eat, and the restau liquor store. The SSD restaurant and gone the liquor store had s police, reporting som stated the facility did report. The DON stat to take R51 to the ho return to the facility a refused the breathaly said R51 had been d police and hospital to calmed him down an The DON stated no a available from the ho if a physician was co increased monitoring expectation that incre completed as well as also stated R54 had stating he was not to for the gazebo. The s lunch, orhe would no gazebo program and serious lately becaus - On 12/5/15, at 1:47 indicated R51 had no Gazebo for breaking (drinking alcohol out - On 12/5/15, at 6:48	m. the DON stated dispatch regarding the 12/4/15 so stated R51 had gone out rant was across from a postated R51 had left the to the liquor store. Staff at subsequently called the eone intoxicated. The SSD not have a copy of the police ed she'd instructed dispatch spital for evaluation. Upon fiter six hours, R51 had exer or vital signs. The DON emanding staff call the enterty return his alcohol. Staff had do R51 returned to his room. Silcohol levels or reports were spital. There was no record exercised for any orders of the DON confirmed her exercised monitoring would be an incident report. The DON posted a note on his door be disturbed unless it was SSD stated R51 had to eat the able to attend the added, "He is taking it more see it is important to him."  p.m. documentation of been allowed to attend the rules yesterday [12/4/15] side the Gazebo program).		323			
	had not been allowe	d to attend the Gazebo luated after the weekend.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245546	B. WING			05	/17/2016
	NAME OF PROVIDER OR SUPPLIER  MISSION NURSING HOME			3	STREET ADDRESS, CITY, STATE, ZIP CODE 1401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	When interviewed on DON stated an incider completed, as well as SSD also stated at the restricted from the Ga which she verified did Gazebo Alcohol Progra one week violation for gazebo program.  A Psychology Progres identified R51 had been mood and alcohol use want [sic?] to control of not had any acute bing of recently." Previous dated 11/17/15.  - On 1/10/16, at 1:44 progressing ice from staff coffee cup noted behind asked if staff could che stated "yes" it was not cup was taken, and the around the front lobby. SSD had been notified from the Gazebo the for rules. The record lack policy was followed, wiviolation for drinking or program.  - On 2/3/16, at 4:53 p.r. identified when he part the gazebo program, hinappropriately/making	5/11/16, at 3:02 p.m. the nt report should have been increased monitoring. The at time that R51 had been zebo program for one day, not correlate with the am Contract which directed or drinking outside of the solutions. Note dated 2/16/16, on treated for depressed disorder. "Patient is now brinking program. He has ge episodes that I am aware visit with psychology was solved the cazebo program after for the Gazebo program after for the Gazebo program after for the was a covered and the resident. R51 was sock the cup, and after R51 and R51 was restricted ollowing day for breaking and R51 was restricted ollowing day for breaking and R51 was restricted ollowing day for breaking and R51 was restricted on the Gazebo hich directed a one week utside of the Gazebo.  The R51's quarterly note icipated in programs after a was noted to be talking	F	323			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A, BUILDII	IIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245546	B, WING_		05/17/2016		
NAME OF PROVIDER OR SUPPLIER  MISSION NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP COD 3401 EAST MEDICINE LAKE BOULEVAR PLYMOUTH, MN 55441	)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ADAGA DECEDENACA TO THE	SHOULD BE COMPLETION		
F 323	Keppra level drawn, aggressive with the pindicated R51 had costomping his feet and be awakened for any program.  A Physician note dat "Patient taking Kepp on request. Nursing keppra level next lat since admission to the company of only war Gazebo program, stoneeded to eat lunch program, and had be SSD stated there has gazebo program for from behaviors of yehis room to offer ser - On 3/13/16, 12:19 been yelling at staff administer insulin, a door indicated to ne gazebo program.  - On 3/13/16, at 9:4	and became verbally oblebotomist. The notes ome to nursing station later, d yelling he did not want to ything but the Gazebo  sed 4/12/16, indicated, ara, refused keppra level draw will attempt again to draw obday. No report of seizures the facility."  p.m. the SSD stated R51 had atting to be awakened for the atting he'd been informed he before attending the een compliant with this. The ad been no restriction from the refusing therapy/services, or elling at staff when they entervices.  p.m. notes indicated R51 had in his room for waking him to and had stated the sign on his ever wake him except for the	F	323 .			
	be offered insulin prindicated R51 had s	9 a.m. resident was noted to rior to lunch. The notes stated, "NODO NOT EVER WAKE ME FOR GAZEBO."					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245546	B. WNG		0	5/17/2016
	PROVIDER OR SUPPLIER  I NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP 3401 EAST MEDICINE LAKE BOUL PLYMOUTH, MN 55441	CODE	5/1//2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O  X (EACH CORRECTIVE AC  CROSS-REFERENCED TO  DEFICIEN	CTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETION DATE
F 323	"Random blood gluco since beginning of Feihigher in the 300s in to the since beginning of Feihigher in the 300s in to the since beginning of Feihigher in the 300s in to the since a part of this program out at 9.4 as at 1/11/16, whas gone 2 point high also indicated, "Patier in Feb [February] 2010 ranging from 132-180 No report of hypoglyce Patient reported to be finger sticks at times."  - On 3/31/16, at 5:45 program to the seen and the since and the since and the since and the since a part of this program. To the sidents cannot drint are a part of this program out and drinking, intoxicated, staff are expended to the since a per nursing should be chemonitor them through the sidents cannot the sidents of the sidents of the penursing should be chemonitor them through the sidents cannot the sidents of the penursing should be chemonitor them through the sidents of the sidents of the sidents of the penursing should be chemonitor them through the sidents of the sidents of the sidents of the penursing should be chemonitor them through the sidents of the sidents	se high from 112 to 298 bruary till date, has been he past months. HgbA1c ides information about a rels of blood glucose, also er the past 3 months) high ras 7.7 in October 2015. er than before." The note it was started on Latus [sik] 6, random blood glucose since the beginning of April. emia, seizure from nursing. refusing blood draws and  o.m. Therapy discontinued resident either refusing or after the gazebo program.  o.m. R51 was informed of his son. R51 stated "I do rgency. I only want to be "  m. R51 requested to never uing but the Gazebo.  o.m. the DON stated no n completed on residents unless they are a part of he DON stated, k at the facility unless they am, and should not be If they come back expected to ask if a erformed. If this is refused,	F3	323		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245546	B. WING		05/	17/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	anyone drinking." The specific policy about breathalyzer level she physician but stated, program and goes of program for a specific the SSD and administrated the SSD and administrated the second that all incidents involved the second to the	hysician should be notified of e DON stated there was no when results of the ould be reported to the "If a person is on the gazebo ut drinking, they are off the c amount of time. After that, strator handle the resident, ation of the policies at the lso stated she would expect	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION NUMBER: A. BUILDING			(X3) D	(X3) DATE SURVEY COMPLETED			
		245546	B. WING				05/17/2016
	ROVIDER OR SUPPLIER  NURSING HOME			3401	ET ADDRESS, CITY, STATE, ZIP CODE EAST MEDICINE LAKE BOULEVARD MOUTH, MN 55441	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROVIDENCY)		D BE	(X5) COMPLETION DATE
F 323	residents, except that program.  R54's annual MDS da medical diagnoses wh disorder and depressimpairment.  R54's Social Services indicated R54 had a himpaired judgement sedependence. The revial cohol related probler any significant behavior social services would interventions including planning as needed.  R54's CAA for psychological services would entervention including planning as needed.  R54's CAA for psychological services would entervention to control of seizures, which were currently there was not a service was not seizures, which were currently there was not seizures and otter failed to address if the others at risk for injury. R54 was independent (ADL's) and had one failed to address if the others at risk for injury. R54 was independent (ADL's) and had one failed to address in the others at risk for injury. R54 was independent (ADL's) and had one failed to address in the others at risk for injury. R54 was independent (ADL's) and had one failed to address in the others at risk for injury. R54 was independent (ADL's) and had one failed to address in the others at risk for injury. R54 was independent (ADL's) and had one failed to address in the others at risk for injury. R54 was independent (ADL's) and had one failed to address in the others at risk for injury. R54 was independent (ADL's) and had one failed to address in the others at risk for injury. R54's care plan dated	R51 was in the Gazebo  ted 12/19/15, identified and included a seizure on, with no memory  Review dated 12/14/15, istory of significantly accondary to alcohol ew identified R54 had no ms and had not displayed ors. The review included continue with active at 1:1 visits and discharge alcohol induced and alcohol use.  Idated 3/10/16, identified ons and cues and/or red. The MDS identified her behaviors, however behaviors put himself or at MDS also identified with activities of daily living all without injury since	F	323			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDIN	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		245546	B. WING_			5/17/2016
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVAR PLYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	fall on 3/3/16, related Interventions included whereabouts and saf is sitting outside. The R54's alcohol abuse may drink which coul The interventions lists should do if his ADL's The care plan also as independent in bed mambulation with a fout the facility and outsid R54 to be independed walker throughout the care plan dated 4/8/1 behavior and mood weither at the facility of denying he did it, with discharge planning. In the facility of denying he did it, with discharge planning. In the facility of denying he did it, with discharge planning. In the facility of denying he did it, with discharge planning. In the facility of denying he did it, with discharge planning. In the facility safety interest of the facility safety inter	to admission as well as a to suspected drinking. d staff to observe the ety of the resident when he care plan also addressed and that R54 will go out and d alter his ability with ADL's. ed did not address what staff is were altered do to drinking. ddressed R54 was nobility, transfers and in wheeled walker throughout le. Interventions included int with ambulation with the e facility and outside. The 6, identified an alteration in with episodes of drinking r outside the facility and then in refusals to comply with interventions listed included concerns and develop d refer to psychologist as incerns. The care plan failed rentions for R54.  The (NP) note dated 3/4/16, elong/ current alcohol abuse, and he will drink any longer.  It lacked any daily tracking for exchol use.  It 4/11/16, identified staff repatient returned from	F 33	23		
	also identified that R and had refused bre	left in a cab daily. The note 54 had falls without injury athalyzer testing. The NP eiving a 30 day notice soon				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245546	B. WING			OE	5/17/2016
	ROVIDER OR SUPPLIER  NURSING HOME			34	TREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST MEDICINE LAKE BOULEVARD LYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD IT TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE
F 323	may be necessary to drinking is allowed and R54's medical record Drug Use policy R54's Order Summary 5/9/16, included diagnother dependence and major The undated nursing a staff to observe for drifthere was alcohol on Find The Resident Classific dated 4/18/16, indicated to be searched The information was no plan.  A progress note dated had a history of alcoholomation was found. A breathaly the the resident's read informed that since he having behaviors he will determine the determined that the determined that the control of the complex of the demonitoring or follow up the facility short termined the definition of the control of	his chronic alcoholism it find him housing where d monitored.  lacked a signed Alcohol and report, last reviewed on oses of alcohol or depressive disorder.  assistant sheet, directed hing and alert the nurse if R54's breath.  action Listing By Room and R54 was a Level 1 and drupon return to the facility, ot included on R54's care  12/13/16, identified R54 all abuse.  2/10/16, indicated a staff she thought R54 had been de had been drinking. A seconducted and no alcohol rever was administered and ing was 0.177, R54 was was not acting drunk or ould not need to go to becumentation lacked any	F	323			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE :			
		245546	B. WNG			05/	17/2016		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 323	stated bags were to be Further, SSD stated to R54 an alternate place company was working stated R54 fell when significant alcohol use stated it would not be while taking Keppra. documentation was a monitoring and no incompleted.  The facility's incident following alcohol relation alcohol relation was found.  On 5/11/16, at 11:15 p.m by the entryway to the was found.  On 5/11/16, at 3:52 per breathalyzer was conchecked with the neurisk for falls when he a skin tear on his right. Resident smelled like alcohol, denies drink breathalyzer. DON report bottles at bedside. Not be the neurological asset on 5/11/16, at 3:52 per	he searched upon his return. hey are working on finding hement, and the insurance g with him on this. The DON he drinks, and has a he history. The DON also he advised for R54 to drink The DON stated no havillable on increased hident report had been  log identified R54 had the hed incidents:  h. R54 was found on the floor he room and a alcohol bottle  h.m. the DON stated no hipleted. Vital signs were her assessment. "He is at his drinking." R54 sustained hat elbow from the fall.  R54 fell in his room. He had been drinking hing and refused to do hotified. Three full Gatorade vital sign checks done with hessment.  h.m. the DON stated he was completed. The SSD hice was provided, the he informed and the he (IDT) would discuss it. She	F	323					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245546	B. WING			01	5/17/2016
	ROVIDER OR SUPPLIER NURSING HOME			340	REET ADDRESS, CITY, STATE, ZIP CODE 1 EAST MEDICINE LAKE BOULEVARD VMOUTH, MN 55441	1 00	, 111 <u>2010</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORR		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
	The SSD stated she to discussed placement believe his last day is - 4/11/16, at 7:50 p.m. go to bed, smelled of a - 4/23/16, at 3:45 p.m. smelled of alcohol.  On 5/11/16, at 3:52 p.m. smelled of alcohol.  On 5/11/16, at 3:52 p.m. would expect staff to dincident report, and not was considered a high drinking. The SSD stat (alcoholics anonymous these guys are not goi R54's Comprehensive 3/3/16, identified R54 smelled bottle of vodka was founable to do a breathan ot blow into the device a 1/2 centimeter abras R54's blood pressure was resulted increased lew in reach and no more a investigation section id to have been consumir analysis and plan included increased included in	alked with the county and options, and stated "I the 14th [5/14/16]".  R54 fell in room trying to alcohol.  R54 found on the floor and  m. the DON stated she all the physician, do an tify the administrator. R54 fall risk when he was ted "We have AA s) that comes here, but ng to do that."  Fall Report Form dated was found on the floor on the and the floor. R54 was lyzer as the resident could be correctly. R54 sustained from the floor. R54 was lyzer as the resident could be correctly. R54 sustained from the floor. R54 was lyzer as the resident could be correctly. R54 sustained from the floor. R54 was lyzer as the resident could be correctly. R54 sustained from the floor. R54 was lyzer as the resident could be correctly. R54 sustained from the floor. R54 was lyzer as the resident could be correctly. R54 sustained from the floor on the floor. R54 was lyzer as the resident could be correctly. R54 sustained from the floor. R54 was lyzer as the resident could be correctly. R54 sustained from the floor. R54 was lyzer as the resident could be correctly. R54 sustained from the floor. R54 was lyzer as the resident could be correctly. R54 sustained from the floor. R54 was lyzer as the resident could be correctly. R54 sustained from the floor. R54 was lyzer as the resident could be correctly. R54 sustained from the floor. R54 was lyzer as the resident could be correctly. R54 sustained from the floor. R54 was lyzer as the resident could be correctly. R54 sustained from the floor. R54 was lyzer as the resident could be correctly. R54 sustained from the floor. R54 was lyzer as the resident could be correctly. R54 sustained from the floor on the floor. R54 was lyzer as the resident could be correctly. R54 sustained from the floor on the floor. R54 was lyzer as the resident could be correctly. R54 sustained from the floor on the floor. R54 was lyzer as the resident floor.	F	323			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	IPLE CONSTRUCTION  NG	COMPLETED
		245546	B. WING_		05/17/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVAR PLYMOUTH, MN 55441	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 323	R54's Social Service indicated R54 had so deficits, especially af episodes of impaired identified throughout episodes of drinking coming back or "som into the facility and d was no evidence an to identify how R54 v. A progress note date identified R54 had fa back. No injuries we pain. R54's pupils whe was drinking alcoalcohol and refused checks were started and director of nursi pressure 128/72 and 94/56 and pulse 88 not provide the correfall Report Form for note on 4/9/16, indic of alcohol and had to the bedside. The content dated 4/11/16, re-educated on alcoalcohol.  R54's Monthly Nurs 4/19/16, indicated Fwithin the last month the gazebo program	Review dated 3/11/16, ome short term memory fiter drinking along with some I judgement. The review also the quarter R54 had either out of the facility and nehow" was sneaking it back trinking in his room. There investigation was completed was accessing alcohol.  and 4/8/16 at 9:49 p.m. allen and was found on his re noted and R54 denied ere dilated and smelled like whol. R54 denied drinking to do a breathalyzer. Neuro , blood pressure running low ng notified. Initial blood of pulse 87. Blood pressure at 9:35 p.m. The facility did esponding Comprehensive this incident. A progress cated R54 continued to smell three full Gatorade bottles at prresponding IDT progress	F:	323	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED
		245546	B. WING			05/17/2016
	PROVIDER OR SUPPLIER  NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP COI 3401 EAST MEDICINE LAKE BOULEVA PLYMOUTH, MN 55441	_	35,117,23,70
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULE TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)		(X5) COMPLETION DATE
F 323	drinking and refused a smelled of alcohol.  R54's Comprehensive 4/23/16, identified R54 near his bed and he sidrinking. R54 was not was 116/65 with a pulsinterventions included supervision, call light is resident to keep walke investigation section ic resident has smelled obreathalyzer. The final continue to search residentified that R54 smelled a breathalyzer test and started due to unwitned corresponding progressidentified that R54 smelled a breathalyzer test and started due to unwitned corresponding IDT revidentified that R54 smelled a breathalyzer test and started due to unwitned corresponding IDT revidentified that R54 safety consumption.  R54's Fall/Safety Risk Assessment dated 3/10 recent fall for R54 was to be a high fall risk duconsumption resulting the alcohol policy and pwith the resident. No of R54's safety were identified this room. R	Fall Report Form dated was found on the floor melled like he had been injured. His blood pressure se of 75. Immediate increased level of a reach and encourage or within reach. The itentified all falls to this point of alcohol and refuses a analysis and plan included ident upon returns to the pain of alcohol policy. The se note dated 4/23/16, elled of alcohol and refused if neuro checks were seed fall. The item progress note dated if were to continue to search mind him of the alcohol interventions identified to by related to his alcohol.  Evaluation and D/16, indicated the most 3/3/16. R54 was assessed et a recent alcohol in a fall without injury and procedures were reviewed their interventions to ensure tified.	F	323		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	TIPLE CONSTRUCTION		(X3) DATE: COMPI	
		245546	B, WING			05/	17/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 3401 EAST MEDICINE LAKE BOULEVA PLYMOUTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIAT		(X5) COMPLETION DATE
F 323	(RM)-A stated that the that needed their bag the facility. RM-A stated but did not "frisk" the found on the resident know. RM-A further s residents stumbling of was on the list to be facility, but RM-A had.  When interviewed on stated he occasionall not drink at the facility the gazebo club. R54 stated the nurses had breathalyzer when he without explaining who of the facility staff me about his drinking his continue drinking. R54 he had problems with than socially, just for On 5/10/16, at 3:38 p assistant (TMA)-B ex TMA-B stated the so assessment before r program. The reside of the program and if in the program on a sparticipating in the protection of the program on a showed they haven't participate in the proresidents that participating that participate in the proresidents that participating that the state of the program in the professional showed they haven't participate in the professional state of the program in the professional showed they haven't participate in the professional state of the program in the professional showed they haven't participate in the professional state of the program in the professional showed they haven't participate in the professional state of the program in the professional showed they haven't participate in the professional state of the program in the professional showed they haven't participate in the professional state of the program in the professional state of the professional state of the professional state of	.m. the resident monitor ere were residents identified as checked upon return to see the searched their bags residents. If alcohol was as we let the charge nurse stated that he looked for or smelling of alcohol. R54 searched upon return to the dinever found alcohol on him.  1.5/16/16, at 1:09 p.m. R54 by had some drinks, but can by because he was not part of a denied drinking, however we asked him to do a sea returned to the facility, by R54 further stated none embers have ever asked him story or whether he wanted to a drinking in the past, more something to do.  2.m. trained medication calcined the gazebo program.	F	323			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		245546	B. WING		0	5/17/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP ( 3401 EAST MEDICINE LAKE BOULE PLYMOUTH, MN 55441	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	was part of the gazeb had seen R51 intoxica facility from a pass for family. TMA-B stated to three times and he breathalyzer when he refused a breathalyzer and he was sent to be "punishment R51 coul gazebo program for a punishment is only thr stated that if a resider should be checked for complete checks ever TMA-B further stated 3. The front desk was su when residents return  On 5/12/16, at 10:41 a smelled like alcohol, b found on him.  On 5/12/16, at 10:46 a came back to the facility. None to two times per mast residents used to had been drinking, but anymore. NA-O stated gazebo program but houtside of the program.  On 5/11/16, from 3:02 SSD, and administrator together. The SSD staif a resident was intoxidone and the resident.	o program, however TMA-B ated after returning to the the day with friends or that she had seen this two often refused a came back. When R51 rhis medications were held at to sleep it off. For Id not participate in the week, but sometimes the ee days, it varies." TMA-B at was intoxicated vital signs the twenty-four hours and yfifteen minutes for a time, sometimes R51 refused, pposed to check for alcohol from leave.  I.m. TMA-C stated R51 ut alcohol hasn't been  I.m. NA-O stated that R11 fty and had been drinking. R11 had snuck alcohol lA-O stated it happened nonth. NA-O stated in the be sent to detox when they ithe facility doesn't do that R51 drank with the ad been known to drink as well.	F	323		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245546	B. WING			05/	17/2016
	ROVIDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 1401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	monitored by checkin DON did not define frindicated the frequen discretion, and confin not been completed fincidences of alcohol further verified after dompliance related to Gazebo program, and out of the facility, that was lacking assessm non-compliance. The needed to be more downs unaware of the facility until they'd stated action after the IJ all residents on the fingo out of the facility abut not all residents in The DON also stated be notified of any including the amount report should be comfacility needed a plan among the nurses. The attention, as we do he safety."  On 5/16/16, at 1:37 plants in R54. No specompleted to determ assessment with the included social services sometimes a therapy therapy. "We look at see how they are dochanges would be more allowed."	g on them frequently. The equently. The administrator cy would be at the nurse's med frequent monitoring had or these documented use. The administrator liscussing the issues of the residents on the dithe residents drinking while the facility's documentation ent and consequences of administrator stated there ocumentation and that he extent of the drinking at the red talking with staff for was called. The DON stated staffoor have the potential to and come back intoxicated, have the motivation to do so, that she or the SSD were to dents involving alcohol, of alcohol, and an incident pleted. She indicated the late of the SSD stated, "It needs ave concerns for their of any level changes with cific written assessment was the levels, just an informal IDT. The SSD said the IDT	F	323			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245546	B. WING			05/1	17/2016
	PROVIDER OR SUPPLIER  NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR  (EACH CORRECTIVE ACTION SH  CROSS-REFERENCED TO THE AP  DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
	changes to the care p "The residents are exp they leave the building resident monitors at the allowed to leave the b privileges, which deter when leaving the build official assessment to  When interviewed on a social services director role with chemically de determining their histor the initial care confere interdisciplinary treatm is appropriate for the in acknowledged if reside could be a danger to the was unable to state which stated definitely if they R51 would have a seiz much.  The IJ that began on 5 5/17/16, when the facil for alcohol use and sat care plans for the iden updated, policies had it developed, an intoxica assessment tool was of	lan regarding the levels. Dected to sign out when gon a sheet with the ge front door. Residents are uilding based on their level mines their safety level ling. However, there is no determine the levels."  5/17/16, at 12:50 p.m. the r (SSD) stated part of her ependent residents is ry. The SSD stated during nce, she lets the sent team (IDT) know what ndividual resident. The SSD ents drink "too much" they nemselves or others, but nat "too much" was, but get alcohol poisoning, or if rure, that would be too  1/12/16, was removed on ity ensured assessments fety had been completed, tified residents had been peen revised and/or ation/impairment leveloped, and it could be at staff had been educated entions. UTRITION STATUS LE	F 3	25			

			(X3) DATE COMP			
		245546	B. WING		05/	17/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDIGINE LAKE BOULEVARD PLYMOUTH, MN 55441		·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 325	status, such as body unless the resident's demonstrates that thi (2) Receives a theragnutritional problem.  This REQUIREMENT by: Based on observation review, the facility fai interventions had been for 1 of 1 residents (For weight loss.  Findings include: R44's order summany indicated R44's diaground cerebral vascular accomplete the loss of los	able parameters of nutritional weight and protein levels,	F 32	Mission strives to ensure that reside maintain body weight and other clin and will receive a therapeutic diet is clinical condition causes a nutrition 1. R44t's and all other residents reconsupplements and their amounts were the MAR 2. Nurse Manager or designee will documentation of amount consume for residents on supplements for for weeks.  3. TMA will be responsible for disponsible for dispons	nical levels If their al problem. eiving e added to audit MAR d weekly or (4) eensing ents as menting be educated ing gers y QA	6/27/2016

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245546	B. WING		ĺ	05/17/	/2016
	ROVIDER OR SUPPLIER NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVAR PLYMOUTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE		(X5) OMPLETION DATE
F 325	A dietitian note dated not maintained weight significant weight loss indicated R44 appears with weight loss. A die indicated R44 remains unable to maintain we R44's care plan dated following problem: Resultritionally due to sign month, skipping break increased needs for he directed staff to providordered, Magic cup two monitor R44 at meal rown Magic cup in the morn meals and if R44 refus On 5/9/16, at 5:55 p.m in the dining room nex observed giving R69 that assistant (NA)-N state when R44 gave R69 that attempt to stop it. NA-different supplement. If Magic cup to R69 "a loo On 5/16/16, at 12:57 p dining room with other R44's Magic cup was a table with a few bites of An interview on 5/16/1 medication assistant (T) gave R44 the Magic cup and other times and the document of the computer or t	3/7/16, indicated R44 had a since admission and had a . The dietitian note ed at moderate to high risk stitian note dated 4/21/16, ed at high risk and was ight.  4/2/16, identified the sident appears at high risk nificant weight loss in one fast, dementia, and ealing fracture. The plan e house supplements as to times a day with meals, bunds, offer R44 to eat ing, record daily intake of ses to have staff feed R44.  1. R44 was observed sitting to R69. R44 was me Magic cup. Nursing do "no no don't do that" he Magic cup but made no end offer R44 a was eating in the residents at the table. Supplements at the table opened and sitting on the gone from the cup.  6, at 1:22 p.m. with trained TMA-A and gave him a few ometimes R44 took the mes it was declined.  Jumentation of intake was uter by the TMA-A, but was room staff.  The R44 was in the small	F	325			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245546	B. WING_			05/17/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI 3401 EAST MEDICINE LAKE BOULEVAR PLYMOUTH, MN 55441			
(X4) ID PREFiX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 325	residents in the room TMA-A was observed room with R44's Mag of the Magic cup from had to encourage R4 On 5/16/16, at 1:35 p (LPN)-A looked at the the second floor. The down for the resident stated lunch was don now, so staff didn't kr cup or not. On 5/16/16, at 2:04 p stated the amount of resident should be do On 5/16/16, at 3:00 p (DM) stated R44's die if R44 was receiving stated staff talk to eareating the Magic cup documentation of a s Magic cup. The DM smade sure R44 did n other residents. The 50 percent of the me assessment." The DM considered at risk for weight. A facility policy Nutrit dated 5/16/14, indica will be recorded in th 483.25(n) INFLUENZ IMMUNIZATIONS	R44 stated lunch was fair. It to come into the small day ic cup and fed R44 the rest of the dining room. TMA-A 4 to eat the Magic cup.  In licensed practical nurse of meal monitoring book for rewere no intakes written is lunch intake. LPN-A e and the tables were clean now if R44 took the Magic of R44 took the Magic of R44 took the Magic of R44 to supplement taken by the focumented in the MAR.  In the dietary manager of card was looked at to see the Magic cup. The DM content to see if R44 was of the total of the total of the magic cup to DM indicated R44 took 25 to als, that is "my visual of stated R44 was weight loss and had lost in High Risk Monitoring ted intake of supplements of MAR.  It AND PNEUMOCOCCAL elop policies and procedures	F 3	25			
		influenza immunization, resident's legal					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245546	B. WING_		05	/17/2016	
	ROVIDER OR SUPPLIER NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPROL  DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 334	representative receive benefits and potential immunization; (ii) Each resident is of immunization October annually, unless the ir contraindicated or the immunized during this (iii) The resident or the representative has the immunization; and (iv) The resident's medocumentation that infollowing:  (A) That the resident representative was protected the benefits and potential immunization; and (B) That the resident influenza immunization influenza immunization ontraindications or resident that ensure that— (i) Before offering the jimmunization, each resident immunization, each resident immunization immunization, each resident immunization, each resident immunization, each resident immunization immunization, each resident immunization, each resident immunization immunization, each resident immunization immunization, each resident immunization im	es education regarding the side effects of the fered an influenza of through March 31 mmunization is medically resident has already been time period; resident's legal opportunity to refuse dical record includes dicates, at a minimum, the corresident's legal evided education regarding tial side effects of influenza either received the nordid not receive the nordid nor	F3	It is facility policy that all residents of offered influenza immunization. Bereceiving the immunization the resid legal representative will receive educe which will be documented along with they received immunization or not.  R68's immunizations were discussed attending physician. Resident will receive educe which will receive educe attending physician. Resident will receive educe will receive educe will be obtained as not current consents will be obtained as not current consents will be obtained as mot current consents will be obtained as mot current educated. Random weekly audit will be initiate Nurse Manager or designee of reside immunization record to assure immunication record to assure immunicated. All licensed nurses will be educated of for completing immunizations and redocumentation.  Responsible: Nurse Managers  Audit outcomes will be reported to the committee monthly for three (3) mon well as reviewed in Infection Prevent Control Committee.  Responsible: DON	ent or their ation whether with the ceive with the new ation.  I by the t's ization en as n process puired e QA hs, as		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		245546	B. WING			5/17/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVAR PLYMOUTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 334	following:  (A) That the resider representative was purely the benefits and potential pneumococcal immutes the pneumococcal immutes pneumococcal incontraindication or recontraindication or recontrai	ndicated, at a minimum, the  nt or resident's legal provided education regarding ential side effects of unization; and nt either received the unization or did not receive nmunization due to medical efusal. In based on an assessment In mendation, a second unization may be given after 5 une province of the province of	F 3:	34			
	by: Based on interview facility failed to main vaccination status for reviewed for influent Findings include: R68 was admitted to consent to receive the signed by R68 on the gave the facility convaccination annually medical contraindict have a facility representation and undated.	T is not met as evidenced and document review, the stain documentation of or 1 of 5 residents (R68) are vaccination status.  The facility on 7/30/15. A he influenza vaccination was see date of his admission. This sent to administer the y in the fall, unless there were ations. The consent did not sentative signature on it. And schedule of vaccinations we flu vacc. [vaccine] 0.5 ml					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DAT	(X3) DATE SURVEY COMPLETED	
		245546	B. WING_			05	/17/2016	
	ROVIDER OR SUPPLIER  NURSING HOME			STREET ADDRESS, CIT 3401 EAST MEDICINE PLYMOUTH, MN 55	LAKE BOULEVARD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION PRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 334	allergy to eggs. Docur when given." No admi documented, instead written on the sheet.  An additional influenzasigned 9/29/15, was recontained a facility rep Again, no additional domedication record as trinfluenza vaccination with the facility rep Again, no additional domedication record as trinfluenza vaccination of the influenza vac	scular], per MD orders if no ment on vaccination record nistration date was 'give in the fall" was hand a vaccination consent, eviewed for R68 and presentative's signature. Soumentation was in R68's to whether or not the was administered.  Jum Data Set (MDS) dated than don't received the during the influenza season.  The director of nursing is were able to give consent nation if they were their in the was unaware if R68 had vaccination. The DON was a information in his paper information in his paper information was documentation was documentation was documentation was a come Nursing Orders, I under INFLUENZA yearly flu vaccine 0.5 ml by Minnesota Health Dept. and or acute	F3	34				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245546	B. WING		05/17	7/2016
	ROVIDER OR SUPPLIER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 1401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	BE '	(X5) COMPLETION DATE
	new admission, admi indicated, and record medical record as we 483.45(a) PROVIDE/REHAB SERVICES  If specialized rehability not limited to, physical pathology, occupation health rehabilitative sand mental retardation resident's comprehermust provide the required services from accordance with §48 provider of specialized. This REQUIREMENT by:  Based on interview a facility failed to ensure plan was included as care planning process reviewed for Preadming Resident Review (PAF Findings include:	nister the vaccine if the vaccination in the Il as the vaccination record. OBTAIN SPECIALIZED  tative services such as, but al therapy, speech-language nal therapy, and mental ervices for mental illness in, are required in the sive plan of care, the facility uired services; or obtain the in an outside resource (in 3.75(h) of this part) from a d rehabilitative services.  T is not met as evidenced and document review, the e an individualized service part of the assessment and is for 1 of 1 resident (66) ission Screening and	F 334	Social Worker has been working with I County regarding resident's level II sor which indicated a need for active treatr for him to follow an ISP. SW spoke wi Nancy King and her supervisor. They is he has not been under active case mana and there is no ISP in Place. They belied does not need active case management Medical issues and need for nursing he placement. They did schedule a date ear month to come out and do his annual swhich is due in July. They were not ab come out sooner and will be here on July 7, 2016 at 10am. They will compl new level II screening at that time. The also change the screening to indicate h not need active treatment at that time us they feel there have been changes in his condition.  DSS will review all residents for Leve PASRR and ensure that it is being follows.	ment and ith indicated agement eve he due to ome arlier this screening le to ete a ey will e does unless is	7/15/2016
	3/10/16, indicated R6 R66's Order Summa included diagnoses of disabilities, impulse of and anxiety disorder 3/11/16, indicated R6	imum bata Set (MbS) dated 36 was cognitively impaired. ry Report dated 5/9/16, of unspecified intellectual disorder, conduct disorder R66's care plan dated 66 had an alteration in ed to a diagnosis of mental		indicated  DSS will review all Level II's to ensurplan is being followed. Will review m for three months then quarterly until Q determines compliance.  Responsible: DSS	e service conthly	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		245546	B. WNG_			05/17/2016
	ROVIDER OR SUPPLIER  NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 406	R66's Evaluative Reprogression and Annua (PASARR) indicated F 8/8/14. R66's propose facility was 2/3/11. The completed by Hennep R66 had mental retard needs required nursin Level II PASARR furth does require active treasures that all active specified in this person and will be met while the nursing facility."  R66's medical record in plan (ISP) by the local When interviewed on the medical record coordinate Level II PASARR was R66's previous facility not repeat Level II PASARR was R66's PASARR was continuous and the medical record back when interviewed on the licensed social worker R66's PASARR was continuous and annual record the medical record by the interviewed by the	ort Level II Preadmission I Resident Review R66 was evaluated on Id date of admission to the E Level II PASARR was in County and indicated dation and R66's medical g facility services. The ier indicated: "This person reatment. The local agency treatment needs have been in's individual service plan his person resides in the  lacked an individual service agency.  5/12/16, at 7:54 a.m. the nator stated that R66's accepted as it was from and that the county does SARR's unless the resident into a community setting.  5/12/16, at 8:37 a.m. (LSW)-B verified that completed on 8/8/14, and did view. LSW-B stated to ervices the facility waited to esident had and then made In addition, medications interdisciplinary team (IDT) ritions. LSW-B stated coted to set boundaries and	F 40	06		

NAME OF PROVIDER OR SUPPLIER  MISSION NURSING HOME  SUMMARY SYNTEMENT OF GETGERNIES  OCH INFORMATION WILL  PREFIX THE COLLAYORY OR IS & DENTIFYING NEFORMATION)  F 406  Continued From page 76 facility did not have a current ISP to ensure active treatment was being provided as directed by the PASARR and stated that R68 does not have an ISP because he resided in a nursing facility and not a group home setting.  On 5/13/16, at 0:36 a.m. the LSW-B stated that he had contacted the county today and R66 did not have an active ISP. The county was updating their software. LSW-B further stated R66 was last assessed by the county in 2015 and the facility did not have the most recent assessment on file. LSW-B had requested a copy from the county.  The county faxed the most recent Evaluative Report Level II PASARR to the facility, which indicated R66 was required nursing facility services. The Level II PASARR further indicated This person does required nursing facility services. The Level II PASARR further indicated This person does required nursing facility. No ISP was included in the Information from the county.  A policy for Level II PASARR was requested and none was provided by the facility. No ISP was included in the Information from the county.  A policy for Level II PASARR was requested and none was provided by the facility. No ISP was included in the Information from the county.  A policy for Level II PASARR was requested and none was provided by the facility. The facility was provided by the facility. The facility was provided by the facility. The facility must establish and maintain an	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
MISSION NURSING HOME  SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) (EACH DEFICIENCY MUST BE PRECEDED BY PLL (PARE) (EACH DEFICIENCY)  F 406  Continued From page 76 facility did not have a current ISP to ensure active treatment was being provided as directed by the PASARR and stated that R66 does not have an ISP because he resided in a nursing facility and not a group home settling.  On 5/13/16, at 9:36 a.m. the LSW-B stated that he had contacted the county today and R66 did not have an active social worker with the county and did not have an exist the social worker with the county and did not have an exist that the had contacted the social worker with the county and the facility did not have the most recent assessment on file. LSW-B had requested a copy from the county.  The county faxed the most recent Evaluative Report Level II PASARR was completed by Hennepin County and indicated R66 was re-evaluated on 7/1/16. R6's proposed date of admission to the facility was 2/3/11. The Level II PASARR was completed by Hennepin County and indicated R66 had mental retardation and R60's medical needs required nursing facility. No ISP was included in the information from the county.  A policy for Level II PASARR was requested and none was provided by the facility. No ISP was included in the information from the county.  A policy for Level II PASARR was requested and none was provided by the facility.  A policy for Level II PASARR was requested and none was provided by the facility.  SSFE SPREAD, LINENS			245546	B. WING			05/17/2016
F 406  Continued From page 76 facility did not have a current ISP to ensure active treatment was being provided as directed by the PASARR and stated that R66 does not have an ISP because he resided in a nursing facility and not a group home setting.  On 5/13/16, at 9:36 a.m. the LSW-B stated that he had contacted the county today and R66 did not have an active social worker with the county and idi not have an active social worker with the county and idi not have an active social worker with the county and idi not have the most freent assessment on file. LSW-B had requested a copy from the county.  The county faxed the most recent Evaluative Report Level II PASARR to the facility, which indicated R66 was re-evaluated on 7/1/15, R66s proposed date of admission to the facility was 2/3/11. The Level II PASARR was completed by Hennepin County and indicated R66 had mental retardation and R66's medical needs required nursing facility services. The Level II PASARR further indicated "This person does require active treatment. The local agency assures that all active treatment. The local agency assures that all active treatment. The local agency assures that all active treatment medes have been specified in this person's individual service plan and will be met while this person resides in the nursing facility." No ISP was included in the unsing facility." No ISP was included in the unsing facility. Pose provided by the facility.  F 441 SS=F SPREAD, LINENS					3401 EAST MEDICINE LAKE BOULEVAR		
facility did not have a current ISP to ensure active treatment was being provided as directed by the PASARR and stated that R66 does not have an ISP because he resided in a nursing facility and not a group home setting.  On 5/3/16, at 9:36 a.m. the LSW-B stated that he had contacted the county today and R66 did not have an active social worker with the county and did not have an active ISP. The county was updating their software. LSW-B further stated R66 was last assessed by the county in 2015 and the facility did not have the most recent assessment on file. LSW-B had requested a copy from the county.  The county faxed the most recent Evaluative Report Level II PASARR to the facility, which indicated R66 was re-evaluated on 77/1/15. R66's proposed date of admission to the facility was 2/3/11. The Level II PASARR was completed by Hennepin County and indicated R66 had mental retardation and R66's medical needs required nursing facility services. The Level II PASARR further indicated "This person does require active treatment. The local agency assures that all active treatment needs have been specified in this person's individual service plan and will be met while this person resides in the nursing facility." No ISP was included in the information from the county.  A policy for Level II PASARR was requested and none was provided by the facility.  F 441 SS=F SPREAD, LINENS	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X6) COMPLETION DATE
The dolling fluor complete and thursday are	F 441	facility did not have a treatment was being passar and stated in ISP because he reside not a group home set.  On 5/13/16, at 9:36 at he had contacted the not have an active so and did not have an aupdating their softwar R66 was last assessed the facility did not have assessment on file. In ISS and the facility did not have assessment on file. In ISS and the facility did not have assessment on file. In ISS and the facility did not have assessment on file. In ISS and the Report Level II PASSA indicated R66 was reproposed date of adr 2/3/11. The Level II Fennepin County and retardation and R669 nursing facility service further indicated "This treatment. The local active treatment need this person's individual met while this person facility." No ISP was from the county.  A policy for Level II in none was provided to 483.65 INFECTION SPREAD, LINENS	current ISP to ensure active provided as directed by the that R66 does not have an led in a nursing facility and ting.  .m. the LSW-B stated that county today and R66 did local worker with the county was re. LSW-B further stated and by the county in 2015 and we the most recent SW-B had requested a copy  .most recent Evaluative IRR to the facility, which revaluated on 7/1/15. R66's mission to the facility was PASARR was completed by dindicated R66 had mental as medical needs required les. The Level II PASARR is person does require active agency assures that all dis have been specified in last service plan and will be in resides in the nursing included in the information PASARR was requested and by the facility.  CONTROL, PREVENT				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245546	B. WING	B. WING			/17/2016
	ROVIDER OR SUPPLIER NURSING HOME			3	STREET ADDRESS, CITY, STATE, ZIP CODE 8401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441	<u> </u>	11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	<u>.</u>	(X5) COMPLETION DATE
	Infection Control Prog safe, sanitary and con to help prevent the de of disease and infection (a) Infection Control P. The facility must estab Program under which (1) Investigates, control in the facility; (2) Decides what proc should be applied to a (3) Maintains a record actions related to infect (b) Preventing Spread (1) When the Infection determines that a resign prevent the spread of it isolate the resident. (2) The facility must procommunicable disease from direct contact will trans (3) The facility must rehands after each direct hand washing is indicate professional practice.	ram designed to provide a infortable environment and velopment and transmission on.  rogram blish an Infection Control it - ols, and prevents infections edures, such as isolation, in individual resident; and of incidents and corrective ctions.  of Infection Control Program dent needs isolation to infection, the facility must ohibit employees with a ero infected skin lesions in residents or their food, if smit the disease. quire staff to wash their tresident contact for which ted by accepted	F	441	Mission Nursing Home has established ar implemented an infection control program under which it: investigates, controls, & p vents infections in the facility; decides whe procedures, such as isolation should be ap to an individual resident; and maintains a record of incidents & corrective actions re to infections. To assure continued complit the following plan has been implemented: The resident infection tracking form will be continued. Use of the infection tracking for will be completed at the time of discovery Nurse Managers will review all new order ensure all infections and cultures are documented on the log.  The infection tracking will be reviewed we in the Interdisciplinary Team Meeting (ID) Infection control tracking will be reviewed analyzed for trends, discussed and evaluate in the monthly Infection Prevention & Cor Committee (IPACC), and presented to the committee at each meeting.  Responsible: DON	n pre- hat oplied elated iance : be form // rs to reekly OT) d, ted ntrol	7/29/2016
	by:	is not met as evidenced d document review, the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		245546	B. WNG		O.E	5/17/2016	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  3401 EAST MEDICINE LAKE BOULEVARD  PLYMOUTH, MN 55441				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
F 441	Continued From page facility failed to develon infection control prog	op a comprehensive	F4	41			
,	comprehensive surve symptoms and culture	illance of resident es and analysis of that I the potential to affect all 85					
	Findings include:						
	Control Logs from 3/ infections were identi infections (UTI's), 17 cellulitis/wound infect infections. All UTI and treated with antibiotic logs lacked evidence tracking to support ar either changed or ext respiratory infections pneumonia) without e cultures/symptoms to extension of antibiotic identified antibiotic of respiratory infection of	respiratory infections, 11 ions, and 2 unidentified d respiratory infections were therapies, however, the of cultures and symptom hibiotic use. Antibiotics were rended on 2 UTI's and 3 (excluding aspiration evidence of support the change or of therapies. The logs hanges for 1 UTI and 1					
	facility lacked any do surveillance infection On 5/13/16, at 2:37 p (DON) stated the infection out by the floor nurse. The logs were review monthly quality assurate did not have a warveillance. The DC of antibiotics the first previous month. She	cumented analysis of the control logs.  b.m., the director of nursing ection control logs were filled as as the infections occurred.  yed by her and in their rance (QA) meetings, but					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/06/2016 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB N	O. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245546	B. WING			O.F	5/17/2016	
	ROVIDER OR SUPPLIER NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION ST TAG CROSS-REFERENCED TO THE AP DEFICIENCY)		BE	(X5) COMPLETION DATE	
F 490 SS=D	to obtain the cultures She further stated syr in the residents' progr were documented on  The facility policy Infe revised in 2013, estate program was to "provi investigation and mon extent possible, the or infection." Furthermor surveillance/monitorin culture and sensitivity to identify types of org monitor for antibiotic re identify potential trans between residents" ar for infections, compile and bring reports to th oversight committee." 483.75 EFFECTIVE ADMINISTRATION/RE A facility must be adm enables it to use its re efficiently to attain or re	and the expectation would be and document on the logs. Inptoms were documented ess notes. No symptoms the logs.  Inction Control Program, shished the intent of the de surveillance, itoring to prevent, to the inset and the spread of e, the policy identified g as to "review microbiology reports on a regular basis anisms causing infections, esistant organisms, and mission of organisms and to "perform surveillance and analyze data, prepare e Infection Control  ESIDENT WELL-BEING  inistered in a manner that sources effectively and maintain the highest mental, and psychosocial		441	DEFIGIENCY)			
	by: Based on interview ar facility failed to ensure addressed concerns o	nts (R11, R51, and R54)						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
		245546	B. WING_			05/	17/2016
	ROVIDER OR SUPPLIER NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441		01 EAST MEDICINE LAKE BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 490	unsafe manner.  Findings include:  Refer to: F323. The comprehensively ass and ensure safety me protect 3 of 3 resident were consuming alco intoxicated resulting if facility failed to ensur to prevent significant and/or others.  On 5/11/16, at 3:02 pafter discussing the isto the residents on the residents drinking who documentation was acconsequences of nor to be more document.  On 5/17/16, at 2:44 pattere have been som R11. The discussion returning intoxicated, into the facility. He as a couple of check-ins Director (SSD) had con R11 on these occ know about an issue administrator added training over the ween heard of the amount that he was not award change has to be im wanting to help, seei Related to R51, administrator, added to R51, administrator added to R51, administrator added to R51, administrator to help, seei Related to R51, administrator	facility neglected to ess, develop interventions, easures were in place to its (R11, R51, and R54) who shol and becoming in unsafe behavior. The re interventions were in place injury to R11, R51, R54  I.m. the administrator verified assues of compliance related re Gazebo program, and the sile out of the facility, facility acking assessments and the in-compliance. There needed	F4		Mission Nursing Home has staff training clarifying the communication procedures resident intoxication incidents being cathe Administrator (including: frequency severity, circumstance, residents having incidents than others etc).  The IDT incident report meeting, which Administrator will attend, will include standing agenda item reviewing any resident intoxication incidences.  *see F323 for additional information Responsible: Administrator	e of lled to y, g more	7/1/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245546	B. WNG_		05/17/		/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 3401 EAST MEDICINE LAKE BOULEVA PLYMOUTH, MN 55441				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIAT		(X5) COMPLETION DATE	
F 493 SS=D	further stating R51 haback, and is better. A of any special recommendation of any special recomm	le aware of it prior to survey, as been taken to detox, is administrator was not aware mendations implemented for my additional care of the administrator also of the extent of the drinking y started talking with staff for was called.  ERNING BODY-FACILITY ADMN  Is a governing body, or unctioning as a governing icies regarding the irration of the facility; and the ints the administrator who is where licensing is required; e management of the  is not met as evidenced and document review, the dy failed to ensure adequate al staff and facility practices tion and development of policies and practices to safety of all residents who	F 49					
•	Findings include:							

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (XP) MULTIPLE CONSTRUCT			(X3) DATE SURVEY COMPLETED			
		245546	B. WNG			05/·	17/2016
•	ROVIDER OR SUPPLIER		.· <b>·</b>	STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 493	to 3 of 3 residents (R consuming alcohol ar resulting in unsafe be immediate jeopardy s R54.  Refer to: F490. The fa administration effective potential neglect of coff 3 residents (R11, For consuming alcohol in Refer to: F501. The fawith the medical directive potential for serious in (R11, R51, and R54) alcohol in an unsafe in Refer to: F520. The faquality assessment (and developed action care and potential for (R11, R51, and R54) alcohol and becoming During interview on 5 governing board men not aware of any dring going on at the facility site and returning to a influence of alcohol at their safety. GBM state administration was they would be brought.	facility failed to ess and develop se the risk of significant harm 11, R51, and R54) who were ad becoming intoxicated havior. This resulted in an ituation for R11, R51, and acility failed to ensure vely addressed concerns of are and potential injury for 3 t51, and R54) who were an unsafe manner.  Cacility failed to collaborate extor to address significant njury for 3 of 3 residents who were consuming manner.  Cacility failed to ensure the QA) committee recognized of injury for 3 of 3 residents who were consuming gintoxicated.  Carlot failed to ensure the QA) committee recognized of injury for 3 of 3 residents who were consuming gintoxicated.  Cacility failed to ensure the QA) committee recognized of injury for 3 of 3 residents who were consuming gintoxicated.	F	493	Mission Nursing Home and its board p proper protocols and policies to ensure safety and security of its residents. The of directors will be informed by the administrator and executive director of resident intoxication event that meets tupdated resident intoxication procedure. In addition, the board agenda will incluaddition of reviewing this topic at its be meetings.  * see F323, F490, F501, F520 for addition information  Responsible person: Mission Nursing I Administrator  Completion Date: May 20, 2016	the board any ne es. de the board ional	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245546	B. WING_		0	5/17/2016	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 496 SS=F	monthly, with the excomeetings are held at the entire board. She policy being revised, a be comfortable in ask policy. A discussion vervisions were necessive facility policy regarding responsibilities was responsibilities and individual has requirements unless the employee in a training evaluation program approved in a training evaluation prog	eption of August, and other imes that may not include asked for a copy of the and stated the board would ng for revisions on this would be held if any sary.  In the governing board quested, but not provided. SE AIDE REGISTRY RAINING  Invidual to serve as a nurse ceive registry verification met competency evaluation met individual is a full-time and competency oproved by the State; or the lat he or she has recently do a training and an program or competency oproved by the State and ded in the registry. In to ensure that such an omes registered.  Ividual to serve as a nurse ek information from every need under sections 1819(e)	F 4	Mission will ensure that all nursin currently employed or applying for are listed on the State's Nursing A Registry and the required training will be accomplished by:  1. Employees mentioned in the sususpended pending certification.  2. Current NA's will be verified the on the registry. New applicants won NA registry by the Staffing Codesignee, prior to job offer.  3. Check registry when annual excompleted.  Responsible: Nurse Manager  4. Audits will be conducted on all to ensure all required verifications completed. Results of audits will to QA until determined compliant.	or a position ssistant This This rvey were at they are Ill be verified ordinator or aluations new hires are be presented	7/25/2016	
	there has been a cont consecutive months d			Responsible: DON			

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER: A. BUILDIN		PLE CONSTRUCTION  G		COMPLETED		
		245546	B. WING		05/1	7/2016		
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARI PLYMOUTH, MN 55441	)			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	IX (EACH CORRECTIVE ACTION SHOULD BE		(X6) COMPLETION DATE		
F 496	Continued From page 84 services for monetary compensation, the		F 4	96				
		lete a new training and on program or a new						
	by: Based on interview a facility failed to ensur (NA-K, NA-I), current were listed on the Sta Registry as required.	is not met as evidenced and document review, the re 2 of 34 nursing assistants by employed by the facility ate's Nursing Assistant This had the potential to be residing in the facility.						
	Findings include:							
	NA-K was hired on 2	/3/16.						
	NA-L was hired on 1	1/10/15.						
	the State Nursing As	ng assistant registration with sistant Registry indicated a no longer active on the						
	NA-K was removed of attended an unapproper and needed to re-tes registry. NA-L had be the certification expirate complete the step registry. In addition, not be working as a facility until back on	the state agency verified from the registry as NA-K had byed nursing assistant course at to be placed back on the een on the registry, however, red on 4/29/16. NA-L needed as to be placed back on the both NA-K and NA-L should nursing assistants in the the registry.						
l	On 5/17/16, at 11:45	a.m. the director of nursing						

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDI		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245546	B. WNG		O/	5/17/2016	
	ROVIDER OR SUPPLIER  NURSING HOME		:	STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	been removed from to an unapproved training a listing of unapproved posted near the time for nursing assistants expected that NA-K wand reported to her a unapproved course. In the previous staffing of facility in November of responsible for submit registry and verifying certification status. The since the staffing condense the staffing condense the staffing compositive in the previous and must provide the staffing compositive in the staffing compositive in the staffing compositive in the staffing compositive impairments the cognitive impairments the cognitive in the staffing compositive in the staffing compositive impairments the cognitive in the staffing cognitive impairments the staffing condense the staffing cognitive impairments the cognitive impairments the staffing compositive impairments the cognitive in the staffing cognitive impairments the cognitive impairments the cognitive impairments the cognitive impairments and may address the as determined by the aides providing service cognitive impairments the cognitive impairments and may address the as determined by the aides providing service cognitive impairments the cognitive impairments and may address the as determined by the aides providing service cognitive impairments the cognitive impairments and may address the as determined by the aides providing service cognitive impairments and may address the as determined by the aides providing service cognitive impairments and may address the as determined by the aides providing service cognitive impairments and may address the aides providing service cognitive impairments and may address the aides and may address and may ad	s unaware that NA-K had he registry due to attending ng course. The DON stated and training course was clock and in the break room to review. The DON would have reviewed the list bout attending an n addition, the DON stated coordinator, who left the ar December of 2015, was ting hours worked to the nursing assistant his had not been completed rdinator left. AIDE PERFORM NSERVICE  Delete a performance review cleast once every 12 wide regular in-service he outcome of these the continuing competence of be no less than 12 hours as of weakness as ides' performance reviews special needs of residents facility staff; and for nurse es to individuals with , also address the care of	F 496	M			

	XTEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED				
		245546	B. WING_			05/1	7/2016	
,	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	OTION SHOULD BE OTHE APPROPRIATE		
F 497	service training was assistants (NA-C, NA-NA-H, NA-I, NA-J) er greater than 12 mont affect all 85 residents.  Findings include:  NA-C was hired on 8 was reviewed and the evaluation completed addition, the personn of the required 12 ho year.  NA-D was hired on 7 was reviewed and lae evaluation. In addition documentation of the in-service training personal to the evaluation. In addition, the personal training personal traini	are 12 hours of annual incompleted for 8 of 8 nursing In-D, NA-E, NA-F, NA-G, apployed by the facility hs. This had the potential to a residing in the facility.  ///////////////////////////////////	F	497	Mission Nursing Home's policy is to complete reviews of every nursing assis at least once every twelve (12) months a provides regular inservice education bas on the outcome for these reviews. To a continued compliance, the following plateen implemented.  1. Performance evaluations will be comfor NA-C, NA-D, NA-E, NA-F, NA-G, NA-I, NA-J & placed in their personnel 2. DON/designee has reviewed personnel files of all NAR's to check for timely performance evaluations and evidence of continuing education requirements.  3. Performance evaluations for NAR's we have not had one within the last 12 monthave been assigned and will be completed DON & Nurse Managers will complete evaluation reviews  HR will track inservice attendance and completion of makeup tests to ensure an nursing staff complete requirements.  HR will do random employee file audit minimum of 3 per week to ensure insert evaluation compliance.  Results will be brought to each QA commeeting.  Responsible: HR	and sed ssure an has pleted NA-H I file. el of who nths ted.	7/29/16	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245546	B. WING_	W		05	/17/2016
	ROVIDER OR SUPPLIER  NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP ( 3401 EAST MEDICINE LAKE BOULE PLYMOUTH, MN 55441			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	FION SHOULD BE THE APPROPRIA		
F 497	was reviewed and lack evaluation. In addition documentation of the in-service training per NA-I was hired on 8/9, was reviewed and the evaluation completed top of the page to be 2 of completion. In addit lacked documentation in-service training per NA-J was hired on 2/2 was reviewed and the evaluation completed addition, the personne of the required 12 houryear.  On 5/16/16, at 11:10 a resources/administrative that NA-C, NA-D, NA-I, NA-J did not have evaluations within the stated that performance conducted annually. Hin-service is completed assistants are required attend the in-service the documentation and a total there is no process.	year.  11/13. NA-H's personnel file ked an annual performance, the personnel file lacked required 12 hours of year.  13. NA-I's personnel file last performance for NA-I was noted at the 2014 without a specific date ion, the personnel file of the required 12 hours of year.  8/13. NA-J's personnel file last performance for NA-J was 6/16/14. In I file lacked documentation rs of in-service training per  .m. the human we assistant (HR)-B verified E, NA-F, NA-G, HA-H, e current performance last year. In addition, HR-B we reviews should be R-B stated that an it monthly that nursing I to attend. If they do not sey are provided written est. HR-B further stated in place to ensure the impleted and no monitoring	F4	497			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245546	B. WNG		05/17/2016	
	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
F 497	(DON) stated each de teaching monthly edu not a process in place completed. Currently infection control class acknowledged perfor to date.  The undated Employ Instructions indicated were to be completed.	p.m. the director of nursing epartment head took turns acation. However, there was to ensure education was hours were only tracked for ses. The DON mance reviews were not up	F 497			
F 501 SS=D	DIRECTOR  The facility must des as medical director.  The medical director implementation of re	BILITIES OF MEDICAL	F 501	Mission Nursing Home and its Medic provides proper protocols and policies ensure the safety and security of its reactive The Medical Director is now meeting site visit with either the Director of N Administrator to review resident into events. When necessary, given severiful Medical Director will be called on resident into the control of the control	s to esidents. at each fursing or exication ty, the	
	by: Based on interview facility failed to collal director to address of issues for 3 of 3 resi reviewed who exces Findings include:	T is not met as evidenced and document review, the borate with the medical oncerns related to significant dents (R11, R51, and R54) sively consumed alcohol.		intoxication matters. In addition, the committee meeting now holds a standagenda item related to resident intoxic events. Problem solving and quality improvement will occur at the QA me (continued next page)	QA ling cation	
	assess and develop	ity failed to comprehensively interventions to reduce the m to 3 of 3 residents (R11,				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245546	B. WING_			05/17/2016	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	1172010
				3	8401 EAST MEDICINE LAKE BOULEVARD		
MISSION	NURSING HOME	,			PLYMOUTH, MN 55441		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 501	Continued From page	89	F 5	501	R11, R51, R54 were discussed at the 5/	17/2016	
	R51, and R54) who ex	xcessively consumed			QA committee meeting with Medical D	irector	
•		became intoxicated. This			in attendance.		
		ate jeopardy situation for			Monthly audit will occur through review	w of the	
	R11, R51, and R54.  When interviewed on 5/17/16, at 2:58 p.m. the				Medical Director site visit notes and QA		
					committee minutes.	•	
		stated he is not the primary			Responsible : DON		7/21/2016
		e residents at the facility,			Responsible . DON		
		ctor. MD denied being					
		residents were drinking					
		program, stating "and that					
		has been brought up to				1	
		rinking. Further MD stated				1	
		s held outside, there were					
		brought into the quality				Į	
	assurance meetings.	He stated he was aware					
		people that go out to drink,		l			
		re was a problem, but more /ID also stated he was not				l	
		eatedly not following the					
	rules. He would exped						
	report filled out, and th			-			
		alcohol be brought to him		ĺ			İ
	for review. When review			l		1	
	results of the residents	s, MD stated be was "agast"		1			ĺ
		a report on these. Years		ŀ			
		gested the breathalyzer,				1	
		as a policy in place as to		1			
		he specific readings. MD					
		not reached out to him for				1	
	breathalyzers tests. A	lo if residents are refusing					ŀ
		nking, with the person quite					
		for falling. At 0.307, would		İ			
		risk of falls. There is also				ĺ	
	potential of issues with						
		ed he was not aware of					
		athalyzer, identifying they					
		be done. The delima is		ļ			

AND PLAN OF COI	DEFICIENCIES DERRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245546	B. WING_		0.5	5/17/2016	
NAME OF PROVI	IDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 501 Co	ontinued From page	90	F 5	01			
When the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second	that to do if someone and issue is monitoring and the property of the provider of the property of the provider of the provider of the property of the provider of the provider of the property of the provider of the property of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider	e is not cooperative. The ig, and the facility has to pay ble leaving the building. Solicy on monitoring exicated. Door monitors buntalbe. The high risk monitored, incident reports need to be brought to quality ement signed 6/10/13, is responsible for the f medical care at the facility. The means provider shares bring facility is providing equired which involves ing implementation of and providing oversight and an services and medical error in a quality assessment and econsisting of the director of hysician designated by the other members of the	F				

PRINTED: 06/06/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i		E CONSTRUCTION		E SURVEY PLETED
		245546	B. WING			05	/17/2016
	ROVIDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441		,3010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFIGIENCY)	BE	(X5) COMPLETION DATE
F 520	except insofar as succompliance of such or requirements of this succompliance of such or requirements of this succompliance of such or requirements of this success and correct quality dea a basis for sanctions.  This REQUIREMENT by:  Based on interview a facility falled to ensure and Assurance (QA) of developed action plar neglect of care and por residents (R11, R51, a consuming alcohol and This had the potential consumed alcohol in the residents (R12).  Refer to: F323. The factom remains and consuming alcohol and an unsafe manner. The popardy situation for On 5/17/16, at 2:35 p. interviewed regarding Assessment and Assumed alcohol use has mand alcohol use has not required.	tary may not require and of such committee to the disclosure is related to the committee with the section.  By the committee to identify diciencies will not be used as a series is not met as evidenced and document review, the expectation of the quality Assessment committee recognized and as to address potential obtained for injury for 3 of 3 and R54) who were do becoming intoxicated. To affect any residents who consafe levels.  Because of the committee to identify the committee recognized and as to address potential obtained for injury for 3 of 3 and R54) who were do becoming intoxicated.  Because of the committee to identify the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recognized and the committee recogn	F	520	Alcohol specific related incidents, incidents, R51, R54 will be added to the assurance agenda (report including: ft severity, circumstance, residents havi incidents than others, certain dates, or resident obtaining for others)  Will be addressed at the next QA com (including Medical Director, Pharmac Department Managers) meeting by 5/Responsible: DSS, Admin Assistant	quality requency, ng more ne nmittee cist &	5/27/2016

STATEMENT AND PLAN OF	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(×		SURVEY PLETED
		245546	B. WING	,		05/	17/2016
	ROVIDER OR SUPPLIER  NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE		(X5) COMPLETION DATE
F 520	getting brought to us 'attention." The plan for have active discussion. He identified there has since the IJ was called they were holding a space purpose of discussions further, the administrative are not discussed at the	to a point requiring or future meetings is to n about safety and drinking. d been a lot of discussion d, and later this afternoon, pecial QAA meeting for the ssing safety and drinking. ator stated resident levels	F	520			

#### F5546025

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

PRINTED: 06/06/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		245546	B. WING		05/10/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLETION
K 000	ALLEGATION OF CODEPARTMENTS AC SIGNATURE AT THE PAGE OF THE CMS VERIFICATION OF CONSITE REVISIT OF CONDUCTED TO VASUBSTANTIAL COMPACTOR ACCORDANCE WITH A Life Safety Code SMinnesota Department Fire Marshal Division time of this survey, Mound not in substant requirements for part Medicare/Medicaid a 483.70(a), Life Safet edition of National Fire Departments for part Medicare/Medicaid a 483.70(a), Life Safet edition of National Fire	C WILL SERVE AS YOUR OMPLIANCE UPON THE CEPTANCE. YOUR EDOTTOM OF THE FIRST -2567 WILL BE USED AS COMPLIANCE.  AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE ALIDATE THAT IPLIANCE WITH THE EDEEN ATTAINED IN HYOUR VERIFICATION.  SEEN ATTAINED IN HYOUR VERIFICATION.  SEEN AUTHOR OF THE FIRE SAFETY AGS) TO:  BECTOR OF THE FIRE SAFETY AGS) TO:	By 1	It is the policy of Mission Nursing Ho follow all Federal, state, and local guilaws, regulations and statutes. This placorrection is not to be construed as an admission of deficient practice by the administrator, employees, agents or of individuals. The response to the allege deficient practice cited in this stateme deficiencies does not constitute agreer with the citations. The preparation, su and implementation of this correction serve as our credible allegation of conserve as ou	delines, an of facility ther ed int of ment bmission will appliance.
(11)	m In	MAN		WILL IS DAY	DR 7/11/1

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

OLIVILIA	OT ON WILDIONIL &	WEDICAID SERVICES		_		1	. 0000-0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	V /		CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245546	B. WING	_		05/10/201	
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		¥
MISSION	NURSING HOME			ı	401 EAST MEDICINE LAKE BOULEVARD LYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 000	Angela.Kappenman@	hitney@state.mn.us and	К	000			
	FOLLOWING INFOR	at has been, or will be, done					
	2. The actual, or prop	osed, completion date.					
	The name and/or to responsible for correct prevent a reoccurrence.	ction and monitoring to					
	was determined to be construction. It has a automatic sprinkler pr facility has a fire alar for fire department no						
K 050	NOT MET as evidend	2 CFR, Subpart 483.70(a) is sed by: ETY CODE STANDARD	К	050			
SS=C	signal and simulation conditions. Fire drills times under varying on each shift. The sta and is aware that drill routine. Responsibilit conducting drills is as	are held at unexpected conditions, at least quarterly aff is familiar with procedures sare part of established			*		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION I - MAIN BUILDING 01	(X3) DATE COMPI	SURVEY LETED
		245546	B. WING_			05/	10/2016
NAME OF PROVIDER OR SUPPLIER  MISSION NURSING HOME  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	34 P1	IREET ADDRESS, CITY, STATE, ZIP CODE  101 EAST MEDICINE LAKE BOULEVARD  LYMOUTH, MN 55441  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
K 050	Continued From page 2  Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms.  18.7.1.2, 19.7.1.2  This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility could not provide documentation that fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 91 residents.  Findings include:		K 050				çı
K 056 SS=F	and 1:30 PM on May revealed that the fire day after silent drills with the fire day after silent drills with the fire day after silent drills with the fire day after silent drills with the fire day after silent drills with the fire and the fire alarm construction, alternationally be permitted to protection in specific	e was confirmed by the noce at the time of inspection. ETY CODE STANDARD ection 19.1.6, Health care ected throughout by an d automatic sprinkler system ection 9.7. Required sprinkler d with water flow and tamper lectrically interconnected to	K	056			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE S COMPL	
		245546	B. WING_		<del></del>	05/1	10/2016
	ROVIDER OR SUPPLIER			34	REET ADDRESS, CITY, STATE, ZIP CODE 101 EAST MEDICINE LAKE BOULEVARD LYMOUTH, MN 55441		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 056	Based on observatio automatic sprinkler symaintained in accord? Standard for the Insta 1999 edition. The fall system in compliance allow system being pleaderease in the fire posterease   Findings include:  1. On a facility tour be and 1:30 PM on May revealed that the facil documentation of quasystem flow testing.  2. On a facility tour be and 1:30 PM on May revealed that the autopressure gauges were 04/19/2011 which are 3. On a facility tour be and 1:30 PM on May revealed that the last the automatic sprinkless the automatic sprinkless.	not met as evidenced by: ns and staff interview, the vistem is not installed and ance with NAPA 13 the allation of Sprinkler Systems lure to maintain the sprinkler with NAPA 13 (99) could ace out of service causing a rotection system capability in gency that could affect all 91  etween the hours of 9:30 AM 10, 2016, observation lity could not provide arterly automatic sprinkler  etween the hours of 9:30 AM 10, 2016, observation contains a sprinkler  etween the hours of 9:30 AM 10, 2016, observation contains a sprinkler  etween the system	K	056	It is the policy of Mission Nursing Hotassure proper sprinkler system docume is in place and available for review, sp quarterly automatic system flow testing. Ahern Fire Protection will conduct the following work: Quarterly automatic system flow testing, calibration/replassprinkler system pressure gauges, interinspection.  Person Responsible: Environmental Security Director  Completion Date: July 14, 2016	entation ecifically g. prinkler ce of mal pipe	
K 064 SS=C	of Maintenance at the	e was verified by the Director e time of inspection . ETY CODE STANDARD	K	064			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FUR MEDICARE &	MEDICAID SERVICES				CIVID IVC	. 0330-0331
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245546	B. WING			05/	10/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MICCIONI	WIDOWO HOME			3	401 EAST MEDICINE LAKE BOULEVARD		
MISSION	NURSING HOME			P	LYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
K 064	inspected, and mainta occupancies in accord 10. 18.3.5.6, 19.3.5.6 This STANDARD is raced on documenta interview, It was deter to maintain portable fraccordance with NFP NFPA 10. This deficies 91 residents. Findings include:	shers shall be installed, ained in all health care dance with 9.7.4.1, NFPA not met as evidenced by: ation review and staff railed	K	064	It is the policy of Mission Nursing Hor assure proper fire extinguisher servicin documentation is in place and available review. Weber/Troseth (fire extinguish company) will conduct its annual servi and will include proper documentation servicing.  Person Responsible: Environmental Second Person Responsible: O7/08/16	g e for er cing of the	6
K 071 SS=B	and 1:30 PM on May revealed that annual inspections were comper inspection tags, his service report kept or This deficient condition. Director of Maintenar NFPA 101 LIFE SAFE Rubbish Chutes, Incichutes:  (1) Any existing linent pneumatic rubbish and directly onto any correconstruction to prevewith a fire door asser	10, 2016, observation portable fire extinguisher ducted in September 2015 owever there was no file at the facility.  on was verified by the ace at the time of inspection.	К	071			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245546	B. WING			05/	10/2016
NAME OF PROVIDER OR SUPPLIER  MISSION NURSING HOME  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	34 P X	PROVIDERS CITY, STATE, ZIP CODE  401 EAST MEDICINE LAKE BOULEVARD  PLYMOUTH, MN 55441  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD B  CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)		(X5) COMPLETION DATE	
K 071	(2) Any rubbish chute pneumatic rubbish an with automatic exting accordance with 9.7.  (3) Any trash chute di collection room used protected in accordance (4) Existing flue-fed ir resistive construction 19.5.4, 9.5, 8.4, NFP/This STANDARD is r Based on observatio linen chute that does of Sections 19.5.4, 9.	or linen chute, including d linen systems, is provided uishing protection in scharges into a trash for no other purpose and ice with 8.4.	К	071	It is the policy of Mission Nursing Horassure proper operation of all laundry of doors with self latching features. Laund latches on first and second floor have be replaced with a latch that will lock prowith out manual manipulation.  Complete Per (NA Mission NH) 5, 07/08/16	chute dry chute peen perly	
K 072 SS=F	and 1:30 PM on May revealed that the laur and second floor laun during self-closing. M latch is required for do This deficient practice of Maintenance at the NFPA 101 LIFE SAFE Means of egress shalfree of all obstructions instant use in the cas No furnishings, decorobstruct exits, access	was verified by the Director time of the inspection.  ETY CODE STANDARD  I be continuously maintained or impediments to full e of fire or other emergency, ations, or other objects shall thereto, egress there from, all be in accordance with	к	072			

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				ONI GIVIO	. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ·		CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE COMP	
		245546	B. WING			05/	10/2016
NAME OF P	ROVIDER OR SUPPLIER		-	s	TREET ADDRESS, CITY, STATE, ZIP CODE		
MISSION	NURSING HOME			ı	401 EAST MEDICINE LAKE BOULEVARD LYMOUTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 072	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has egress corridor obstructions which violates LSC 7.1.10. These obstructions could interfere with the convenient and effective removal of residents in an emergency situation.  Findings include:  On a facility tour between the hours of 09:30 AM and 01:30 PM on May 10, 2016, observation revealed that exit doors leading to stainways require a numerical keypad entry, however instructions for unlocking are not made available.  These deficient practices were verified by the Director of Maintenance at the time of the inspection.  K 144 NFPA 101 LIFE SAFETY CODE STANDARD  Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110-1999 edition, Section 6-4. This deficient practice could affect all 91 residents.  Findings include:  On a facility tour between the hours of 09:30 AM		К0		It is the policy of Mission Nursing Hoassure means of egress are free from obstructions or impediments, specific availability of the code for releasing to magnetized stairwell doors. The instruction how to unlock the doors are posted the keypad, to ensure MNH stays in or Person Responsible: Environmental Stairwell Director  Completion Date: June 30, 2016	ally the he ` uctions I next to ompliance	
			К	144	It is the policy of Mission Nursing Ho assure proper generator maintenance documentation is in place. A disclaim minutes cool down has been added to generator log, Person Responsible: Environmental S Director Completion Dato: May 17. 20160	er of 20 the	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245546	B. WING_			05/	10/2016
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441		01 EAST MEDICINE LAKE BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
K 144	,	ed after the monthly as conducted.  ces were verified by the	К-	144			
K 154 SS=F	inspection.  NFPA 101 LIFE SAFE  Where a required autout of service for morperiod, the authority hand the building is evwatch system is proviunprotected by the sh system has been return this STANDARD is represented by the shaded on observation facility did implement system out of service LSC (00) Section 9.7.	nese deficient practices were verified by the rector of Maintenance at the time of the spection.  FPA 101 LIFE SAFETY CODE STANDARD  There a required automatic sprinkler system is at of service for more than 4 hours in a 24-hour eriod, the authority having jurisdiction is notified, and the building is evacuated or an approved fire atch system is provided for all parties left approtected by the shutdown until the sprinkler estem has been returned to service.  9.7.6.1 his STANDARD is not met as evidenced by: assed on observation and document review, the cility did implement an automatic sprinkler estem out of service policy in accordance with SC (00) Section 9.7.6.1. This deficient practice and effect all 91 residents.		1154	It is the policy of Mission Nursing Home have proper procedures and plans for the automatic fire sprinkler system.  Mission Nursing Home has created a new automatic sprinkler system outage proced. Copies have been placed at the nurses stain the emergency procedure manual.  Person Responsible: Environmental Serv. Director  Completion Data: June 29, 2016		
	and 01:30 PM on Mar revealed that the facil	utomatic sprinkler system					
K 155 SS=F	of Maintenance at the NFPA 101 LIFE SAFI	e was verified by the Director e time of inspection. ETY CODE STANDARD e alarm system is out of	к	155			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				(X3) DATE SURVEY COMPLETED	
		245546	B. WING	11		05/	10/2016	
	ROVIDER OR SUPPLIER  NURSING HOME  SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	3	TREET ADDRESS, CITY, STATE, ZIP CODE  401 EAST MEDICINE LAKE BOULEVARD  LYMOUTH, MN 55441  PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
K 155	service for more than the authority having jubuilding is evacuated provided for all parties shutdown until the fire returned to service. Service of this STANDARD is represented to service policy in acceptable of service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service policy in acceptable service	4 hours in a 24-hour period, urisdiction is notified, and the or an approved fire watch is sleft unprotected by the e alarm system has been 0.6.1.8 not met as evidenced by: n and document review, the tent a fire alarm system out cordance with LSC (00) deficient practice could	K	155	It is the policy of Mission Nursing Hor have proper procedures and plans for the automatic fire sprinkler system.  Mission Nursing Home has created a nautomatic sprinkler system outage proof that includes a fire watch protocol. Copbeen placed at the nurses stations in the emergency procedure manual.  Person Responsible: Environmental Secompletion Date: June 29, 2016	ne ew cedure pies have		



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 6139 June 22, 2016

Mr. Timothy Meyer, Administrator Mission Nursing Home 3401 East Medicine Lake Boulevard Plymouth, Minnesota 55441

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5546026 & H5546050

Dear Mr. Meyer:

The above facility was surveyed on May 9, 2016 through May 17, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5546050 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Mission Nursing Home June 22, 2016 Page 2

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 3333 W Division #212, St Cloud MN, 56301. 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 Pam Kerssen, RN, APM at (218) 308-2129.

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

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

Please feel free to call me with any questions.

Sincerely.

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted June 6, 2016

Mr. Timothy Meyer, Administrator Mission Nursing Home 3401 East Medicine Lake Boulevard Plymouth, Minnesota 55441

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5546026 & H5546050

Dear Mr. Meyer:

The above facility was surveyed on May 9, 2016 through May 17, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5546050 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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.

Mission Nursing Home June 6, 2016 Page 2

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 Pam Kerssen, RN, APM @ (218) 308-2129.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

PRINTED: 06/06/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SU COMPLE		
		00235	B. WING		05/17	7/2016
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 00/17	72010
MISSION	NURSING HOME			AKE BOULEVARD		
	OLUMBA DV OT		TH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEN	TION*****				
	NH LICENSING CO	ORRECTION ORDER				
	144A.10, this correction pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart Determination of whee corrected requires correquirements of the running pursuant to a survey.	ther a violation has been mpliance with all				
	When a rule contains comply with any of the lack of compliance. L re-inspection with any result in the assessment	several items, failure to e items will be considered ack of compliance upon titem of multi-part rule will ent of a fine even if the item ng the initial inspection was				
	that may result from norders provided that a	earing on any assessments and con-compliance with these a written request is made to a 15 days of receipt of a for non-compliance.				
	receipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electronic ure orders consistent with ment of Health 14-01, available at e.mn.us/divs/fpc/profinfo/inf icensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

PRINTED: 06/06/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMF	SURVEY	
		00235	B. WING		05	/17/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
MISSION	NURSING HOME		MEDICINE LA H, MN 55441	KE BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
2 000	Department of Health you electronically. Al is necessary for State enter the word "correct text. You must then in State licensure proce completion date, the corrected prior to elect Minnesota Department on May 9th, 10th, 11 2016, surveyors of this the above provider arorders are issued. Plelectronic plan of correviewed these orders they will be completed. Minnesota Department the State Licensing Confederal software. Tag assigned to Minnesota Nursing Homes.  The assigned tag nurcolumn entitled "ID Festatute/rule out of consummary Statement and replaces the "To correction order. This findings which are in after the statement," evidence by." Following are the Suggested Matter Tomatter the Suggested Matter Tomatter the Suggested Matter Tomatter the Suggested Matter Tomatter Tomat	orders being submitted to though no plan of correction as Statutes/Rules, please cted" in the box available for indicate in the electronic iss, under the heading date your orders will be ctronically submitting to the int of Health.  Ith, 12th, 13th, 16th and 17th is Department's staff, visited ind the following correction ease indicate in your rection that you have is, and identify the date when id.  Int of Health is documenting correction Orders using numbers have been in a state statutes/rules for in the far left in the interest of Deficiencies" column Comply" portion of the column also includes the violation of the state statute. This Rule is not met as ing the surveyors findings ethod of Correction and ction.  Differ THE HEADING OF THE	2 000			

Minnesota Department of Health

STATE FORM 91PN11 If continuation sheet 2 of 91

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		00235	B. WING		05	/17/2016
MISSION NURSING HOME 3401 EAS			ADDRESS, CITY, STATE ST MEDICINE LAK JTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 000		ON EACH PAGE.  IREMENT TO SUBMIT A ION FOR VIOLATIONS OF	2 000			
2 190		esponsible for the: tten policies, procedures, tration, management, and	2 190			
	by: Based on interview at facility failed to ensuraddressed concerns injury for 3 of 3 reside	t is not met as evidenced and document review, the e administration effectively of neglect and potential ents (R11, R51, and R54) consuming alcohol in an				
	and ensure safety me protect 3 of 3 residen were consuming alco intoxicated resulting i facility failed to ensur to prevent significant and/or others.  On 5/11/16, at 3:02 p after discussing the is	ess, develop interventions, easures were in place to ts (R11, R51, and R54) who				

Minnesota Department of Health

STATE FORM 91PN11 If continuation sheet 3 of 91

PRINTED: 06/06/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING.		
		00235	B. WING		05/17/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
MISSION NURSING HOME 3401 EAST			MEDICINE LA	KE BOULEVARD	
		PLYMOUT	H, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
2 190	Continued From page	e 3	2 190		
2 190	residents drinking wh documentation was la consequences of non to be more document.  On 5/17/16, at 2:44 p there have been som R11. The discussions returning intoxicated, into the facility. He al a couple of check-ins Director (SSD) had con R11 on these occa know about an issue, administrator added h training over the weel heard of the amount of that he was not aware change has to be immore wanting to help, seein Related to R51, administrator added to R51, administrator administrator administrator added that he was not aware change has to be immore wanting to help, seein Related to R51, administrator administrator administrator administrator administrator administrator added here.	ile out of the facility, facility acking assessments and the a-compliance. There needed ation.  I.m. the administrator stated e discussions related to a did not involve outings and but sneaking alcohol back as overified being involved in with R11. Social Services completed the breathalyzer asions. He stated, "If we we address it." The ne was involved in the staff kend, and this was when he of issues related to drinking, e of. He also stated the nediate. The staff are	2 190		
	the residents, or of ar conferences being he	ld. The administrator also			
		of the extent of the drinking y started talking with staff for was called.			
	The facility's administ of nursing, could revie and procedures relate and resident safety. ensure all appropriate policies. The facility of	OD OF CORRECTION: crator, along with the director ew and revise facility policies ed to alcohol consumption The administrator could e staff are educated to the ould ensure the ted on all alcohol related			

Minnesota Department of Health

STATE FORM 91PN11 If continuation sheet 4 of 91

Minnesota Department of Health

	TEMENT OF DEFICIENCIES  O PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED
		00235	B. WING		05/17/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MISSION	NURSING HOME		MEDICINE LA H, MN 55441	KE BOULEVARD	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
2 190	Continued From page	<del>2</del> 4	2 190		
		s all incident and grievance oing compliance by staff.			
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one			
2 255	MN Rule 4658.0070 ( Assurance Committee	Quality Assessment and e	2 255		
	of the administrator, to services, the medical designated by the medical designated by the medical three other members representing disciplinaresident care. The quassurance committee respect to which qualinecessary and developpropriate plans of a quality deficiencies. The quality deficiencies address, at a minimum	director of nursing director or other physician director or other physician dical director, and at least of the nursing home's staff, es directly involved in uality assessment and must identify issues with the dity assurance activities are op and implement action to correct identified			
	by: Based on interview are facility failed to ensure and Assurance (QA) of developed action plare injury for 3 of 3 resides who were consuming intoxicated. This had	nd document review, the ethe Quality Assessment committee recognized and instead to address potential for ents (R11, R51, and R54) alcohol and becoming the potential to affect any ned alcohol in unsafe levels.			
	Findings include:				

Minnesota Department of Health STATE FORM

PRINTED: 06/06/2016 FORM APPROVED

Minnesota Department of Health

A. BUILDING: COMPLETED  00235  B. WING 05/17/2016  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441  (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 255  Continued From page 5  Refer to: F323. The facility failed to comprehensively assess and develop  A. BUILDING: COMPLETED  DEFICIENCY  B. WING 05/17/2016  DEFICIENCY  B. WING 05/17/2016  TAG (EACH CORRECTION CORRECTION SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOULD BE COMPLETED SHOU	E SURVEY PLETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441   (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)  2 255 Continued From page 5  Refer to: F323. The facility failed to		
MISSION NURSING HOME  3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 255  Continued From page 5 Refer to: F323. The facility failed to		
(X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  2 255 Continued From page 5  Refer to: F323. The facility failed to		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 255 Continued From page 5  Refer to: F323. The facility failed to		
Refer to: F323. The facility failed to	ETE	
interventions to reduce the risk of significant harm to 3 of 3 residents (R11, R51, and R54) who were consuming alcohol and becoming intoxicated in an unsafe manner. This resulted in an immediate jeopardy situation for R11, R51, and R54).  On 5/17/16, at 2:35 p.m. the administrator was interviewed regarding the facility's Quality Assessment and Assurance (QA&A) program. The administrator stated drinking at the facility and alcohol use has not been specifically brought to the QAA meetings, further stating it was not getting brought to us "to a point requiring attention." The plan for future meetings is to have active discussion about safety and drinking. He identified there had been a lot of discussion since the IJ was called, and later this afternoon, they were holding a special QAA meeting for the sole purpose of discussing safety and drinking. Further, the administrator stated resident levels are not discussed at these meetings.  Facility policy related to QAA was requested but not provide.  SUGGESTED METHOD OF CORRECTION: The quality assurance committee could review the quality assurance rogram, policies and procedures to ensure the appropriate programs/systems are being reviewed in a timely manner. The quality assurance committee could appoint staff to perform routine system(s) performance audits to identify areas that could be enhanced or improved on. The committee could then audit the systems in place and report to the committee to ensure ongoing compliance.  TIME PERIOD FOR CORRECTION: Twenty-one		

Minnesota Department of Health

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Minnesota Department of Health

WIIIIIICSOL	a Department of Fleatti	1				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	EIED
		00235	B. WING		05/1	7/2016
NAME OF P	ROVIDER OR SUPPLIER	STREFT AD	DRESS, CITY, STA	TE, ZIP CODE		
				KE BOULEVARD		
MISSION NURSING HOME			TH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 255	Continued From page	2.6	2 255			
	. •	. 0				
	(21) days.					
2 300	MN Rule 4658.0105 (	Competency	2 300			
	are able to demonstrate techniques necessary needs, as identified the resident assessments comprehensive plan of perform their assigned.  This MN Requirement by: Based on interview are facility failed to comple evaluations and ensure service training was consistents (NA-C, NANA-H, NA-I, NA-J) emgreater than 12 month.	arough the comprehensive and described in the of care, and are able to diduties.  It is not met as evidenced and document review the ete annual performance are 12 hours of annual inompleted for 8 of 8 nursing -D, NA-E, NA-F, NA-G,				
	Findings include:					
	was reviewed and the evaluation completed addition, the personne	8/13. NA-C's personnel file last performance for NA-C was 10/6/14. In el file lacked documentation ars of in-service training per				
	was reviewed and lac					
	NA-E was hired on 7/	11/12. NA-E's personnel file				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		00235	B. WING		05	5/17/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MISSION	NURSING HOME		ST MEDICINE LAK JTH, MN 55441	E BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 300	was reviewed and ladevaluation. In additional documentation of the in-service training per NA-F was hired on 7/1 was reviewed and the evaluation completed addition, the personn of the required 12 housear.  NA-G was hired on 5/2 was reviewed and ladevaluation. In additional documentation of the in-service training per NA-H was hired on 7/2 was reviewed and ladevaluation. In additional documentation of the in-service training per NA-I was hired on 8/3 was reviewed and the evaluation completed top of the page to be of completion. In additional lacked documentation in-service training per NA-J was hired on 2/1 was reviewed and the evaluation completed addition, the personnal lacked documentation completed addition, the personnal lacked and the evaluation completed addition the evaluation completed addition the evaluation completed addition the evaluation completed addition the evaluation completed addition the evaluation completed addition the evaluation c	cked an annual performance in, the personnel file lacked is required 12 hours of required 12 hours of required 12 hours of regard.  /29/14. NA-F's personnel file is last performance if for NA-F was 10/10/14. In it liel file lacked documentation is of in-service training per in the personnel file lacked an annual performance in, the personnel file lacked is required 12 hours of required 12 hours of required 12 hours of required 12 hours of required 12 hours of required 12 hours of required 12 hours of required 12 hours of required 14 hours of required 15 hours of required 16 hours of required 17 hours of required 18 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of required 19 hours of require	2 300			

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00235	B. WING		05/17/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	ΓE, ZIP CODE	
MISSION	NURSING HOME	3401 EAS	T MEDICINE LA	KE BOULEVARD	
		PLYMOU	TH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRICIENCY)	ULD BE COMPLETE
2 300	resources/administrat that NA-C, NA-D, NA-NA-I, NA-J did not ha evaluations within the stated that performan conducted annually. It in-service is complete assistants are require attend the in-service to documentation and a that there is no proce education had been of the total hours of the completed by staff.  On 5/17/16, at 11:45 (DON) stated each deteaching monthly edunot a process in place completed. Currently, infection control class acknowledged perform to date.  The undated Employed Instructions indicated were to be completed employee's anniversal completed the employed sufficient of Nursin could review and reviprocedures for nursin training/in-service to end the DON could composition of the polycetic could review and reviprocedures for nursin training/in-service to end the DON could composition education how certificiations. The Quantum condition of the polycetic could review and reviprocedures for nursin training/in-service to end the polycetic could composition education how certificiations. The Quantum condition and the polycetic could review and reviprocedures for nursin training/in-service to end the polycetic could composite the polycetic could composite the polycetic could composite the polycetic could composite the polycetic could be  tive assistant (HR)-B verified -E, NA-F, NA-G, HA-H, ve current performance elast year. In addition, HR-B ce reviews should be -HR-B stated that an ed monthly that nursing ed to attend. If they do not they are provided written test. HR-B further stated ss in place to ensure the completed and no monitoring ne continuing education  p.m. the director of nursing epartment head took turns cation. However there was e to ensure education was hours were only tracked for ses. The DON mance reviews were not up  ee Performance Evaluation performance evaluations I annually during the ary month, and were to be yee's supervisor.  OD OF CORRECTION: ng (DON) and/or designee se the policies and	2 300			

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Minnesot	a Department of Health	1				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
			D MINO			
		00235	B. WING		05/1	7/2016
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MISSION	NURSING HOME	3401 EAS	T MEDICINE LA	KE BOULEVARD		
	TORONTO FIGURE	PLYMOUT	TH, MN 55441			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
2 300	Continued From page	9	2 300			
	audits to ensure ongo	ing compliance.				
		CORRECTION: Twenty One				
	(21) days.					
2 302	MN State Statute 144	.6503 Alzheimer's disease	2 302			
	or related disorder tra					
	ALZHEIMER'S DISEA					
	DISORDER TRAININ	<del>-</del> -				
	MN St. Statute 144.65	503				
	(a) If a nursing facility	serves persons with				
	Alzheimer's					
	disease or related dis					
		I unit, the facility's direct				
	care staff	must be trained in dementia				
	care.	must be trained in dementia				
	(b) Areas of required					
	(1) an explanation of <i>i</i> related disorders;	Alzheimer's disease and				
	(2) assistance with ac	tivities of daily living:				
		ith challenging behaviors;				
	and					
	(4) communication sk					
		rovide to consumers in				
		orm a description of the categories of employees				
		of training, and the basic				
	topics covered.	or training, and the basic				
		ocument compliance with				
	this section.					

by:

This MN Requirement is not met as evidenced

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		I \ /	E SURVEY PLETED	
		00235	B. WING		05	5/17/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
MISSION	NURSING HOME		ST MEDICINE LAK JTH, MN 55441	E BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 302	Based on interview a facility failed to provio members information Training staff receive frequency of training, training provided. This all 85 residents of the Findings include:  A review of the facility In-Service," indicated was presented to fact course modules including the scope of the seven stages of symptoms for each stapproaches. The review included managing of communicating with indisease, and accommodaily living. A review In-Service Sign-In" stafform the all discipline training.  During review of admits to the residents, the finformation regarding provided. Further, the information was provided. Further, the information was provided admission, residents dementia unit, but stareceive training in dethe facility did not prodementia training in view of the facility did not prodementia training in view of the facility did not prodementia training in view of the facility did not prodementia training in view of the facility did not prodementia training in view of the facility did not prodementia training in view of the facility did not prodementia training in view of the facility did not prodementia training in view of the facility did not prodementia training in view of the facility did not prodementia training in view of the facility did not prodementia training in view of the facility did not prodementia training in view of the facility did not prodementia training in view of the facility did not prodementia training in view of the facility did not prodementia training in view of the facility did not prodementia training in view of the facility did not prodementia training in view of the facility did not prodementia training in view of the facility did not prodementia training in view of the facility did not prodementia training in view of the facility did not prodementia training in view of the facility did not prodementia training in view of the facility did not prodementia training in view of the facility did not prodementia training in view of the facility did not prodementia training in view of the f	nd document review, the de residents and/or family regarding Alzheimer's d, who received training, and a description of the s had the potential to affect e facility and their families.  If documents "Dementia a live, interactive training dity staff on 4/8/16. The ded a summary of dementia of the illness), a review of lementia, recognition of the tage, and caregiver ew of caregiver approaches nallenging behaviors, tips for individuals who have modating for their activities of the "Mission Nursing Home neet, indicated facility staff is received this dementia dission documents provided facility included no lalzheimer's training for was no evidence the	2 302			

Minnesota Department of Health

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	CONSTRUCTION	(X3) DATE S COMPLI	
		00225	B. WING		05/4	7/2046
NAME OF P	ROVIDER OR SUPPLIER	00235	RESS, CITY, STA		05/1	7/2016
	NURSING HOME	3401 EAST	MEDICINE LA	KE BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 302	aware we had to do the SUGGESTED METH administrator and/or of facility's process to er completed in a timely and contracted nursing resident/interested padementia training protraining, the frequency description of the train administrator and/or ongoing compliance.  TIME PERIOD FOR 0 (21) days.	nator reported she "wasn't nat."  OD OF CORRECTION: The designee could review the nsure Alzheimer's training is manner by both the facility ag staff, and arties are made aware of the vided to staff (who receives y of training, and a ning topics). The designee could monitor for	2 302			
2 550	Resident Assessment Subp. 4. Review of a home must examine of quarterly and must re comprehensive assess continued accuracy of this MN Requirement by: Based on interview and facility failed to ensure comprehensively assess Preadmission Screen Findings include: R66's admission Mini	ssessments. A nursing each resident at least vise the resident's ssment to ensure the of the assessment.  It is not met as evidenced and document review, the e 1 of 1 residents (R66) was	2 550			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		FIED
		00005	B. WING			7/0046
		00235	J. WING		05/1	7/2016
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
MISSION	NURSING HOME		MEDICINE LA 1, MN 55441	KE BOULEVARD		
	CLIMMA DV CT		Ī	DDOWDEDIS DI AN OF CODDECTIO	NI.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 550	Continued From page	e 12	2 550			
	mental illness, menta illness. The MDS indi assessed for a Level	SRR) for residents with a I retardation or related cated that R66 had not been II PASRR, and the MDS If the resident had been				
	Screening for Person Related Conditions in on 8/8/14. R66's prop the facility was 2/3/11 completed by Henney R66 had mental retar needs required nursir Level II PASRR furthed does require active to assures that all active specified in this person	ort Level II Preadmission s with Mental Retardation or dicated R66 was evaluated bosed date of admission to . The Level II PASRR was bin County and indicated dation and R66's medical ang facility services. The er indicated " This person eatment. The local agency e treatment needs have been on's individual service plan this person resides in the				
	director of nursing (Dothere was an error in and it should have be DON further stated the were not provided accepasses as the facility individualized service agency. If the MDS has county could have be the facility could provide SUGGESTED METHING The director of nursing and it should be the service agency.	plan (ISP) from the county ad been coded correctly the en contacted for the ISP, so ide the needed services.  HOD OF CORRECTION: g (DON) or designee could				
	to ensuring that each comprehensive asses					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		00235	B. WING	<del></del>	05/17/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MISSION	NURSING HOME		MEDICINE LA 1, MN 55441	KE BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPL	LETE
2 550	could develop a syste develop a monitoring accurately complete a	tor of nursing or designee om to educate staff and system to ensure staff	2 550			
2 830	2 830 MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General  Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.		2 830			
	by: Based on interview at facility failed to compile develop safety interversions consumption to reduct harm to residents or consumption withdrawal for 3 of 3 may be were known to continuous and who with the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the work of the wo	t is not met as evidenced and document review, the rehensively assess, and entions related to alcohol the the risk of significant others, and to monitor for residents (R11, R51, R54) consume alcohol, become were not being medically ted in an immediate for R11, R51 and R54.				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	A. BUILDING:		
		00235	B. WING		05/1	7/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		3401 EAST	MEDICINE LA	KE BOULEVARD		
MISSION	NURSING HOME	PLYMOUTH	l, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	) BE	(X5) COMPLETE DATE
2 830	Continued From page	e 14	2 830			
	Findings include:					
	The immediate jeopar R51 had an extremely reading and clinical sy appropriate intervention determined R11, R51 for significant harm do intoxication without in including comprehens implementation of appleased on facility protop.m. the facility admir (DON), and social senotified of the IJ for R was removed on 5/17 noncompliance remain and severity level, with immediate jeopardy (IThe facility policy Alcoidentified: "Purpose: Mission Nursing Hom residents who are chrough dependent. While enough the efforts of residents facility also recognize relapse or continue to This policy is adopted use of alcohol and druand healthy environm supporting and encounted the policy included:  1. Mission Nursing Hefforts at sobriety and assistance at all times 2. In order to particip	on. During review it was, and R54 had the potential ue to multiple incidents of tervention by the facility sive assessment and/or propriate interventions ocols. On 5/12/16, at 3:54 histrator, director of nursing rvices director (SSD) were 11, R51, and R54. The IJ r/16, at 2:30 p.m., but ned at an isolated scope th actual harm that is not Level G).  The bhol and Drug Use, undated, A primary mission of e is to provide care to conically chemically couraging and supporting so to maintain sobriety, the so that some persons will be use alcohol and drugs. It to provide guidelines on the lugs, with the goals of a safe tent in mind, while also traging sobriety." In addition ome will support any and all I is available to give you so attein the Gazebo program, seessed by therapy, nursing, hagement committee.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	-ETED
		00235	B. WING		05/	17/2016
NAME OF D	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZID CODE	1 55.	
NAIVIL OF T	NOVIDER OR 3011 EIER		, ,	AKE BOULEVARD		
MISSION	NURSING HOME		H, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
	alcohol in the building 4. Inappropriate beha of alcohol will not be a addressed according management policy.  The facility policy title indicated "violent, crir behavior in public will	ted to ensure there is no  j.  avior resulting from the use allowed and will be to the facility behavior  d Behavior Policy, undated, minal or inappropriate sexual not be tolerated by Mission				
	behavior in public will facility." Examples of assault (including threalso identified other in affecting the health, so resident and/or the coallowed. "Residents win public and who republe discharged from the sound in public and who republe discharged from the sound in public and who republe discharged from the sound in public and who republic	ents who engage in such be discharged from the such behavior included eats of assault). The policy nappropriate behavior in eafety, or welfare of the mmunity would not be who engage in such behavior eat the behavior twice will ne facility." Examples of ed self-endangerment.				
	Consent for Random residents signed auth room/surroundings se "reasonable suspicior present. The policy in the search can result planning procedures"  The facility's Gazebo	dicated "Failure to authorize in immediate discharge				
	a physician approved provided by staff, in a at a specific time each identified in part:  1. Drinking can only	, set amount of alcohol specific area of the building h day] Contract, undated, be done in the designated arbershop. No drinking is				

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		(X3) DATE SURVEY COMPLETED
		00235	B. WING		05/17/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
MISSION	NURSING HOME		MEDICINE LA H, MN 55441	KE BOULEVARD	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
2 830	grounds.  2. If you drink alcoho the gazebo program, room or on your person level 4 (cannot go out escort) and you will be as follows:  First violation = one second violation.  Third violation = one second violation.  Third violation = one second violation.  Third violation = one second violation.  Third violation = one second violation.  Third violation = one second violation.  Third violation = one second violation.  Third violation = one second violation.  Third violation = one second violation.  Third violation = one second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  There may be a second violation.  Ther	e in the building or on the  I in the building, outside of alcohol is found in your on, you will be placed on of the building without an erestricted from the gazebo one week to be the weeks off program or buy alcohol give it to the any outings, you will be earch of your room or the sthat you are hiding on outing, and you have you cannot go to the of a fight, are belligerent or splay any other disruptive of to the gazebo and drink out on a 3 day restriction from Multiple offenses will result ons.  I giving or receiving alcohol be restricted from the alyzed before participating ay. Refusal to cooperate result in restrictions. To detox, hospital, or create tuation, your level will annot go out of the building d will be restricted from the stricted from the stri	2 830		
	An undated facility po	licy. Resident Monitoring			

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	a Department of Fleatt		т		ı	
	AN OF CORRECTION IN IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF GURREGIUN	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	FIED
		00235	B. WING		05/1	7/2016
			1		1 00/1	772010
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MISSION	NURSING HOME	3401 EAST	MEDICINE LA	KE BOULEVARD		
MICOIOIVI	TORONIO TIOME	PLYMOUT	H, MN 55441			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				,		
2 830	Continued From page	e 17	2 830			
	System, identified a le	eveling system for all				
	residents. The purpos	se of this system was to				
	keep the residents sa	fe and prevent them from				
	behaviors while out in					
		ments were conducted at				
	admission and annua	lly thereafter unless there				
		condition. The levels were				
	•	rterly care conference.				
	Classifications were:	,				
	Level I: A reside	nt can go out without				
	restrictions.	3				
	Level II: A reside	ent can sign out and walk				
	around the building fo	~				
	•	return within half an hour,				
	the door monitor will g					
	resident could be cha					
	restricted level for fail					
	limitations of this leve	I.				
	Level III: Reside	nts in this category must				
	remain within eyesigh	t of the door monitor (in				
	the front yard).					
	Level IV: Reside	nts in this category must				
	have an escort at all t	imes when outside the				
	facility. Resident	s who have had significant				
	behavioral issues or s	significant cognitive				
	deficits are also i					
		nts in this category must stay				
	on their individual floo	or and cannot go to the				
	other floor without esc	cort.				
	A					
	_	of all resident levels was				
		door, each nursing station,				
	and with each social v	worker.				
	Per the noticy all resi	dents sign to acknowledge				
		all rules related to the use of				
	•	ne facility and when out on				
	_	ne use of alcohol and the				
	•	hen the rules were followed				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
A. BUILDING:	00 22.25
00235 B. WING	05/17/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
MISSION NURSING HOME 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD PROPERTIES OF CROSS-REFERENCED TO THE APPROPERTIES OF CROSS-REFERENCED TO THE	D BE COMPLETE
Review of resident records indicated that although these policies were in place, the provider did not consistently use the leveling system, or have any consistent protocol for use or refusal of the breathalyzer, vital sign monitoring, or frequency and length of clinical and safety monitoring for intoxicated residents.  R11's quarterly Minimum Data Set (MDS) dated 3/8/16, identified admission to the facility on 3/1/02. It also identified R11 had modified independence with cognitive skills for daily decision making, and demonstrated feeling down, depressed or hopeless. R11 was noted to be independent with activities of daily living (ADLs). Active diagnoses included diabetes mellitus, non-Alzheimer's dementia, anxiety, depression, cognitive communication defict, alcoholic cirrhosis of liver, and alcohol dependence. The MDS also identified R11 exhibited other behavioral symptoms not directed toward others, and rejection of care.  R11's behavioral symptom Care Area Assessment (CAA) dated 7/2/15, identified R11 had episodes of impaired judgment and poor decision making, noting an episode in which he was in a verbally aggressive altercation with another resident which lead to threatening and physical aggression. "He also has been warned about not going out into the community to drink alcohol or take drugs and/or bring anything back in with him." The CAA documentation lacked any direction or guidance in dealing with these behaviors.  R11's medical record lacked a comprehensive assessment related to safety of alcohol use.  R11's medical record lacked a signed Alcohol and	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00235	B. WING		0,5	5/17/2016
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	7IP CODE	1 00	71772010
NAME OF F	ROVIDER OR SUFFLIER		ST MEDICINE LAK			
MISSION	NURSING HOME		TH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	Drug Use policy. The his own responsible potential alteration in dependence. It also out 'for a few drinks'. encouraging sobriety initiated 12/11/11), priget along with roommy physical and verbal a also indicated R11 wadue to alcohol or drug included: independential orthostatic blood presilacked specific interviuse.  The facility provided a Listing by Room date identified as a Level I information provided  On 5/16/16, at 10:01 director (SSD) was as	face sheet identified R11 as party.  If 4/8/16, identified a cognition related to alcohol identified a history of going Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interventions included: Interv	2 830	DEFICIENC		
		on Listing. The SSD stated, d has been since 9/23/12.				
	last 90 days. Addition on the form. The ass had a current issue wan extensive history coirrhosis of the liver, calcohol-induced persi	7/16, identified no falls in the nally, no seizures were noted essment did indicate R11 rith alcohol and/or drug use, of alcoholism, alcoholic				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00235	B. WING		05/17/2016	
NAME OF PROVIDER OR SUPPLIER  MISSION NURSING HOME	3401 EAS	DRESS, CITY, STA  T MEDICINE LA  TH, MN 55441	TE, ZIP CODE AKE BOULEVARD		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE	
confrontational with especially if drinking the specially if drinking the specially if drinking the specially if drinking the special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special special	ged "occasionally resident is a staff and other residents, g alcohol."  ministration Record (MAR) for hysician's order dated 9/26/13, ent out on the evening shift, he alyzer when he returned. If the efused, he was to be on 15 e order lacked a length of time ks were to continue.  ogress notes dated 4/22/15 entified the following:  .m. R11 went for a walk at rned at 9:10 p.m. Refused g, "I'm not on the Gazebo ave to do that anymore."  on 5/11/16, at 4:21 p.m. the (DON) stated an incident been completed, as well as ng when there was a refusal of the DON stated there was no sed or increased monitoring. stated R11 should have been as for refusal of the	2 830			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00235	B. WING		0:	5/17/2016
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE	,		
MISSION	NURSING HOME	****	ST MEDICINE LAK JTH, MN 55441	E BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	- 5/23/15, at 9:45 a.m staff in a "foul langual shared with dietary s. The documentation in around room do not s. bottles/containers."  On 5/11/16, at 4:21 p. would expect a breat offered, with 15 minut DON also indicated s. incident report to be sincident sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sincident report to be sinciden	n. R11 had been speaking to age". It also noted R11 taff he had been drinking. Included: "In a brief glance see any alcohol."  o.m. the DON stated she chalyzer to have been attended. The she would have expected an completed.  In. identified at 9:50 p.m. R11 and the door entrance, with staff outside. R11 began staff and threatening to door monitor." R11 walked attening manner, swearing, the physically harmed staff, called. R11 went to his room, for p.m. cursing, gritting his attended to the nursing station. He was would be called if he didn't so noted R11's eyes were out." R11 was checked on x 2 to have calmed down.  o.m. the DON stated a have been attempted, and 15 letted if this was refused. She ident report to have been attempted and had with a peer, and when being	2 830			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		00235	B. WING		05/1	7/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MISSION	NURSING HOME		MEDICINE LA I, MN 55441	KE BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	suspected he had bee "Did he laugh at me, of him." A correspond 6/16/15 was complete content.  On 5/11/16, at 4:21 p would expect a breath offered, and if refused initiated.  - 6/17/15, at 5:55 p.m discussed recent beh informed he could not building unless in the intoxicated he has to when they ask for a b comply he will be sen police will be called to understood and certa called due to his behat that he will be given a are any more incident leaving soon anyway was going he could in Administrator reiterate and he again said that hours later he came to he was given a dischato find a place for him responded yes.  - 6/19/15, at 9:30 a.m. entry) identified R11 vigiven notice to leave	en drinking. R11 stated, I'm gonna knock the shit out ding incident report dated ed, but lacked any additional  I.m. the DON stated she halyzer to have been d, 15 minute checks  I. the SSD and administrator aviors with R11, and he was d drink in or out of the gazebo program. If he gets cooperate with the nurses reathalyzer and if he doesn't t to the hospital and/or the o assist. He stated that he inly did not want the police aviors. Finally he was told in notice to discharge if there its, he responded with "I am ' and when asked where he ot give an answer. ed everything one final time it he understood. A couple of up to this writer and said if arge notice we would have	2 830			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		
		00235	B. WING		05/17/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MISSION I	NURSING HOME		MEDICINE LA I, MN 55441	KE BOULEVARD	
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
2 830	Continued From page	23	2 830		
	- 7/7/15, at 7:46 p.m. altercation with a pee yelling and cursing at	r, entering peer's room,			
		. R11 complained of an abdominal x-ray was "Don't send them in my			
	-8/20/15, at 1:24 a.m. issues to staff. He the became agitated.	R11 was complaining about en began cursing and			
	appeared to be drunk administrator entered breathalyzer. When a last night or this morn speech was somewharead 0.204, and a rete 0.203. "This writer ar reminded him of a disthat he understood the happened again he will leave. He said that he writer then informed him ade for the Glennweresidential facility for homeless men and will planning could begin. This."  On 5/11/16, at 4:21 p would expect 15 minuter for refusal of the breat report to be complete	R11's room with the sked if he had been drinking ling, R11 denied it. His at slurred. Breathalyzer est of the breathalyzer was and Administrator then iccussion in which he stated at if an incident like this rould be given a notice to be remembered this. This him that a referral would be cod, (wethouse) [a chronically alcoholic and lomen], so that discharge he stated understanding of lim. the DON stated she atte checks to be completed thalyzer, and an incident d.			
	referred to the Glenny accepted there, due to				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00235	B. WING		05/1	7/2016
NAME OF PR	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE KE BOULEVARD		
MISSION I	NURSING HOME		I, MN 55441	INE BOOLEVAND		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	despite the fact that F cares for this. The re residents share a batt - 9/8/15, at 10:22 p.m near the door in his robut refused breathaly assessment. Resider police I am already in incident report comple "possibly" give reside discharge.  On 5/11/16, at 4:21 p. documentation was a checks for refusal of the complete of the same as saying the R11 continued to refuse on 5/11/16, at 4:21 p. refused the breathaly expect 15 minute chebe completed.  - 10/19/15, at 6:15 p.r. p.m. and returned at 90.105.  On 5/11/16, at 4:21 p. incident report should well as 15 minute chebe  ough the abdominal wall), R11 is independent in the ason provided was that hroom.  R11 was found on the floor form. He appeared drunk over and vital sign in the stated "don't call the trouble." Corresponding eted, identified plan to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day notice to into a 30 day	2 830				
	p.m 9:35 pm. Brea					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00235	B. WING		05	5/17/2016
NAME OF F	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
MISSION	NURSING HOME		ST MEDICINE LAK JTH, MN 55441	E BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	On 5/11/16, at 4:21 p would expect an incic checks to have been - 10/31/15 at 7:15 p.r altercation with hous incident report compifurther information 11/7/15, at 7:27 p.m returning at 7:11 p.m On 5/11/16, at 4:21 p incident report should - 11/9/15, at 9:45 p.m returned at 8:50 p.m. On 5/11/16, at 4:21 p incident report should - 11/16/15, at 12:30 a station asking for me refused. He became cursing". Staff attemprefused to listen and - 11/16/15, at 6:30 p. from 6:30 p.m 8:30 0.08. On 5/11/16, at 4:21 p incident report should well as 15 minute check.	o.m. the DON stated she dent report and 15 minute completed.  m. R11 had a verbal ekeeping. A corresponding leted on 10/31/15 lacked any in the DON stated and have been completed.  m. R11 left at 8:00 p.m., and have been completed.  m. R11 left at 8:00 p.m., and have been completed.  m. R11 lout of the building p.m. Breathalyzer was in the DON stated and have been completed.	2 830			

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NAME OF PROVIDER OR SUPPLIER  MISSION NURSING HOME  A. BUILDING:  B. WING  O5/17/2016  STREET ADDRESS, CITY, STATE, ZIP CODE  A. BUILDING:  B. WING  O5/17/2016		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  MISSION NURSING HOME  3401 EAST MEDICINE LAKE BOULEVARD				A. BUILDING: _			
MISSION NURSING HOME 3401 EAST MEDICINE LAKE BOULEVARD			00235	B. WING		05/1	7/2016
MISSION NURSING HOME	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
,	MISSION	NURSING HOME			KE BOULEVARD		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLI	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE	(X5) COMPLETE DATE
Imit, and she wouldn't expect any increased monitoring. The DON stated she was not notified, and would expect herself or the SSD to have been notified of any incident involving drinking of any amount, and would expect an incident report completed.  - 12/24/15, at 5:30 p.m. R11 was found with two cans of beer in his room, observed to be dumping it down the drain when staff entered. R11 began cursing, slammed the cabinet door shut with his foot.  On 5/11/16, at 4:21 p.m. the DON stated no breathalyzer was done. The DON also stated a room search revealed no further alcohol, and she was notified of this incident. There were no further symptoms, and she would not expect 15 minute checks. Further, the DON stated R11 was aggressive, but he was also aggressive without alcohol.  - 3/29/16, at 9:13 p.m. R11 left the facility at 6:20 p.m. and returned at 9:20 p.m. R11 reported being down by the lake, and breathalyzer reading was 0.143.  On 5/11/16, at 4:21 p.m. the DON stated she would expect 15 minute checks and an incident report to have been completed.  - 4/13/16, at 9:06 p.m. R11 left the building and refused breathalyzer upon return.  On 5/11/16, at 4:21 p.m. the DON stated she would expect an incident report be completed as well as 15 minute checks for refusal of the breathalyzer.  - 5/7/16, at 6:40 p.m. R11 left the facility at 2:05	2 830	limit, and she wouldn' monitoring. The DON and would expect her been notified of any ir any amount, and would completed.  - 12/24/15, at 5:30 p.r cans of beer in his roo it down the drain whe cursing, slammed the foot.  On 5/11/16, at 4:21 p. breathalyzer was don room search revealed was notified of this indurther symptoms, and minute checks. Furth aggressive, but he was alcohol.  - 3/29/16, at 9:13 p.m p.m. and returned at 9 being down by the law was 0.143.  On 5/11/16, at 4:21 p. would expect 15 minute report to have been considered.  - 4/13/16, at 9:06 p.m refused breathalyzer.  On 5/11/16, at 4:21 p. would expect an incided well as 15 minute checks breathalyzer.	stated she was not notified, self or the SSD to have notident involving drinking of all expect an incident report.  The R11 was found with two permoders of the self or the SSD to have notident involving drinking of all expect an incident report.  The R11 was found with two permoders of the self entered. R11 began to cabinet door shut with his self.  The DON stated notine. There were noted she would not expect 15 therefore, the DON stated R11 was as also aggressive without.  The R11 left the facility at 6:20 are and breathalyzer reading self.  The DON stated she are checks and an incident completed.  R11 left the building and upon return.  The DON stated she are checks for refusal of the self.	2 830			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
ANDIEAN	or dortheorion	IDENTIFICATION NOMBER.	A. BUILDING: _		OOWII L	
		00235	B. WING		05/1	7/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MISSION	NURSING HOME			AKE BOULEVARD		
	OLIMAN DV OT		H, MN 55441	DDO//DEDIO DI AN OF GODDECTIO	A1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
2 830	Continued From page	e 27	2 830			
	On 5/11/16, at 4:21 p. not on the Gazebo pro	.m. the SSD stated R11 was ogram because he didn't				
	drink. The DON also reached R11's breathalyzer reached gone to his room. The provide any documen	ted assessment at that time				
	and safety monitoring	dings, or increased clinical having been done. The d have expected an incident checks to have been				
	term memory deficits selective memory. He judgement." The note also be verbally aggreespecially when they He does not want any knocking. He has epioutside of the building has. Social Service w	e does display some short some of which could be has episodes of impaired is also included, "He can essive towards staff want him to do something. Yone in his room even after isodes of drinking inside or g and then denying that he ill remain actively involved and behavior management				
	5/13/16, at 10:41 a.m 5/16/16, at 1:10 p.m.,	on 5/11/16, at 2:25 p.m., ., 5/15/16, at 11:44 a.m., and 5/16/16, at 3:00 p.m., d, and did not reply when				
	if a resident returned expect a nursing asse	m. the DON reiterated that intoxicated, she would essment to be completed, er reading of 0.256, she				

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PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SO PLAN OF CORRECTION (DENTIFICATION NUMBER: A. BUILDING: COMPL					
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3401 EAST MEDICINE LAKE BOULEVARD  PLYMOUTH, MN 55441   (X4) ID  PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  3401 EAST MEDICINE LAKE BOULEVARD  PLYMOUTH, MN 55441  ID  PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CONSTRUCTION SHOULD BE CONSTRUC			00235	B. WING		05	5/17/2016
(X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PLYMOUTH, MN 55441  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CONTROL TO THE APPROPRIATE DEFICIENCY)	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STATE	, ZIP CODE		
PLYMOUTH, MN 55441  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CONTAGE TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG DEFICIENCY	MISSION	NURSING HOME	3401 EAS	T MEDICINE LAK	E BOULEVARD		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  PREFIX TAG  PREFIX TAG  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	WIIOSION	NORSING HOME	PLYMOUT	TH, MN 55441			
2 830 Continued From page 39	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
would expect increased monitoring to be done. She also stated R11 had a history of coming back to the facility intoxicated, but was unable to find any documentation of increased monitoring done for any of the incidents when R11 returned with signs and symptoms of intoxication and refused a breathalyzer.  R51's quarterly MDS dated 4/28/16, identified the resident had modified independence in cognitive skillis for daily decision making, behavioral symptoms not directed toward others, and required the use of a wheelchair. Diagnoses included hypertension, diabetes mellitus, seizure disorder/epilepsy, and depression.  R51's CAA dated 11/3/15, identified diagnoses of acute alcohol intoxication/withdrawal, physical weakness, depression, limited range of motion, poor coordination, poor balance, and visual impairment. It also identified behavior problems including disruptive, loud talking in the dining room "especially after Gazebo/alcohol program." The CAA noted impaired balance during transitions, and difficulty maintaining sitting balance as well as agitation and decreased mobility. The CAA lacked any direction or guidance in dealing with these behaviors. R51 did not have a comprehensive assessment related to the safe use of alcohol.  R51's medical record included a signed contract to participate in the Gazebo program dated 8/7/15. However, there was not a signed Alcohol and Drug Use policy. The face sheet identified R51 as his own responsible party.  R51's care plan dated 4/27/16, identified a self care performance deficit related to alcohol use. It also identified R51 had a potential risk for falls	2 830	would expect increas She also stated R11 to the facility intoxica any documentation of for any of the incident signs and symptoms breathalyzer.  R51's quarterly MDS resident had modified skills for daily decision symptoms not directed required the use of a included hypertension disorder/epilepsy, and R51's CAA dated 11/2 acute alcohol intoxical weakness, depression poor coordination, point including disruptive, I room "especially after The CAA noted impaitment. It also indirected in the CAA noted impaitment in the CAA lact guidance as well as a genobility. The CAA lact guidance in dealing who have a comprehent the safe use of alcohology. R51's medical record to participate in the CAB/7/15. However, the and Drug Use policy. R51's care plan dated care performance decrease.	led monitoring to be done. had a history of coming back ted, but was unable to find for increased monitoring done ts when R11 returned with of intoxication and refused a dated 4/28/16, identified the doindependence in cognitive on making, behavioral ed toward others, and wheelchair. Diagnoses on, diabetes mellitus, seizure dopression.  3/15, identified diagnoses of ation/withdrawal, physical on, limited range of motion, nor balance, and visual entified behavior problems oud talking in the dining of Gazebo/alcohol program." irred balance during ulty maintaining sitting gitation and decreased cked any direction or with these behaviors. R51 did ensive assessment related to oil.  I included a signed contract Gazebo program dated ere was not a signed Alcohol The face sheet identified onsible party.  dd 4/27/16, identified a self ficit related to alcohol use. It	2 830			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SU COMPLE	
		00235	B. WING		05/1	7/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MISSION	NURSING HOME		MEDICINE LA I, MN 55441	KE BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	) BE	(X5) COMPLETE DATE
2 830	alcohol with the Gaze care indicated both lo problems, and poor jumaking due to alcohol plan also identified arbehavior related to ac intoxication/withdrawaremind of the rules arprogram. The care plant alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring lever alcohol monitoring	elchair bound, and the use of abo program. The plan of ang and short term memory adgement and decision of dependence. The care in alteration in mood and cute alcohol al. Interventions included to cound the gazebo/ alcohol an failed to identify R51's yel.  cation Listing By Room dentified R51 as a Level III.  ress notes from 4/28/15 - e following:  Note for R51 dated 6/2/15, as remained stable since he spital in February for alcohol continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke and amount of alcohol here at the continues to smoke a	2 830	DEL ROILING TY		

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE	SURVEY PLETED
		00235	B. WING		05	/17/2016
	PROVIDER OR SUPPLIER  NURSING HOME	3401 EA	DDRESS, CITY, STATE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	JTH, MN 55441 ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
2 830	instructed to not drink evidence their Gazeb On 5/11/16, at 3:02 p mess up like this whe would be suspended are sent to the hospit.  On 7/2/15, at 10:48 had been seen by the note indicated R51 is smoke when he want or anyone else."  On 7/2/15, at 1:59 p was on a three day suprogram.  A Physician Progress identified the chief co intoxication. It noted reading of 0.258, and to be low at 87/56, wi note indicated during the resident had state someone and had soil will do whatever I wadrink and smoke. If I gwill do it. I am not hur when I drink, so I sho nursing progress note allowed to sleep it off aggressive behavior to "Patient will be off Gadays. Nursing will cor of withdrawal."	a." The record lacked o policy was followed.  Im. the SSD stated, "if they in the program, they for 3 days, or a week if they all or detox."  Im. a note indicated R51 in the nurse practitioner, and the an adult and can drink and in the series. "He is not hurting himself in the interview of the program of the distribution of the program of the interview with the physician red, "I am fine, I went out with me drinks. I am an adult and ant. I am here because I can get the opportunity again, I ting myself or anyone else uld be left alone." The	2 830			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION (X3) DATE SUR COMPLETE		
		00235	B. WING		05	5/17/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
MISSION	NURSING HOME		ST MEDICINE LAK JTH, MN 55441	E BOULEVARD		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETE DATE
2 830	Continued From page	31	2 830			
	resident had left with returned at 3:45 p.m., talkative. "Social work be monitored." It was refused the breathaly assessments. The re Gazebo policy was for On 5/11/16, at 3:02 p enhanced monitoring completed as well as incidents.	cord lacked evidence the illowed.  m. the DON stated should have been an incident report for these				
	Gazebo program in a p.m., attempting to ta documentation indica to stop the resident, be returned at approxima paper bag, and a bott indicated staff had take resident was verbally	taxi at approximately 3:13 ke a peer with him. The ted the SSD had attempted but he'd left anyway and had ately 3:46 p.m. with a brown de of alcohol in it. The notes ken the bag, and the abusive toward staff. The ce the Gazebo policy was				
	alcohol was taken fro cabinet. A Code B (a controlled, where all a was called since R54 threatening her. When was intoxicated, slurri at this time was 0.336 was running low. The called, and instructed encourage fluids, and decline. DON stated	m. the DON stated the m R54 and locked up in a behavior that cannot be available staff come to help) was following the staff and in the nurse went in, R54 ing his words. Breathalyzer 6, and his blood pressure e on call physician was staff to monitor resident, I to call back if there was a the blood pressure was DON stated there is not				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPL	ETED
		00235	B. WING		05/17/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MICCIONI	NURSING HOME	3401 EAST	MEDICINE LA	KE BOULEVARD		
MISSION	NORSING HOME	PLYMOUTH	H, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	Continued From page 32		2 830			
	policy or procedure to follow and the physician does not specify a frequency of the checks.  - On 8/17/15, at 11:10 p.m. noted resident was examined by a registered nurse in his room at approximately 7:25 p.m. He was "clearly intoxicated, fatigued, and slurring his words."  Breathalyzer was 0.336. Blood pressure 94/59 and 86/54. Physician notified and orders received					
	to monitor resident ar back with a decline. A	notified and orders received nd encourage fluids. Call at 10:00 p.m. blood pressure ted at this time to be more				
		ords, and drinking fluids. idence the Gazebo policy				
	On 5/11/16, at 3:02 p.m., the DON stated the only documentation of checks was in the note from the nurse which indicated R54 was checked on every 1-2 hours. She would expect that an incident report and increased monitoring were completed.					
	12:15 a.m. staff attem and resident was incr language. Noted staf	a.m. noted at approximately apted to obtain vital signs, easingly agitated, using foul f obtaining frequent checks to two hours for safety.				
	where resident return breathalyzer of 0.33. signs were now norm	Note dated 8/21/15, the incident [dated 8/17/15] ed to the facility and had a The note indicated the vital al and resident is back to his rview with the physician,				
	can not allow him to be facility. He was also a Gazebo program for 3	ngry that the social worker oring his own 'Booze' into the angry that he will be off the 3 days since he got himself gress note identified no ers were provided for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00235	B. WING		05/1	7/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MISSION	NURSING HOME		MEDICINE LA I, MN 55441	KE BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	increased monitoring Then note indicated in monitor for any signs  - On 9/28/15, at 10:36 the facility via taxi at a was met at the door be alcohol bottles, and be Resident was informed attending Gazebo ton On 5/11/16, at 3:02 puliked to go out and driverified the Gazebo poutside the program was suspension, which had case. At that time, the assuming that he is government of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program, so the program, so the program, so the program of the program of the program, so the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of	when R51 was intoxicated. ursing was to continue to or symptoms of withdrawal.  6 p.m. resident returned to approximately 6:00 p.m. and by SSD. He turned in his reathalyzer was 0.141. d by SSD that he will not be norrow.  m., the SSD stated R51 nk with his meals. She olicy identified that drinking vould result in a one week d not been enforced in this be DON also stated, "we are oing to go out and drinking." was no assessment sidents consuming alcohol. dent report and increased we been initiated.  8 p.m. notes indicated R51 r the evening before, and be could not attend the had become very upset and  9 p.m. identified R51 had from going out on a visit t 12:05 p.m.] The note alk and went to his room after record lacked evidence the	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMF	PLETED
		00235	B. WING		05	/17/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
MICCION	NUBCING HOME	3401 EAS	ST MEDICINE LA	AKE BOULEVARD		
MISSION	NURSING HOME	PLYMOU	TH, MN 55441			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	COMPLETE DATE
2 830	Continued From page 34					
	should have been a r	actriction for not following				
	the gazebo contract.	estriction for not following				
	   - On 12/4/15, at 10:26	6 p.m. the notes indicated				
		12:05 p.m. At approximately				
		een received about the				
	resident being drunk	at a local liquor store, and				
	being under supervisi	ion of the police. R51 had				
		oital. The hospital visit note				
		ted R51 had arrived via				
	ambulance. "Report that patient was outside a					
		th with intoxication. Police				
	were called. Arrives w	• •				
	intoxication and slurri	-				
		eportedly lives at Mission				
		er information included,				
		ing in room when he had s on the cart lasting about				
		unresponsive to sternal rub.				
		onds and started yelling				
	incoherently." The la					
	identified "Pt [patient]					
		or his belongings and to be				
	allowed to leave. MD	0 0				
	speaking with pt."					
	On 5/11/16, at 3:02 p	.m. the DON stated dispatch				
		regarding the 12/4/15				
		so stated R51 had gone out				
		rant was across from a				
	liquor store. The SSD	stated R51 had left the				
		to the liquor store. Staff at				
		ubsequently called the				
		eone intoxicated. The SSD				
	_	not have a copy of the police				
		ed she'd instructed dispatch				
		spital for evaluation. Upon				
		fter six hours, R51 had				
		zer or vital signs. The DON				
	said R51 had been de	emanding staff call the				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND I LAN OF GONNEOTION	IDENTIFICATION NOMBER.	A. BUILDING: _		JOWN EETEB	
	00235	B. WING		05/17/2016	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MISSION NURSING HOME		MEDICINE LA 1, MN 55441	KE BOULEVARD		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLI	ETE
calmed him down and The DON stated no ale available from the hose if a physician was consincreased monitoring. expectation that increased completed as well as a also stated R54 had postating he was not to be for the gazebo. The Stating he was not to be for the gazebo program and a serious lately because - On 12/5/15, at 1:47 prindicated R51 had not Gazebo for breaking recompliance company at taken his bottle of alcomplated R51 had become agitated additional note at 1:05 returned to the facility and rude with increases breathalyzer, eyes we slurring his words.  - On 12/5/15, at 6:49 phad not been allowed program until re-evaluation. When interviewed on the same program until re-evaluation of the same program until re-evaluation.	return his alcohol. Staff had R51 returned to his room. cohol levels or reports were pital. There was no record tacted for any orders of The DON confirmed her ased monitoring would be an incident report. The DON costed a note on his door be disturbed unless it was SD stated R51 had to eat a be able to attend the added, "He is taking it more at it is important to him."  D.m. documentation been allowed to attend the ules yesterday [12/4/15] de the Gazebo program). In ame date at 1:47 a.m. In a staff call the land the police as they had cohol. The notes indicated ated, and was arguing. An a.m. identified R51 via ambulance, demanding and agitation. R51 refused a re blood shot, and he was a re blood shot, and he was a re blood shot, and he was a report should have been increased monitoring. The at time that R51 had been zebo program for one day,	2 830			

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Minnesota Department of Health						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		00235	B. WING		05/17/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
Mocion	AULDOING HELL	3401 EAS	T MEDICINE LA	KE BOULEVARD		
MISSION	NURSING HOME	PLYMOUT	ΓH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
2 830	Continued From page 36		2 830			
	Gazebo Alcohol Program Contract which directed a one week violation for drinking outside of the gazebo program.					
	identified R51 had be mood and alcohol use want [sic?] to control not had any acute bin	es Note dated 2/16/16, en treated for depressed e disorder. "Patient is now drinking program. He has age episodes that I am aware s visit with psychology was				
	- On 1/10/16, at 1:44 p.m. notes indicated R51 quickly returned from the Gazebo program after receiving ice from staff. There was a covered coffee cup noted behind the resident. R51 was asked if staff could check the cup, and after R51 stated "yes" it was noted to smell of alcohol. The cup was taken, and the resident chased staff around the front lobby. The note indicated the SSD had been notified and R51 was restricted from the Gazebo the following day for breaking rules. The record lacked evidence the Gazebo policy was followed, which directed a one week violation for drinking outside of the Gazebo program.					
	identified when he pa	.m. R51's quarterly note rticipated in programs after he was noted to be talking g sexual comments.				
	Keppra level drawn, a aggressive with the plindicated R51 had colored	hlebotomist. The notes me to nursing station later, yelling he did not want to				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
74401 2744	or contraction	IDENTIFICATION NO.	A. BUILDING: _		JOHN EET	
		00235	B. WING		05/17/	2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MISSION	NURSING HOME			KE BOULEVARD		
			H, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	Continued From page 37		2 830			
	A Physician note dated 4/12/16, indicated, "Patient taking Keppra, refused keppra level draw on request. Nursing will attempt again to draw keppra level next lab day. No report of seizures since admission to the facility."					
	a history of only wanti Gazebo program, starneeded to eat lunch be program, and had bee SSD stated there had gazebo program for re	en compliant with this. The I been no restriction from the efusing therapy/services, or ling at staff when they enter				
	- On 3/13/16, 12:19 p.m. notes indicated R51 had been yelling at staff in his room for waking him to administer insulin, and had stated the sign on his door indicated to never wake him except for the gazebo program.					
		p.m. notes indicated R51 f should only wake him for				
	be offered insulin prior indicated R51 had sta	a.m. resident was noted to or to lunch. The notes ated, "NODO NOT EVER AKE ME FOR GAZEBO."				
	since beginning of Fe higher in the 300s in t (a blood test that prov person 's average lev called blood sugar, ov at 9.4 as at 1/11/16, v	ted 4/12/16, identified use high from 112 to 298 obruary till date, has been the past months. HgbA1c vides information about a vels of blood glucose, also ver the past 3 months) high was 7.7 in October 2015.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED
		7 50.125			
	00235	B. WING	· · · · · · · · · · · · · · · · · · ·	05	/17/2016
DER OR SUPPLIER	STREET ADI	DRESS, CITY, STAT	E, ZIP CODE		
SING HOME	3401 EAS	T MEDICINE LA	KE BOULEVARD		
ONGTIONE	PLYMOUT	H, MN 55441			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD				ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830 Continued From page 38		2 830			
Feb [February] 201 nging from 132-180 oreport of hypoglyc tient reported to be	6, random blood glucose since the beginning of April. emia, seizure from nursing. refusing blood draws and				
gait training due to	resident either refusing or				
- On 4/12/16, at 3:00 a.m. R51 was informed of an emergent call from his son. R51 stated "I do not care if it is an emergency. I only want to be woke up for GAZEBO."					
	•				
sessments had been atted to alcohol use the gazebo program. The esidents cannot drive a part of this program out and drinking oxicated, staff are estathalyzer can be pursing should be cheomitor them through danger and not medianger and not medianger and not medianger and specific policy about we eathalyzer level show you can be gram and goes our ogram for a specific pogram for a specific part of the program and goes our ogram for a specific part of the program and goes our ogram for a specific part of the program and goes our ogram for a specific part of the program and goes our ogram for a specific part of the program and goes our ogram for a specific part of the program and goes our ogram for a specific part of the program and goes our ogram for a specific part of the program and goes our ogram for a specific part of the program and goes our ogram for a specific part of the program and goes our ogram for a specific part of the program and goes our ogram for a specific part of the program and goes our ogram for a specific part of the program and goes our ogram for a specific part of the program and goes our ogram for a specific part of the program and goes our ogram for a specific part of the program and goes our ogram for a specific part of the program and goes our ogram for a specific part of the program and goes our ogram for a specific part of the program and goes our ogram for a specific part of the program and goes our ogram for a specific part of the program and goes our ogram for a specific part of the program and goes our ogram for a specific part of the program and goes our ogram for a specific part of the program and goes our ogram and goes our	an completed on residents unless they are a part of The DON stated, nk at the facility unless they ram, and should not be g. If they come back expected to ask if a erformed. If this is refused, ecking vital signs, and the night. If the resident is dically stable, they should be ysician should be notified of DON stated there was no when results of the full be reported to the of a person is on the gazebo the drinking, they are off the				
	DER OR SUPPLIER  SING HOME  SUMMARY STA  (EACH DEFICIENCY REGULATORY OR L  ontinued From page to indicated, "Patier Feb [February] 201 nging from 132-180 o report of hypoglyce tient reported to be ger sticks at times."  On 3/31/16, at 5:45 p gait training due to empting to be seen  On 4/12/16, at 3:00 a emergent call from t care if it is an eme oke up for GAZEBO  On 5/6/16, at 8:55 p awakened for anyt a 5/10/16, at 12:17 p sessments had bee ated to alcohol use a gazebo program.  The sessments had bee ated to alcohol use a gazebo program. The sessments had bee ated to alcohol use a gazebo program. The sessments had bee ated to alcohol use a gazebo program. The sessments had bee ated to alcohol use a gazebo program. The sessments had bee ated to alcohol use a gazebo program. The sessments had bee ated to alcohol use a gazebo program. The sessments had bee ated to alcohol use a gazebo program. The sessments had bee ated to alcohol use a gazebo program. The sessments had bee ated to alcohol use a gazebo program. The sessments had bee ated to alcohol use a gazebo program. The sessments had bee ated to alcohol use a gazebo program. The sessments had bee ated to alcohol use a gazebo program. The sessments had bee ated to alcohol use a gazebo program. The sessments had bee ated to alcohol use a gazebo program. The sessments had bee ated to alcohol use a gazebo program. The sessments had bee ated to alcohol use a gazebo program. The sessments had bee ated to alcohol use a gazebo program. The sessments had bee ated to alcohol use a gazebo program. The sessments had bee a gazebo program. The sessments had bee ated to alcohol use a gazebo program. The sessments had bee ated to alcohol use a gazebo program. The sessments had bee a gazebo program. The sessments had bee a gazebo program. The sessments had bee a gazebo program and gazebo program and gazebo program.	DER OR SUPPLIER  SING HOME  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Intinued From page 38  Iso indicated, "Patient was started on Latus [sik] Feb [February] 2016, random blood glucose riging from 132-180 since the beginning of April. In report of hypoglycemia, seizure from nursing. It interpreted to be refusing blood draws and ger sticks at times."  In 3/31/16, at 5:45 p.m. Therapy discontinued gait training due to resident either refusing or empting to be seen after the gazebo program.  In 4/12/16, at 3:00 a.m. R51 was informed of emergent call from his son. R51 stated "I do to care if it is an emergency. I only want to be ske up for GAZEBO."  In 5/6/16, at 8:55 p.m. R51 requested to never awakened for anything but the Gazebo.  In 5/10/16, at 12:17 p.m. the DON stated no sessments had been completed on residents ated to alcohol use unless they are a part of a gazebo program. The DON stated, esidents cannot drink at the facility unless they are a part of this program, and should not be ing out and drinking. If they come back poxicated, staff are expected to ask if a sathalyzer can be performed. If this is refused, rising should be checking vital signs, and sonitor them through the night. If the resident is danger and not medically stable, they should be not to detox. The physician should be notified of yone drinking." The DON stated there was no ecific policy about when results of the eathalyzer level should be reported to the yone drinking. The DON stated there was no ecific policy about when results of the gazebo program and goes out drinking, they are off the pagram for a specific amount of time. After that,	DER OR SUPPLIER  SING HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Ontinued From page 38  On indicated, "Patient was started on Latus [sik] Feb [February] 2016, random blood glucose ging from 132-180 since the beginning of April. Trapped to be refusing blood draws and ger sticks at times."  On 3/31/16, at 5:45 p.m. Therapy discontinued gait training due to resident either refusing or empting to be seen after the gazebo program.  On 4/12/16, at 3:00 a.m. R51 was informed of emergent call from his son. R51 stated "I do to care if it is an emergency. I only want to be kee up for GAZEBO."  On 5/6/16, at 8:55 p.m. R51 requested to never awakened for anything but the Gazebo.  On 5/10/16, at 12:17 p.m. the DON stated no sessments had been completed on residents ated to alcohol use unless they are a part of egazebo program. The DON stated, esidents cannot drink at the facility unless they are a part of this program, and should not be ing out and drinking. If they come back oxicated, staff are expected to ask if a eathalyzer can be performed. If this is refused, rising should be checking vital signs, and onitor them through the night. If the resident is langer and not medically stable, they should be notified of the yone drinking." The DON stated there was no ecific policy about when results of the sathalyzer level should be reported to the ysician but stated, "If a person is on the gazebo pogram for a specific amount of time. After that,	DER OR SUPPLIER  SING HOME  SING HOME  SING HOME  SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Intinued From page 38  Io indicated, "Patient was started on Latus [sik] Feb [February] 2016, random blood glucose giging from 132-180 since the beginning of Aprill, report of hypoglycemia, selzure from nursing, titent reported to be refusing blood draws and ger sticks at times."  Intinuing the seen after the gazebo program.  Intinuing the seen after the gazebo program. So in 5/6/16, at 8:55 p.m. Therapy discontinued grait training due to resident either refusing or empting to be seen after the gazebo program. The DON stated no sessments had been completed on residents at the facility unless they are a part of the gazebo program. The DON stated, esidents cannot drink at the facility unless they are a part of this program, and should not be ing out and drinking. If they come back oxicated, staff are expected to ask if a pathalyzer can be performed. If this is refused, rising should be checking vital signs, and ontor them through the night. If the resident is larger and not medically stable, they should be not of the pathalyzer level should be reported to the yaician but stated, "14 person is on the gazebo orgam not a specific policy about when results of the pathalyzer level should be reported to the yaician but stated," if a person is on the gazebo orgam not a specific amount of time. After that,	DER CETON  DER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP COBE  3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  DEFICIENCY  AND Indicated, "Patient was started on Latus [sik] Feb [February] 2016, random blood glucose ging from 132-180 since the beginning of April. report of hypoglycemia, seizure from nursing, tient reported to be refusing blood draws and ger sticks at times."  DIA 3/31/16, at 5.45 p.m. Therapy discontinued gait training due to resident either refusing or empting to be seen after the gazebo program.  DIA 4/12/16, at 3:00 a.m. R51 was informed of emergent call from his son. R51 stated "I do tacer if it is an emergency. I only want to be kee up for GAZEBO."  DIA 5/10/16, at 12:17 p.m. the DON stated no sessments had been completed on residents ated to alcohol use unless they are a part of gazebo program. The DON stated, esidents cannot drink at the facility unless they a part of this program, and should not be ing out and drinking. If they come back boxicated, staff are expected to ask if a stahalyzer can be performed. If this is refused, rsing should be checking vital signs, and onlot them through the night. If the resident is langer and not medically stable, they should be not to detox. The physician should be notified of yone drinking." The PON stated three was no ecific policy about when results of the stahalyzer can be performed to time. After that,

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STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE	SURVEY
		00235	B. WING	B. WING		/17/2016
NAME OF D	ROVIDER OR SUPPLIER		DDRESS, CITY, STA		U5	/1//2016
				KE BOULEVARD		
MISSION	MISSION NURSING HOME PLYMOU					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETE DATE
2 830	O Continued From page 39		2 830			
	facility." The DON also that all incidents involude breathalyzers be reported on 5/13/16, at 10:44 been at the facility for and had been part of since. He agreed to combecause I was able to stated he signed a compact was not exactly sure read it thoroughly. It further, R51 stated the SSD, and it was long restricted on one or to more than I should have shospitalized, he is 1-2 days. "I don't drin have nobody locally the stated in the stated that it is should have nobody locally the stated that it is should have nobody locally the stated that it is should have nobody locally the stated that it is should have nobody locally the stated that it is should have nobody locally the stated that it is should have nobody locally the stated that it is should have nobody locally the stated that it is should have no stated that it is should have no stated that it is should have no should have no stated that it is should have no stated that it is should have no stated that it is should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no should have no sho	so stated she would expect ving alcohol and orted to her.  a.m. R51 stated he had about a year and a half, the Gazebo program ever ome to this nursing home of drink and smoke." R51 intract for the program, but what it specified. "I didn't had to sign to participate." he alcohol was purchased by bocked up. "I have been wo occasions, when I drank have." R51 stated when he had only been restricted for k on outings anymore. I to take me on outings. I				
	When interviewed on consultant registered would not be recomm taking Keppra, due to effect of sedation whe used together. The M for the medication. The had not informed her residents, except that program.  R54's annual MDS da medical diagnoses will disorder and depress impairment.	5/17/16, at 8:26 a.m. the pharmacist (RP) stated it lended to use alcohol while the sedation and the side en alcohol and Keppra were D had addressed the need he RP also stated the facility of the alcohol use by the R51 was in the Gazebo ated 12/19/15, identified hich included a seizure ion, with no memory				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE S COMPLI		
		00235	B. WING		05/1	7/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
MISSION	NURSING HOME		ST MEDICINE LAK JTH, MN 55441	E BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	MARY STATEMENT OF DEFICIENCIES  EFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION)  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			OULD BE	(X5) COMPLETE DATE
2 830	impaired judgement dependence. The revalcohol related proble any significant behavior social services would interventions including planning as needed.  R54's CAA for psych 12/19/15, identified Four (medication to control of seizures, which we currently there was not related to address if the others at risk for injurently the same admission.  R54's medical record assessment related at high risk for falls reached at high risk for falls prior fall on 3/3/16, related interventions include whereabouts and satis sitting outside. The R54's alcohol abuse may drink which cout the interventions list should do if his ADL' The care plan also at the services whereabouts and satis sitting outside. The R54's alcohol abuse may drink which cout the interventions list should do if his ADL' The care plan also at the services whereabouts and satis sitting outside. The R54's alcohol abuse may drink which cout the interventions list should do if his ADL' The care plan also at the services whereabouts and satis sitting outside. The R54's alcohol abuse may drink which cout the interventions list should an also at the services whereabouts and satis sitting outside. The R54's alcohol abuse may drink which cout the services whereabouts and satis sitting outside. The R54's alcohol abuse may drink which cout the services whereabouts and satis sitting outside.	secondary to alcohol view identified R54 had no ems and had not displayed viors. The review included discontinue with active ing 1:1 visits and discharge of the received Keppra of seizures) daily for a history ere alcohol induced and ito alcohol use.  I dated 3/10/16, identified sions and cues and/or uired. The MDS identified other behaviors, however the behaviors put himself or ry. The MDS also identified of the with activities of daily living fall without injury since.  I lacked a comprehensive alcohol use.  I lacked a comprehensive alcohol use and had to admission as well as a late to suspected drinking. It is suspected drinking. It is suspected drinking of the resident when he are care plan also addressed and that R54 will go out and it did alter his ability with ADL's, ed did not address what staff is were altered do to drinking.	2 830			

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MIN 55441    CALL   D		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  MISSION NURSING HOME    XSUMMARY STATEMENT OF DEFICIENCIES   TAGGED   TA							
MISSION NURSING HOME   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   DEFICIENCY MUST BE PRECEDED BY FILL   REGULATORY OR LSC IDENTIFYING INFORMATION)   To DEFICIENCY MUST BE PRECEDED BY FILL   REGULATORY OR LSC IDENTIFYING INFORMATION)   To DEFICIENCY MUST BE PRECEDED BY FILL   REGULATORY OR LSC IDENTIFYING INFORMATION)   To DEFICIENCY   DEFICIENCY   DEFICIENCY   DATE			00235	B. WING		05/1	7/2016
CAST   Department   Departmen	NAME OF P	ROVIDER OR SUPPLIER					
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  2 830  Continued From page 41  ambulation with a four wheeled walker throughout the facility and outside. Interventions included R54 to be independent with ambulation with the walker throughout the facility and outside. The care plan dated 4/8/16, identified an alteration in behavior and mood with episodes of drinking either at the facility or outside the facility and then denying he did it, with refusals to comply with discharge planning. Interventions listed included 1:1 visits to discuss concerns and develop positive solutions and refer to psychologist as needed for mood concerns. The care plan failed to identify safety interventions for R54.  R54's nurse practitioner (NP) note dated 3/4/16, identified R54 had lifelong/ current alcohol abuse, and noted R54 denied he will drink any longer. Staff to monitor.  R54's medical record lacked any daily tracking for behaviors and/ or alcohol use. R64's NP note dated 4/11/16, identified staff smelled alcohol after patient returned from outings, and that he left in a cab daily. The note also identified that R54 had falls without injury and had refused breathalyzer testing. The NP indicated he was receiving a 30 day notice soon and noted, that due to his cirronic alcoholism it may be necessary to find him housing where drinking is allowed and monitored.  R64's medical record lacked a signed Alcohol and Drug Use policy	MISSION	NURSING HOME			IKE BOULEVARD		
ambulation with a four wheeled walker throughout the facility and outside. Interventions included R54 to be independent with ambulation with the walker throughout the facility and outside. The care plan dated 4/8/16, identified an alteration in behavior and mood with episodes of drinking either at the facility or outside the facility and then denying he did it, with refusals to comply with discharge planning. Interventions listed included 1:1 visits to discuss concerns and develop positive solutions and refer to psychologist as needed for mood concerns. The care plan failed to identify safety interventions for R54.  R54's nurse practitioner (NP) note dated 3/4/16, identified R54 had lifelong/ current alcohol abuse, and noted R54 denied he will drink any longer. Staff to monitor.  R54's medical record lacked any daily tracking for behaviors and/ or alcohol use.  R54's NP note dated 4/11/16, identified staff smelled alcohol after patient returned from outings, and that he left in a cab daily. The note also identified that R54 had falls without injury and had refused breathalyzer testing. The NP indicated he was receiving a 30 day notice soon and noted, that due to his chronic alcoholism it may be necessary to find him housing where drinking is allowed and monitored.  R54's medical record lacked a signed Alcohol and Drug Use policy	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE
R54's Order Summary Report, last reviewed on 5/9/16, included diagnoses of alcohol dependence and major depressive disorder.  The undated nursing assistant sheet, directed	2 830	ambulation with a four the facility and outside R54 to be independent walker throughout the care plan dated 4/8/1 behavior and mood weither at the facility or denying he did it, with discharge planning. In 1:1 visits to discuss a positive solutions and needed for mood conto identify safety interestable. R54's nurse practition identified R54 had life and noted R54 denied Staff to monitor.  R54's medical record behaviors and/ or alcomplete alcohol after outings, and that he leads identified that R5 and had refused breat indicated he was receased and noted, that due to may be necessary to drinking is allowed and R54's medical record Drug Use policy  R54's Order Summar 5/9/16, included diagradependence and major states.	r wheeled walker throughout e. Interventions included ht with ambulation with the e facility and outside. The 6, identified an alteration in with episodes of drinking r outside the facility and then he refusals to comply with hereventions listed included oncerns and develop I refer to psychologist as cerns. The care plan failed ventions for R54.  Her (NP) note dated 3/4/16, elong/ current alcohol abuse, d he will drink any longer.  I lacked any daily tracking for bohol use.  4/11/16, identified staff patient returned from eft in a cab daily. The note fied had falls without injury thalyzer testing. The NP elving a 30 day notice soon of his chronic alcoholism it find him housing where and monitored.  I lacked a signed Alcohol and  y Report, last reviewed on hoses of alcohol or depressive disorder.	2 830			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			5 444140			
		00235	B. WING		05/1	7/2016
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	, and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second		
MISSION	NURSING HOME		MEDICINE LA 1, MN 55441	KE BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	Continued From page 42		2 830			
	staff to observe for drinking and alert the nurse if there was alcohol on R54's breath.  The Resident Classification Listing By Room dated 4/18/16, indicated R54 was a Level 1 and needed to be searched upon return to the facility. The information was not included on R54's care plan.  A progress note dated 12/13/16, identified R54 had a history of alcohol abuse.  A progress note dated 2/10/16, indicated a staff member reported that she thought R54 had been drinking. R54 denied he had been drinking. A search of his room was conducted and no alcohol was found. A breathalyzer was administered and the the resident's reading was 0.177. R54 was informed that since he was not acting drunk or having behaviors he would not need to go to detox this time. The documentation lacked any monitoring or follow up of R54's condition.					
	at the facility short ter "don't want him to drir when he says he goe stated bags were to b Further, SSD stated to R54 an alternate place company was working stated R54 fell when be significant alcohol use stated it would not be while taking Keppra. I documentation was a monitoring and no indicompleted.	e history. The DON also advised for R54 to drink The DON stated no vailable on increased cident report had been				
	The facility's incident	log identified R54 had the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
		00235	B. WING		05	5/17/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
MISSION	NURSING HOME		ST MEDICINE LAK TH, MN 55441	E BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	2 830 Continued From page 43		2 830		<u>,                                      </u>	
	following alcohol related incidents:					
		. R54 was found on the floor e room and a alcohol bottle				
	On 5/11/16, at 3:52 p.m. the DON stated no breathalyzer was completed. Vital signs were checked with the neuro assessment. "He is at risk for falls when he is drinking." R54 sustained a skin tear on his right elbow from the fall.  - 4/8/16, at 9:49 p.m. R54 fell in his room. Resident smelled like he had been drinking alcohol, denies drinking and refused to do breathalyzer. DON notified. Three full Gatorade bottles at bedside. Vital sign checks done with the neurological assessment.					
	stated if a 30 day noti administrator would b interdisciplinary team also stated R54 was ' Medicare coordinator relocation thing and the The SSD stated she to	was completed. The SSD ce was provided, the e informed and the (IDT) would discuss it. She 'hooked up with the . The county does the ney help him look at places." alked with the county and options, and stated "I				
	- 4/11/16, at 7:50 p.m go to bed, smelled of	. R54 fell in room trying to alcohol.				
	- 4/23/16, at 3:45 p.m smelled of alcohol.	. R54 found on the floor and				
	would expect staff to	.m. the DON stated she call the physician, do an otify the administrator. R54				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	1 ' '	(X3) DATE SURVEY COMPLETED	
		00225	B. WING		0.5	/47/2040
		00235			05	/17/2016
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
MISSION	NURSING HOME		MEDICINE LA H, MN 55441	KE BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From page	÷ 44	2 830			
2 830	drinking. The SSD state (alcoholics anonymout these guys are not good R54's Comprehensive 3/3/16, identified R54 his back in the entry a identified R54 smelled bottle of vodka was founable to do a breath not blow into the devira 1/2 centimeter abra R54's blood pressure 79, neuro checks were unwitnessed fall. Immincluded increased legin reach and no more investigation section in to have been consum analysis and plan included included increased legin reach and no more investigation section in the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallohol policy of the fallo	th fall risk when he was lated "We have AA las) that comes here, but bring to do that."  Fall Report Form dated was found on the floor on late are of his room. The form do falcohol and an empty bund on the floor. R54 was alyzer as the resident could be correctly. R54 sustained sion to his right elbow. It was 98/50 with a pulse of the initiated due to an latediate interventions well of observation, call light alcohol tonight. The dentified that R54 appeared ling alcohol. The final lated re-education on the lacility. The corresponding mote dated 3/7/16, indicated do nalcohol policies. No late identified to assist with with the use of alcohol.  Review dated 3/11/16, me short term memory er drinking along with some judgement. The review also	2 830			
	to identify how R54 w A progress note dated	nvestigation was completed as accessing alcohol.  d 4/8/16 at 9:49 p.m.  len and was found on his				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		00235	B. WING		05	5/17/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
MISSION	NURSING HOME		ST MEDICINE LAK	E BOULEVARD		
		PLYMOL	JTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	back. No injuries were pain. R54's pupils we he was drinking alcohalcohol and refused to checks were started, and director of nursin pressure 128/72 and 94/56 and pulse 88 a not provide the correst Fall Report Form for note on 4/9/16, indicated alcohol and had the the bedside. The cornote dated 4/11/16, in re-educated on alcohalcoharge planning. Nassist with ensuring Falcohol.  R54's Monthly Nursin 4/19/16, indicated R5 within the last month the gazebo program. identified that R54 had drinking and refused smelled of alcohol.  R54's Comprehensive 4/23/16, identified R5 near his bed and he should be drinking. R54 was now was 116/65 with a pulinterventions included supervision, call light resident to keep walk investigation section resident has smelled breathalyzer. The finacontinue to search resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident res	e noted and R54 denied re dilated and smelled like nol. R54 denied drinking o do a breathalyzer. Neuro blood pressure running low g notified. Initial blood pulse 87. Blood pressure to 9:35 p.m. The facility did sponding Comprehensive this incident. A progress atted R54 continued to smell ree full Gatorade bottles at responding IDT progress adicated R54 was ol policy, with active do other interventions to R54's safety when drinking g Assessment dated 4 had been drinking alcohol and was not a member of The assessment also d a history of falling while a breathalyzer when he	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3)  A. BUILDING:			
			7 11 BOILES IN CO			
		00235	B. WING		05	5/17/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
MISSION	NURSING HOME		ST MEDICINE LAK	E BOULEVARD		
			TH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	corresponding progrei identified that R54 sm a breathalyzer test an started due to unwith corresponding IDT re 4/25/16, indicated started for alcohol and repolicy. There were not assist with R54's safe consumption.  R54's Fall/Safety Risl Assessment dated 3/recent fall for R54 was to be a high fall risk doconsumption resulting the alcohol policy and with the resident. No R54's safety were ided On 5/11/16, at 2:22 p sleeping in his room. appropriately with a febedside.  On 5/11/16, at 2:10 p (RM)-A stated that the that needed their bag the facility. RM-A stated that the found on the resident know. RM-A further s residents stumbling of was on the list to be sfacility, but RM-A had	ss note dated 4/23/16, nelled of alcohol and refused and neuro checks were essed fall. The view progress note dated fff were to continue to search emind him of the alcohol interventions identified to ety related to his alcohol (Evaluation and 10/16, indicated the most is 3/3/16. R54 was assessed ue to a recent alcohol g in a fall without injury and all procedures were reviewed other interventions to ensure entified.	2 830			
	stated he occasionall not drink at the facility	y had some drinks, but can y because he was not part of denied drinking, however				

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AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   A. BUILDING:   COMPLETED  00235   B. WING   05/17/2	
00235 B. WING 05/17/2	/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
MISSION NUIDSING HOME 3401 EAST MEDICINE LAKE BOULEVARD	
MISSION NURSING HOME PLYMOUTH, MN 55441	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
stated the nurses have asked him to do a breathalyzer when he returned to the facility, without explaining why. R54 further stated none of the facility staff members have ever asked him about his drinking history or whether he wanted to continue drinking. R54 continued to explain that he had problems with drinking in the past, more than socially, just for something to do.  On 5/10/16, at 3:38 p.m. trained medication assistant (TMA)-B explained the gazebo program. TMA-B stated the social worker did an assessment before residents could join the program. The resident had to agree to the rules of the program and if approved could participate in the program on a daily basis. Everyday prior to participating in the program the resident came to the nursing station and took a breathalyzer if it showed they haven't been drinking they can participate in the program. After the program the residents that participated have an assessment to see if they can count backward from ten. R51 was part of the gazebo program, however TMA-B had seen R51 intoxicated after returning to the facility from a pass for the day with friends or family. TMA-B stated that she had seen this two to three times and he often refused a breathalyzer when he came back. When R51 refused a breathalyzer have he came back. When R51 refused a breathalyzer have he came back. When R51 refused a breathalyzer have he came back. When R51 refused a breathalyzer have he came back. When R51 refused a breathalyzer have he came back. When R51 refused a breathalyzer have he came back. Whon R51 refused a breathalyzer his medications were held and he was sent to bed to sleep it off. For "punishment R51 could not participate in the gazebo program for a week, but sometimes the punishment is only three days, it varies." TMA-B stated that if a resident was intoxicated vital signs should be checked for twenty-four hours and complete checks every fifteen minutes for a time. TMA-B further stated sometimes R51 refused.  The front desk was supposed to check for alcohol when reside	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3  A. BUILDING:		
	A. BOILDING.			
00235	B. WING		05	/17/2016
STREET A	DDRESS, CITY, STATE	. ZIP CODE		
	, ,	•		
		L DOOLL VARD		
		PROVIDER'S PLAN OF	CORRECTION	(VE)
NCY MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
ge 48	2 830			
acility and had been drinking.  That R11 had snuck alcohol  That R12 had snuck alcohol  That R14 had snuck alcohol  That R15 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol  That R16 had snuck alcohol				
stated that generally speaking oxicated, vital signs were ent was asked to lay down. The resident should be closely sing on them frequently. The frequently. The administrator ency would be at the nurse's firmed frequent monitoring had do for these documented of use. The administrator discussing the issues of to the residents on the end the residents on the inat the facility's documentation ment and consequences of the administrator stated there documentation and that he extent of the drinking at the started talking with staff for IJ was called. The DON stated first floor have the potential to				
no la fibration in teakeenoning another services.	STREET A	STREET ADDRESS, CITY, STATE  3401 EAST MEDICINE LAK PLYMOUTH, MN 55441  STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)  Age 48  41 a.m. TMA-C stated R51  all, but alcohol hasn't been  46 a.m. NA-O stated that R11 acility and had been drinking. hat R11 had snuck alcohol y. NA-O stated it happened ber month. NA-O stated in the d to be sent to detox when they but the facility doesn't do that ated R51 drank with the ut had been known to drink ram as well.  302 p.m. to 5:02 p.m. the DON, rator were interviewed stated that generally speaking toxicated, vital signs were ent was asked to lay down. e resident should be closely king on them frequently. The e frequently. The administrator ency would be at the nurse's firmed frequent monitoring had d for these documented hol use. The administrator r discussing the issues of I to the residents on the and the residents drinking while hat the facility's documentation sment and consequences of the adminsitrator stated there decumentation and that he e extent of the drinking at the started talking with staff for IJ was called. The DON stated first floor have the potential to y and come back intoxicated,	STREET ADDRESS, CITY, STATE, ZIP CODE  3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MM 55441  STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL RLSC IDENTIFYING INFORMATION)  10 PREFIX TAG  10 PREFIX TAG  11 PREFIX TAG  12 B30  PREFIX TAG  13 PREFIX TAG  14 a.m. TMA-C stated R51 III, but alcohol hasn't been  15 a.m. NA-O stated that R 11 acility and had been drinking, hat R11 had snuck alcohol y. NA-O stated it happened er month. NA-O stated in the d to be sent to detox when they but the facility doesn't do that stated R51 drank with the ut had been known to drink ram as well.  10 p. PREFIX TAG  10 PREFIX TAG  11 PREFIX TAG  12 B30  PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REPERENCED TO T DEFICIENC  13 DEFICIENC  14 a.m. TMA-C stated R51 III, but alcohol hasn't been  15 to be sent to detox when they but the facility doesn't do that stated that generally speaking toxicated, vital signs were ent was asked to lay down. 10 er resident should be closely king on them frequently. The 10 frequently. The administrator ency would be at the nurse's firmed frequent monitoring had d for these documented fol use. The administrator r discussing the issues of to the residents on the and the residents on the and the residents on the and the residents on the and the facility's documentation sment and consequences of the administrator stated there documentation and that he e extent of the drinking at the started talking with staff for 1.1 was called. The DON stated dirst floor have the potential to y and come back intoxicated,	STREET ADDRESS, CITY, STATE, ZIP CODE  3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, NN 55441  STATEMENT OF DEFICIENCIES NOY MUST SEE PRECEDED BY BUIL PRESX RISC IDENTIFYING INFORMATION)  100 PRESX RISC IDENTIFYING INFORMATION)  110 PRESX RISC IDENTIFYING INFORMATION)  111 A.m. TMA-C stated R51 II, but alcohol hasn't been  112 A.m. TMA-O stated that R11 III add snuck alcohol III, No-O stated it happened are month, NA-O stated in the III to be sent to detox when they but the facility doesn't do that stated R51 frank with the III that been known to drink ram as well.  100 p.m. to 5:02 p.m. the DON, ratfor were interviewed stated that generally speaking toxicated, vital signs were ent was asked to lay down. II resident should be closely king on them frequently. The frequently. The administrator ency would be at the nurse's firmed frequent monitoring had did for these documented to luse. The administrator ridscussing the issues of to the residents on the and the residents on the and the residents on the and the residents or the started talking with staff for IJ was called. The DON stated first floor have the potential to y and come back intoxicated,

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		00225	B. WING		05/	47/0046
		00235	3: 1110		05/	17/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
MISSION	NURSING HOME		ST MEDICINE LAK	E BOULEVARD		
		PLYMOU	TH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From page	e 49	2 830			
	be notified of any inci including the amount report should be com facility needed a plan	that she or the SSD were to dents involving alcohol, of alcohol, and an incident pleted. She indicated the , so there was consistency ne SSD stated, "It needs ave concerns for their				
	was no documentation R51 or R54. No spect completed to determing assessment with the included social service sometimes a therapy therapy. "We look at lease how they are doing changes would be made as the seen of the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care processes to the care	staff if the resident was in behaviors and cognition and ang with both of these. Any ade on the level sheet." The sponsible for making any plan regarding the levels. pected to sign out when				
	social services director role with chemically of determining their histor the initial care conferon interdisciplinary treatr is appropriate for the acknowledged if residuould be a danger to was unable to state w	5/17/16, at 12:50 p.m. the or (SSD) stated part of her ependent residents is ory. The SSD stated during ence, she lets the ment team (IDT) know what individual resident. The SSD lents drink "too much" they themselves or others, but what "too much" was, but y get alcohol poisoning, or if				

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IVIIIIIICSUL	a Department of Health	l				
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		±1ĒD
		00235	B. WING		05/1	7/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
				KE BOULEVARD		
MISSION	NURSING HOME	PLYMOU	TH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	Continued From page	: 50	2 830			
	R51 would have a seizure, that would be too much.  The IJ that began on 5/12/16, was removed on 5/17/16, when the facility ensured assessments for alcohol use and safety had been completed, care plans for the identified residents had been updated, policies had been revised and/or developed, an intoxication/impairment assessment tool was developed, and it could be verified by interview that staff had been educated regarding these interventions.					
	The director of nursing train all staff and mon were assessed for sa intoxication including nursing care and treat educate all staff on the designee could report Assurance Committee ensure compliance.	-				
2 850	MN Rule 4658.0520 S Proper Nursing Care; Subp. 2. Criteria for oproper care. The critiadequate and proper D. Assistance with	determining adequate and eria for determining	2 850			
	This MN Requirement	t is not met as evidenced				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
00235 B. WING	05/17/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
MISSION NURSING HOME 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORF	R'S PLAN OF CORRECTION (X5)  RECTIVE ACTION SHOULD BE COMPLETE  RENCED TO THE APPROPRIATE DATE  DEFICIENCY)
by: Based on observation, interview, and document review, the facility failed to provide daily assistance with shaving for 1 of 3 residents (R 38) who required assistance with activities of daily living.  Findings include:  R38 was admitted to the facility on 5/21/15. R38's quarterly minimum data set (MDS), dated 2/16/16, identified R35 had moderate cognitive impairment. Further more, R38's MDS identified him as having Alzheimer's Disease, receiving hospice care, and requiring extensive physical assistance with personal hygiene.  R38's care plan, dated 4/26/16, identified him as having a self care deficit in ADL's requiring one staff to assist with grooming. R38's care plan further specified for staff to "Encourage to wash his face and hands." The care plan did not specify any preferences in the cares provided with grooming.  R38's face sheet included an admission photo in which R38 had a thick white and gray mustache.  On 5/9/16, at 7:00 p.m., R38 was observed sitting in his wheelchair. White hairs, approximately 1/8" (inch) long, were noted on his upper lip and scattered on both cheeks.  On 5/10/16, at 11:33 a.m., R38 was observed with the same white hairs on his upper lip and scattered on both cheeks. The stubble was approximately the same as the day before.  On 5/11/16 at 8:24 a.m., family member (FA)-1 had concerns that R38 was not being shaved	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00235	B. WING		05/1	7/2016
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
MISSION	NURSING HOME		MEDICINE LA 1, MN 55441	KE BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 850	only receiving assista week. FA-1 stated that important to R38, who particular person you shaving. FA-1 went of a huge thing for him." kept his mustache in "not feel good" about On 5/11/16, at 7:14 a observed sitting in his medication cart. R38 facial hair on his upper on R38's upper lip and when observed on 5/5 On 5/12/16, at 7:43 a sitting in wheelchair erroom. His hair appears R38 stated he had had white hair on his upper approximately 1/4" lost on 5/13/16, at 10:10 (NA)-M stated that R3 bathing, and shaving aides and the facility stated shaving was the nursing assistants, not had his own razor and resident use as well. I refused offers to shave that morning. Later the R38 was observed sit looking out the windo shaven, including the	arther thought that R38 was noce with shaving once a st shaving was very to had been "the most can imagine" regarding in to state that shaving "was FA-1 stated R38 always his younger years and would the mustache being shaved.  a.m., R38 was again as wheelchair, waiting by a continued to have white ear lip and cheeks. The hair dicheeks was longer than 20/16.  a.m., R38 was observed stating breakfast in the dining in wet and had been combed. In a bath that morning. The ear lip and cheeks was nowing.  a.m., nursing assistant as received grooming, assistance from the hospice nursing assistants. NA-M are responsibility of the facility of thospice. NA-M stated R38 dichere was a floor razor for NA-M stated R38 never we and NA-M shaved him at same day at 11:29 a.m., ting in his wheelchair w. His face was clean	2 850			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		00235	B. WING		05	/17/2016
	ROVIDER OR SUPPLIER	3401 EAS	DDRESS, CITY, STATE ST MEDICINE LAK TH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 850	residents were shave stated nursing staff we needed it because the LPN-B further stated identified how often the groomed. LPN-B verishaving with morning cares under the faciliti (activities of daily living explained if the document had not been done, the day.  On 5/16/16, at 10:38 was suppose to be a included in "grooming was having trouble fire time and thought some how to use non electrostated she would assolve know that shaving is to remind staff. LPN-7 nursing assistants changed assistance. All other of "shaving" between the "activity did not occare sheets were required months. None were provided to assist with ground assist of the same as a self care defined as a self care defined as a self care defined as a self care defined for self-the specified for self-the spec	went on to state that most d every third day. LPN-B ould shave a resident if they ey would "see it [facial hair]." residents' care plans ney needed to shaved or fied nursing staff charted cares and documented on ty document entitled "ADL ng) Care Provided." LPN-B mentation reported shaving nen R38 was not shaved that a.m., LPN-A stated the facility nding electric razors at one ne nursing staff did not know ric razors. LPN-A further ume nursing staff would part of grooming but has had a was unaware of where arted grooming cares.  The ets were reviewed from cocumentation identified that e on 5/15/16 with extensive documentation under at period of time identified ccur." ADL Care Provided uested for the previous three	2 850			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		00235	B. WING		05	/17/2016
	ROVIDER OR SUPPLIER	3401 EA	DDRESS, CITY, STATE ST MEDICINE LAK ITH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 850	Continued From page	e 54	2 850			
	last reviewed 4/20/06	d Resident Cares Grooming, , directed staff to "Assist or ent with shaving on a daily				
	director of nursing (D review systems for re designee could in-ser activities of daily living	OD OF CORRECTION: The ON) or designee could sident ADL's. The DON or vice all staff on performing g (such as shaving) for or designee could monitor ce.				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				
2 920	MN Rule 4658.0525	Subp. 6 B Rehab - ADLs	2 920			
	comprehensive reside home must ensure th B. a resident who is activities of daily living	unable to carry out g receives the necessary good nutrition, grooming,				
	by: Based on observation	t is not met as evidenced n and interview, the facility rence of facial hair for 1 of 2 wed for choices.				
	Findings include:					
	quarterly minimum da	the facility on 5/21/15. R38's ata set (MDS), dated				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDIEAN	SI GORREGION	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		LILD
		00235	B. WING		05/	17/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
MISSION	NURSING HOME		「MEDICINE LA H, MN 55441	AKE BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 920	him as having Alzheir hospice care, and red assistance with person R38's care plan, date having a self care def staff to assist with grofurther specified for shis face and hands." any preferences in the grooming.  R38's face sheet incluwhich R38 had a thick which R38 had a thick which R38 had a thick which long, were note scattered on both che scattered on both che approximately the sar On 5/10/16, at 11:33 a with the same white h scattered on both che approximately the sar On 5/11/16 at 8:24 a. I had concerns that R3 often enough. FA-1 fu only receiving assista week. FA-1 stated that important to R38, who particular person you shaving. FA-1 went on a huge thing for him." kept his mustache in "not feel good" about	nore, R38's MDS identified ner's Disease, receiving quiring extensive physical nal hygiene.  d 4/26/16, identified him as icit in ADL's requiring one roming. R38's care plan taff to "Encourage to wash The care plan did not specify e cares provided with  aded an admission photo in a white and gray mustache.  In., R38 was observed sitting ite hairs, approximately 1/8" and on his upper lip and reks.  a.m., R38 was observed nairs on his upper lip and reks.  The stubble was me as the day before.  In., family member (FA)-1  8 was not being shaved urther thought that R38 was noce with shaving once a real shaving was very on had been "the most can imagine" regarding in to state that shaving "was FA-1 stated R38 always his younger years and would the mustache being shaved.	2 920			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COWIFEE	ileb
	00235	B. WING		05/17	7/2016
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MISSION NURSING HOME		MEDICINE LA	AKE BOULEVARD		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIEM DEFICIENCY)	D BE	(X5) COMPLETE DATE
on R38's upper lip and when observed on 5/9/ On 5/12/16, at 7:43 a.m sitting in wheelchair ear room. His hair appear were R38 stated he had had white hair on his upper approximately 1/4" long. On 5/13/16, at 10:10 a. (NA)-M stated that R38 bathing, and shaving as aides and the facility nustated shaving was the nursing assistants, not had his own razor and resident use as well. Not refused offers to shave that morning. NA-M reproutine, some residents some would say "go rig day at 11:29 a.m., R38 wheelchair looking out clean shaven, including R38 was stated he did "a mustache I like."  On 5/13/16, at 1:39 a.m (LPN)-B stated R38 was and facility staff and we residents were shaved stated nursing staff wor	ontinued to have white lip and cheeks. The hair cheeks was longer than 16.  In., R38 was observed ting breakfast in the dining wet and had been combed. In a bath that morning. The lip and cheeks was now g.  In., nursing assistant Is received grooming, ssistance from the hospice cursing assistants. NA-M responsibility of the facility hospice. NA-M stated R38 there was a floor razor for A-M stated R38 never and NA-M shaved him ported that shaving was a swould say yes or no, ght ahead." Later that same was observed sitting in his the window. His face was go the hair on his upper lip. not like having a beard but  In., licensed practical nurse as shaved by both hospice ent on to state that most every third day. LPN-B uld shave a resident if they would "see it [facial hair]." esidents' care plans	2 920			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		00235	B. WING		05/17/2016
	ROVIDER OR SUPPLIER	3401 EA	DDRESS, CITY, STATE ST MEDICINE LAK ITH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETE
2 920	was suppose to be a included in "grooming any assessment regar or not a resident wan"  SUGGESTED METH director of nursing (D develop, review, and/procedures to ensure preferences with activ The director of nursin educate all appropria procedures. The director designee could develensure ongoing comp	a.m., LPN-A stated shaving daily event and was g." LPN-A was unaware of ording facial hair and whether sted to keep a mustache.  OD OF CORRECTION: The ON) or designee could for revise policies and stall residents personal wities of daily living are met. If g (DON) or designee could staff on the policies and ordinate staff on the policies and ordinate ordinate ordinates or monitoring systems to	2 920		
21230	Implement ResCare  Subp. 2. Duties. The conjunction with the a director of nursing se for:  B. implementatio  This MN Requirement by: Based on interview at facility failed to collab director to address coissues for 3 of 3 resident.	e medical director, in	21230		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		LETED
		00235	B. WING		05/	17/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		3401 EAS	T MEDICINE LA	AKE BOULEVARD		
MISSION	NURSING HOME	PLYMOU1	H, MN 55441			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TO DEFICIENCE		DATE
					•	
21230	Continued From page	e 58	21230			
	See F323. The facilit	y failed to comprehensively				
		nterventions to reduce the				
		n to 3 of 3 residents (R11,				
	R51, and R54) who e	xcessively consumed				
	alcohol and regularly	became intoxicated. This				
	resulted in an immedi	ate jeopardy situation for				
	R11, R51, and R54.					
		5/17/16, at 2:58 p.m. the				
	, ,	stated he is not the primary				
		ne residents at the facility,				
		ector. MD denied being				
	_	residents were drinking				
	_	program, stating "and that				
		has been brought up to				
		Irinking. Further MD stated				
		as held outside, there were  d brought into the quality				
		He stated he was aware				
	_	y people that go out to drink,				
		ere was a problem, but more				
		MD also stated he was not				
		peatedly not following the				
		ect there be an incident				
	report filled out, and t					
		alcohol be brought to him				
	for review. When rev	iewing the breathalyzer				
	results of the resident	ts, MD stated be was "agast"				
	that nursing did not de	o a report on these. Years				
	ago, MD stated he su	ggested the breathalyzer,				
	and expected there w	as a policy in place as to				
		the specific readings. MD				
	_	not reached out to him for				
		do if residents are refusing				
		A result of 0.256, would				
		rinking, with the person quite				
		k for falling. At 0.307, would				
		risk of falls. There is also				
	potential of issues wit	th the resident's				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00235	B. WING	<del></del>	05/1	7/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MISSION	NURSING HOME		MEDICINE LA I, MN 55441	KE BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21230	anyone refusing a brecannot allow nothing what to do if someone real issue is monitoring more attention to proporthere needs to be a presidents that are into need to be more accoresidents need to be completed, and they passurance.  Medical Director Agresidentified the provider overall coordination of care responsibility for assurance appropriate care as remonitoring and ensur resident care policies supervision of physicicare of residents.  SUGGESTED METH The administrator and could ensure collabor director regarding responsedures including facility could ensure to all policies, procedure grievance reports to enter the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care	ted he was not aware of eathalyzer, identifying they to be done. The delima is a is not cooperative. The ing, and the facility has to pay be leaving the building. Dolicy on monitoring exicated. Door monitors buntalbe. The high risk monitored, incident reports need to be brought to quality be means provider shares uring facility is providing equired which involves ing implementation of and providing oversight and an services and medical consumption. The high risk medical consumption. The high risk medical director reviews	21230	DEPICIENCY)		
21375	MN Rule 4658.0800 S Program	Subp. 1 Infection Control;	21375			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOWIBER.	A. BUILDING: _	A. BUILDING:		LLILD
		00235	B. WING		05/	17/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
MISSION	NURSING HOME	3401 EAS	T MEDICINE LA	AKE BOULEVARD		
	NOTONIC HOME	PLYMOUT	H, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21375	Continued From page	e 60	21375			
	Subpart 1. Infection home must establish	control program. A nursing and maintain an infection gned to provide a safe and				
	by: Based on interview at facility failed to develor infection control progressymptoms and culture	ram that included illance of resident es and analysis of that If the potential to affect all 85				
	Findings include:					
	Control Logs from 3/1 infections were identifinfections (UTI's), 17 cellulitis/wound infect infections. All UTI and treated with antibiotic logs lacked evidence tracking to support an either changed or ext respiratory infections pneumonia) without ecultures/symptoms to extension of antibiotic identified antibiotic ch respiratory infection on hospitalization or "acc facility lacked any doc surveillance infection"	respiratory infections, 11 ions, and 2 unidentified d respiratory infections were therapies, however; the of cultures and symptom hibiotic use. Antibiotics were ended on 2 UTI's and 3 (excluding aspiration evidence of support the change or therapies. The logs hanges for 1 UTI and 1 hoccurred due to quired healthcare." The cumented analysis of the				
		.m., the director of nursing ction control logs were filled				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE Co			E SURVEY PLETED	
		00005	B. WING			14710040
		00235			08	5/17/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MISSION	NURSING HOME		ST MEDICINE LAK	E BOULEVARD		
		PLYMOU	JTH, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21375	out by the floor nurse The logs were review monthly quality assur she did not have a wr surveillance. The DO of antibiotics the first previous month. She changes that occurre hospitalized and state to obtain the cultures She further stated syr in the residents' prograwere documented on  The facility policy Inferevised in 2013, estal program was to "prov investigation and mor extent possible, the o infection." Furthermor surveillance/monitorir culture and sensitivity to identify types of or monitor for antibiotic identify potential trans between residents" ar for infections, compile and bring reports to the oversight committee.'  SUGGESTED METH The Director of Nursir revise infection contro ensure adequate trace infections. The DON control program analy identifying patterns ar and symptom tracking involved staff. The que	es as the infections occurred. ed by her and in their ance (QA) meetings, but itten analysis of the N stated she received a list week of every month for the also noted the antibiotic d while residents were ed the expectation would be and document on the logs. mptoms were documented ress notes. No symptoms the logs.  ection Control Program, colished the intent of the ide surveillance, nitoring to prevent, to the nset and the spread of re, the policy identified re as to "review microbiology or reports on a regular basis ganisms causing infections, resistant organisms, and smission of organisms and to "perform surveillance and analyze data, prepare the Infection Control	21375			

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	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00235	B. WING		05/17/2016	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
21375		e 62  Infection control program.  CORRECTION: Twenty-one	21375			
21426	Prevention And Control  (a) A nursing home production control progrecurrent tuberculosis in issued by the United Structure and Prevention Tuberculosis Eliminat Morbidity and Mortality This program must indirection control plant unpaid employees, corresidents, and volunted Health shall provide to regarding implementation.	provider must establish and asive tuberculosis am according to the most affection control guidelines. States Centers for Disease on (CDC), Division of ion, as published in CDC's ay Weekly Report (MMWR). Clude a tuberculosis that covers all paid and contractors, students, eyers. The Department of echnical assistance attion of the guidelines.	21426			
	by: Based on interview ar facility failed to mainta tuberculosis symptom employees (NA-A, NA administer the tubercu					

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STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00235	B. WING		05/	17/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MISSION	NURSING HOME		T MEDICINE LA ГН, MN 55441	KE BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
21426	Continued From page	e 63	21426			
	no previous history o admission.	f tuberculosis testing prior to				
	Findings include:					
	Worksheet for Health	•				
	Facility policy entitled: Tuberculosis Screening- Employees, revised in 2013, indicated that new employees of the facility be tested and screened for TB upon hire and with an annual screening. The policy also indicated that a new employee could start working if the first tuberculin skin test (TST) and employee risk screening tool (symptom screen) were negative.					
	following: Nursing assistant (NANA-A's employee file dated 8/17/15, to rule a symptom screen for hired. NA-B was hired on 4/contained a chest X-medical evaluation, dbut did not contain a TB symptoms when hicense practical nurs 3/19/16. LPN-A's employed Quantiferon-TB Gold 11/22/14, but did not for active TB symptoms.	se (LPN)-A was hired on bloyee file contained a (TB blood test), dated contain a symptom screen ms when hired.				
	On 5/16/16, at 11:11 a confirmed that there	a.m., human resources (HR) was no additional TB				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE S COMPLI		
			A. BUILDING:			
		00235	B. WING		05/1	7/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MISSION	NURSING HOME		MEDICINE LA H, MN 55441	AKE BOULEVARD		
240.15	CLIMMADY CT	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTIO	NI	0/5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
21426	Continued From page	e 64	21426			
	information in the em	ployee files.				
	Residents, revised in new admissions a tub be done within 72 hou	: Tuberculosis Screening- 2013, indicated that "for all perculin skin test (TST) will urs after admission if there is result from within 3 months				
	contained the followin R100 was admitted to symptom screen for a upon admission. How not administered until order for the two step 5/13/16. Immunization previous facility indica August/September of prior). R38 was admitted to symptom screen for a upon admission. How not administered until for a TST to be admir	o the facility on 5/5/16. A active TB was completed vever; R100's first TST was 5/13/16. A physician's TST was obtained on				
	director of nursing (Director of nursing (Director of nursing (Director) residents to receive the week of admission, if previously. The DON	stated R38 was admitted ab facility. Documentation of				
	was admitted from a confirmed his last TS	a.m., the DON stated R100 different facility and T testing had been in 2014. rst TST should have been				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00235	B. WING		05/17/2016
	ROVIDER OR SUPPLIER	3401 EA	ADDRESS, CITY, STATE  ST MEDICINE LAK  JTH, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
21426	obtained.  Additional information provided.  SUGGESTED METHOM The director of nursing revise policies and prosurveillance. The DOI appropriate staff on the DON could monit TB screening to ensure	was requested but not  OD FOR CORRECTION: g (DON) could review and ocedures for TB	21426		
21435	home must provide an recreation program. based on each individual strengths, and needs, meet the physical, mewell-being of each rescomprehensive reside comprehensive plan of 4658.0400 and 4658 provided opportunities planning and develop recreation program.  This MN Requirement by: Based on observation	General requirements. A nursing of organized activity and organized activity and organized activity and organized activity and organized activity and resident's interests, and must be designed to ental, and psychological sident, as determined by the ent assessment and of care required in parts of core required in parts.	21435		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			7. BOILDING.			
		00235	B. WING		05/17/2	2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MISSION	NURSING HOME		MEDICINE LA H, MN 55441	KE BOULEVARD		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	DN	(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETE DATE
21435	Continued From page	e 66	21435			
	activities for 1 of 3 res	sidents (R16) reviewed for				
	Findings include:					
	diagnoses included so Alzheimer's disease, pulmonary disease (C Data Set (MDS) dated severe cognitive impa R16 felt it was very in have newspapers/ma with groups of people outside and get fresh	d 4/14/16, indicated R16's chizoaffective disorder, and chronic obstructive COPD). An annual Minimum d 5/6/16, indicated R16 had airment. It also indicated aportant to listen to music, gazines to read, to do things, and important to go air. A quarterly MDS dated was independent with				
	interest such as televi and special events. A Interest Survey dated	end upcoming programs of ised sporting events, socials A Therapeutic Recreation 5/15/15, indicated some of d smoking, cards, Bingo,				
	the activities that were morning music, creati and cards. A daily ac 5/6, 5/9, 5/10, and 5/	ated 5/16, indicated some of e planned included Bingo, ve arts, movies, gardening, tivity log dated 5/1, 5/3, 5/5, 11/16 did not indicate R16 ate in the activities, if R16 f R16 attended any				
	smoking with other re smoking room. At 3:2	.m. R16 was observed sidents in the second floor 3 p.m. R16 was sitting in the ew of the smoking room.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
		00235	B. WING		05/17/2016
	ROVIDER OR SUPPLIER	3401 EA	DDRESS, CITY, STA ST MEDICINE LA TH, MN 55441	TE, ZIP CODE KE BOULEVARD	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
21435	activity.  On 5/11/16, at 3:25 p. to activities when they from the chair in the hamber of the smoking room when in the was going to have.  On 5/11/16, at 3:28 p. (DA) stated resident's encouragement to try thier own. The DA stated invited to the activities approached for an activities approached for an activities approached for an activities approached for an activities approached for an activities approached for an activities approached for an activities in a big problem.  A facility policy Basic Follow Each Time Who dated 2/14 directed signarticipant's involvem.  SUGGESTED METHE activity director (AD) densure residents are attend activities of preensure individualized available as able. The educate all staff on the develop programs to develop programs to develop activities when the properties are attended activities of preensure individualized available as able. The educate all staff on the develop programs to develop programs to develop activities when the properties are attended activities of preensure individualized available as able. The educate all staff on the develop programs to develop activities of preensure individualized available as able.	m. with R16 stated he went were offered. R16 got up hallway and walked into the twas opened. R16 stated a cigarette now.  m. the director of activities needed a lot of things in their rooms and on ted every resident should be so the DA stated if R16 were tivity then it should be civity log. The DA stated here with documentation.  Activity Program-Steps to be Running a Program that to document the ent in the activity.  OD OF CORRECTION: The could develop systems to offered and encouraged to be ference. The AD could	21435		
21495	Providing Social Serv	Subp. 5 Social Services; ices ocial services. Social	21495		
			1		

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00235	B. WING		0.5	5/17/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
MISSION	NURSING HOME		AST MEDICINE LAK	E BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21495	services must be providentified social service according to the compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compassessment and compas	vided on the basis of ce needs of each resident, prehensive resident prehensive plan of care 558.0400 and 4658.0405.  It is not met as evidenced in, interview, and document led to provide medically is for residents who abuse insistent implementation of otocols and/or to assist with or 2 of 3 residents (R11 and othol use and other.  5/17/16, at 12:50 p.m. the or (SSD) stated part of her dependent residents is ory. The SSD stated during ence, she lets the ment team (IDT) know what individual resident. The SSD dents drink "too much" they themselves or others, but what "too much" was, she ey get alcohol poisoning, or if eizure, that would be too	21495			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00235	B. WING		05/17/2016
NAME OF D	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZIR CODE	1 05/17/2016
			, ,	KE BOULEVARD	
MISSION	NURSING HOME	PLYMOUT	H, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
21495	Continued From page	e 69	21495		
	Active diagnoses inclinon-Alzheimer's demicognitive communicate cirrhosis of liver, and MDS also identified Ribehavioral symptoms and rejection of care.  R11's behavioral symptoms and episodes of impart decision making, notion was in a verbally agginanother resident whice physical aggression. In about not going out in alcohol or take drugs	alcohol dependence. The k11 exhibited other not directed toward others,  ptom Care Area ated 7/2/15, identified R11 ired judgment and pooring an episode in which he ressive altercation with the lead to threatening and "He also has been warned ato the community to drink and/or bring anything back A documentation lacked any			
		lacked a comprehensive o safety of alcohol use.			
		lacked a signed Alcohol and face sheet identified R11 as party.			
	dependence. It also is out 'for a few drinks'. encouraging sobriety, initiated 12/11/11), priget along with roomm physical and verbal a also indicated R11 wadue to alcohol or drug	cognition related to alcohol dentified a history of going Interventions included: Level I monitoring (date vate room due to inability to lates, and identifying ggression. The care plan as at moderate risk for falls			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00235	B. WING		05/17/2016
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIP CODE	1 00/11/2010
				KE BOULEVARD	
MISSION I	NURSING HOME	PLYMOUT	H, MN 55441		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
21495	Continued From page	<del>2</del> 70	21495		
	lacked specific interveuse.	esure monthly. The care plan entions related to alcohol			
	The facility provided a Listing by Room date identified as a Level I information provided	I (which contradicted			
	director (SSD) was as level information for F was unsure why R11 Resident Classification	n Listing. The SSD stated, d has been since 9/23/12.			
	R11's Fall/Safety Risks Evaluation and Assessment dated 3/7/16, failed to indicate R11 had a current issue with alcohol and/or drug use, an extensive history of alcoholism, alcoholic cirrhosis of the liver, drunkenness, and alcohol-induced persisting dementia. The assessment indicated "occasionally resident is confrontational with staff and other residents, especially if drinking alcohol."				
		ress notes dated 4/22/15 tified the following incidents:			
	6:55 p.m., and returned breathalyzer, stating, program. I don't have facility's Gazebo Alco by the facility, which aphysician approved, s	specific area of the building			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	CONSTRUCTION	(X3) DATE COMP	SURVEY
			D. MINIO			
		00235	B. WING		05/	/17/2016
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	,		
MISSION	NURSING HOME		H, MN 55441	KE BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21495	Continued From page	e 71	21495			
	agitated, jumping fron times not making sen his room. - 5/23/15, at 9:45 a.m	R11 exited his room, n one subject to another, at se, talking about drinking in  R11 had been speaking to				
	shared with dietary st	ge". It also noted R11 aff he had been drinking. icluded: "In a brief glance ee any alcohol				
	- 5/24/15, at 3:30 a.m. identified at 9:50 p.m. R11 was observed blocking the door entrance, with the door monitoring staff outside. R11 began yelling racial slurs to staff and threatening to "physically harm the door monitor." R11 walked toward staff in a threatening manner, swearing, and was informed if he physically harmed staff, the police would be called. R11 went to his room, and returned at 10:05 p.m. cursing, gritting his teeth, and leaning on the nursing station. He was informed the police would be called if he didn't calm down. It was also noted R11's eyes were "extremely blood shot." R11 was checked on x 2 [twice] and appeared to have calmed down.					
	a verbal altercation we scorted out of the did threaten the peer, may and attempted to get. The note indicated R suspected he had been "Did he laugh at me, of him." A correspond 6/16/15 was complete content.	m. R11 confronted and had ith a peer, and when being ning room, began to king the motion of a fist, back in the dining room. 11 had slurred speech and en drinking. R11 stated, I'm gonna knock the shit out ding incident report dated ed, but lacked any additional at the SSD and administrator				

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Minnesot	<u>a Department of Health</u>	າ				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
		00235	B. WING		05/4-	7/2046
		00235			05/1/	7/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		3401 EAS	T MEDICINE LA	AKE BOULEVARD		
MISSION I	NURSING HOME	PLYMOUT	H, MN 55441			
0(1) 15	STIMMADV ST	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
21495	Continued From page	e 72	21495			
	discussed recent beh	aviors with R11, and he was				
	informed he could not					
		gazebo program. The notes				
	•	nt gets intoxicated he has to				
		irses when they ask for a				
		e doesn't comply he will be				
	-	nd/or the police will be called				
	· ·	hat he understood and				
		the police called due to his				
		was told that he will be				
	given a notice to discl	harge if there are any more				
	incidents, he respond	led with "I am leaving soon				
	anyway" and when as	sked where he was going he				
	could not give an ans	wer. The documentation				
	indiated the administr	ator had reiterated				
		me and the resident had				
		d. A couple of hours later the				
		hether if they would find him				
	a place to go if given	a discharge notice.				
	- 6/19/15, at 9:30 a.m	. (documented as a late				
		was told that he would be				
		if his behaviors continued.				
	- 7/5/15, at 5:36 p.m.	R11 had a verbal altercation				
	with a peer, threatening	ng to "beat each other up."				
	Four staff intervened	until the peers walked away				
	from each other.					
	- 7/7/15, at 7:46 p.m.	R11 was in a verbal				
		r, entering peer's room,				
	yelling and cursing at					
	7/10/15 0+ 2:12 =	D11 complained of				
	- 7/10/15, at 3:12 p.m	•				
		an abdominal x-ray was				
	room, I'll kill them."	"Don't send them in my				
	TOOTH, TH KIII UICHI.					
	-8/20/15 at 1:24 a m	R11 was complaining about				
		en began cursing and				

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MILLIESOL	a Department of Health	 				
	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
		00235	B. WING		05/	17/2016
			1		1 30/	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
MISSION	NURSING HOME	3401 EAS	ST MEDICINE LA	KE BOULEVARD		
MICOIOIT	TOTOME	PLYMOU'	TH, MN 55441			
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETE DATE
TAG	REGOLATORI ORE	100 IDENTIFY TING IN CHAINATION,	TAG	DEFICIENCY)	COLINALE	
			0445-			
21495	Continued From page	e 73	21495			
	became agitated.					
	3					
	- 9/4/15, at 4:32 p.m.	staff reported to nurse R11				
	appeared to be drunk	. The SSD and				
	administrator entered					
	-	sked if he had been drinking				
	_	ing, R11 denied it. His				
	•	at slurred. Breathalyzer				
	read 0.204, and a retest of the breathalyzer was 0.203. "This writer and Administrator then reminded him of a discussion in which he stated that he understood that if an incident like this happened again he would be given a notice to					
		e remembered this. This				
		nim that a referral would be				
	made for the Glennwo					
		chronically alcoholic and				
	_	omen], so that discharge				
		He stated understanding of				
	this."	· ·				
	- 9/8/15, at 10:22 p.m	. R11 was found on the floor				
		oom. He appeared drunk				
	but refused breathaly					
		nt stated "don't call the				
		trouble." Corresponding				
		eted, identified plan to				
	"possibly" give reside	nt a 30 day notice to				
	discharge.					
	- 9/9/15, at 5:44 p.m.	Staff reported D11				
		D and another staff entered				
		ised breathalyzer. He was				
		do the breathalyzer, "it was				
		nat he had been drinking."				
		se, and closed his eyes.				
		,				
	- 10/19/15, at 6:15 p.r	m. R11 left facility at 8:30				
		9:50 p.m. Breathalyzer read				
	0.105.	-				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00235	B. WING		05/	17/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
MISSION	NURSING HOME		MEDICINE LA H, MN 55441	KE BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21495	Continued From page	e 74	21495			
	p.m 9:35 pm. Brea - 10/31/15 at 7:15 p.n altercation with house incident report completurther information 11/7/15, at 7:27 p.m returning at 7:11 p.m 11/9/15, at 9:45 p.m returned at 8:50 p.m 11/16/15, at 12:30 a station asking for me refused. He became cursing". Staff attemp	•				
	- 11/16/15, at 6:30 p.r from 6:30 p.m 8:30 0.08.	m. R11 out of the building p.m. Breathalyzer was				
	and breathalyzer read When interviewed on DON stated breathaly limit, and she wouldn monitoring. The DON and would expect her been notified of any in any amount, and wou completed.  - 12/24/15, at 5:30 p.i cans of beer in his roo	•				

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STATEMEN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		00235	B. WING		05/17/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE	
MISSION	NURSING HOME		ST MEDICINE LA TH, MN 55441	KE BOULEVARD	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
21495	Continued From page	: 75	21495		
	cursing, slammed the foot.	cabinet door shut with his			
	breathalyzer was don room search revealed was notified of this ind further symptoms, and minute checks. Furth aggressive, but he was alcohol.  - 3/29/16, at 9:13 p.m. p.m. and returned at 9	m. the DON stated no e. The DON also stated a I no further alcohol, and she cident. There were no d she would not expect 15 er, the DON stated R11 was as also aggressive without  . R11 left the facility at 6:20 2:20 p.m. R11 reported te, and breathalyzer reading			
		. R11 left the building and upon return.			
		R11 left the facility at 2:05 3:39 p.m. Breathalyzer read t to his room.			
	not on the Gazebo pri want to follow the rule drink'. The DON also R11's breathalyzer re- gone to his room. The provide any documen such as vital sign read and safety monitoring	ted assessment at that time dings, or increased clinical having been done. The d have expected an incident			
		Review notes dated e does display some short some of which could be			

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	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   A. BUILDING:	COMPLETED
00235 B. WING	05/17/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
MISSION NURSING HOME 3401 EAST MEDICINE LAKE BOULEVARD	
PLYMOUTH, MN 55441	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIADE DEFICIENCY)	
selective memory. He has episodes of impaired judgement." The notes also included, "He can also be verbally aggressive towards staff especially when they want him to do something. He does not want anyone in his room even after knocking. He has episodes of drinking inside or outside of the building and then denying that he has. Social Service will remain actively involved through 1 to 1 visits and behavior management interventions as needed."  During interview with the SSD, she stated the original plan for R11 was to discharge him to a wethouse [a residential facility for chronically alcoholic and homeless men and women]. However, he was not accepted there because he has a colostomy, and even though he is independent with the cares of his colostomy, there was a concern from the wethouse about shared bathrooms. The SSD serified the nursing home was not an appropriate placement for R11, as he requires no skilled care, and stated she had been trying to convince him to go to a more independent setting, but stated there was no current plan in place for discharge.  The SSD stated on 5/17/16 at 12:50 p.m., that R51 remained adamant he wanted to comtinue to drink, and that a reason he wanted to comitioue to drink, and that a reason he wanted to comitioue to drink in unsing home was to be a part of the alcohol program. The SSD verified no discharge plans were in progress for this resident.  R51's quarterly MDS dated 4/28/16, identified the resident had modified independence in cognitive skills for daily decision making, behavioral symptoms not directed toward others, and required the use of a wheelchair. Diagnoses included hypertension, diabetes mellitus, seizure	

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Minnesot	Vinnesota Department of Health					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	E I E D
		00235	B. WING		05/1	7/2016
NAME OF D	ROVIDER OR SUPPLIER	STDEET AF	DRESS, CITY, STA	TE ZIR CODE		
IVAIVIL OI II	TOVIDER OR OUT FEER			KE BOULEVARD		
MISSION I	NURSING HOME		TH, MN 55441	ARE BOOLEVARD		
	OLIMANA DV OT		<u>,                                      </u>	PROVIDERIO DI ANI OF CORRECTION		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
21495	Continued From page	e 77	21495			
	1 0					
	D51's CAA dated 11/3	3/15, identified diagnoses of				
		tion/withdrawal, physical				
		n, limited range of motion,				
		or balance, and visual				
		entified behavior problems				
	including disruptive, lo	oud talking in the dining				
		Gazebo/alcohol program."				
	The CAA noted impai					
	transitions, and difficu					
	mobility. The CAA lac	itation and decreased				
		rith these behaviors. R51 did				
	9	nsive assessment related to				
	the safe use of alcoho					
	R51's medical record	included a signed contract				
	to participate in the G	. •				
		re was not a signed Alcohol				
		The face sheet identified				
	R51 as his own respo	risible party.				
	R51's care plan dated	4/27/16, identified a self				
	•	icit related to alcohol use. It				
	•	d a potential risk for falls				
	related to being whee	Ichair bound, and the use of				
	alcohol with the Gaze	bo program. The plan of				
		ng and short term memory				
		idgement and decision				
	•	I dependence. The care				
	behavior related to ac	alteration in mood and				
		al. Interventions included to				
		ound the gazebo/ alcohol				
		an failed to identify R51's				
	alcohol monitoring lev					
	ŭ					
		cation Listing By Room				
	form, dated 4/18/16, i	dentified R51 as a Level III.				

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  21495  Continued From page 78  Review of R51's progress notes from 4/28/15 - 5/15/16, identified "Patient has remained stable since he returned from the hospital in February for alcohol intoxication. Patient continues to smoke and consume controlled amount of alcohol here at the facility."  - On 7/1/15, at 6:47 p.m. it was reported that resident (R51) was drinking outside the Gazebo program. "Client monitored closely". Blood		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE S COMPL	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21495  Continued From page 78  Review of R51's progress notes from 4/28/15 - 5/15/16, identified the following:  A Physician Progress Note for R51 dated 6/2/15, identified "Patient has remained stable since he returned from the hospital in February for alcohol intoxication. Patient continues to smoke and consume controlled amount of alcohol here at the facility."  - On 7/1/15, at 6:47 p.m. it was reported that resident (R51) was drinking outside the Gazebo				A. BOILDING			
MISSION NURSING HOME  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21495  Continued From page 78  Review of R51's progress notes from 4/28/15 - 5/15/16, identified the following:  A Physician Progress Note for R51 dated 6/2/15, identified "Patient has remained stable since he returned from the hospital in February for alcohol intoxication. Patient continues to smoke and consume controlled amount of alcohol here at the facility."  - On 7/1/15, at 6:47 p.m. it was reported that resident (R51) was drinking outside the Gazebo			00235	B. WING		05/1	7/2016
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21495  Continued From page 78  Review of R51's progress notes from 4/28/15 - 5/15/16, identified the following:  A Physician Progress Note for R51 dated 6/2/15, identified "Patient has remained stable since he returned from the hospital in February for alcohol intoxication. Patient continues to smoke and consume controlled amount of alcohol here at the facility."  - On 7/1/15, at 6:47 p.m. it was reported that resident (R51) was drinking outside the Gazebo	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  21495  Continued From page 78  Review of R51's progress notes from 4/28/15 - 5/15/16, identified the following:  A Physician Progress Note for R51 dated 6/2/15, identified "Patient has remained stable since he returned from the hospital in February for alcohol intoxication. Patient continues to smoke and consume controlled amount of alcohol here at the facility."  - On 7/1/15, at 6:47 p.m. it was reported that resident (R51) was drinking outside the Gazebo	MISSION	NURSING HOME			KE BOULEVARD		
Review of R51's progress notes from 4/28/15 - 5/15/16, identified the following:  A Physician Progress Note for R51 dated 6/2/15, identified "Patient has remained stable since he returned from the hospital in February for alcohol intoxication. Patient continues to smoke and consume controlled amount of alcohol here at the facility."  - On 7/1/15, at 6:47 p.m. it was reported that resident (R51) was drinking outside the Gazebo	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF	D BE	COMPLETE
pressure upon waking is 75/54 and heart rate 75.  Given meal tray and drank 300 ml (milliliters) of water. Blood pressure at 6:30 p.m. 87/53.  Physician notified and orders received to check blood pressure every four hours and continue to encourage fluids. Other notes from this date identified resident left at 10:35 a.m. with his niece and returned at 1:05 p.m. He was searched and breathalyzer was 0.258. Staff found a bottle of whiskey in his room, which was locked in the liquor cabinet. An incident report was completed for this incident on 7/1/15, noting "Resident was instructed to not drink." The record lacked evidence their Gazebo policy was followed.  On 5/11/16, at 3:02 p.m. the SSD stated, "if they mess up like this when in the program, they would be suspended for 3 days, or a week if they are sent to the hospital or detox."  - On 7/2/15, at 10:48 a.m. a note indicated R51 had been seen by the nurse practitioner, and the note indicated R51 is an adult and can drink and smoke when he wants. "He is not hurting himself or anyone else."  - On 7/2/15, at 1:59 p.m. a note identified R51	21495	Review of R51's prog 5/15/16, identified the A Physician Progress identified "Patient has returned from the hos intoxication. Patient of consume controlled a facility."  - On 7/1/15, at 6:47 president (R51) was diprogram. "Client mon pressure upon waking Given meal tray and of water. Blood pressure Physician notified and blood pressure every encourage fluids. Oth identified resident left and returned at 1:05 preathalyzer was 0.25 whiskey in his room, liquor cabinet. An incifor this incident on 7/2 instructed to not drink evidence their Gazeb  On 5/11/16, at 3:02 press up like this whe would be suspended are sent to the hospital control of the indicated R51 is smoke when he want or anyone else."	ress notes from 4/28/15 - e following:  Note for R51 dated 6/2/15, a remained stable since he spital in February for alcohol continues to smoke and amount of alcohol here at the sinking outside the Gazebo itored closely". Blood g is 75/54 and heart rate 75. drank 300 ml (milliliters) of e at 6:30 p.m. 87/53. d orders received to check four hours and continue to her notes from this date at 10:35 a.m. with his niece p.m. He was searched and 58. Staff found a bottle of which was locked in the ident report was completed 1/15, noting "Resident was a." The record lacked o policy was followed.  Im. the SSD stated, "if they en in the program, they for 3 days, or a week if they all or detox."  a.m. a note indicated R51 enurse practitioner, and the an adult and can drink and s. "He is not hurting himself	21495			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SI COMPLE	
			_			
		00235	B. WING		05/1	7/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MISSION	NURSING HOME		MEDICINE LA I, MN 55441	KE BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21495	A Physician Progress identified the chief co intoxication. It noted reading of 0.258, and to be low at 87/56, wi note indicated during the resident had state someone and had so I will do whatever I wadrink and smoke. If I will do it. I am not hur when I drink, so I sho nursing progress note allowed to sleep it off aggressive behavior to "Patient will be off Gadays. Nursing will cor of withdrawal."  - On 7/8/15, at 1:20 p was restricted from the having the bottle.  - On 8/6/15, at 10:11 resident had left with returned at 3:45 p.m., talkative. "Social work be monitored." It was refused the breathaly assessments. The refused policy was for a 8/17/15, at 3:51 p.m.	note for R51 dated 7/2/15, mplaint as alcohol resident had a breathalyzer blood pressure was noted th a retake at 75/54. The interview with the physician ed, "I am fine, I went out with me drinks. I am an adult and eart. I am here because I can get the opportunity again, I ting myself or anyone else uld be left alone." The es indicated R51 was there was no report of cowards staff and included, zebo program for three entinue to monitor for any sign of the gazebo program due to the his niece at 2:15 p.m. and appearing drunk and very ter notified, and resident will as also documented R51 had zer as well as other ecord lacked evidence the	21495	DEFICIENCY)		
	documentation indica	ke a peer with him. The ted the SSD had attempted out he'd left anyway and had				

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MILLIESOL	a Department of Fleatti	1				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	EIED
		00235	B. WING		05/1	7/2016
NAME OF D	ROVIDER OR SUPPLIER	STDEET AD	DRESS, CITY, STA	TE ZIR CODE		
NAME OF FI	NOVIDER OR SUFFLIER		, ,	•		
MISSION	NURSING HOME		1 MEDICINE L <i>e</i> TH, MN 55441	AKE BOULEVARD		
			H, WIN 33441			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE		DATE
			1	DEFICIENCY)		
21495	Continued From page	e 80	21495			
	returned at approxima	ately 3:46 p.m. with a brown				
		le of alcohol in it. The notes				
	indicated staff had tak					
		abusive toward staff. The				
		ce the Gazebo policy was				
	followed.					
		.m. the DON stated the				
		m R54 and locked up in a behavior that cannot be				
	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	available staff come to help)				
		was following the staff and				
		n the nurse went in, R54				
	9	ing his words. Breathalyzer				
		6, and his blood pressure				
		e on call physician was				
		staff to monitor resident,				
	encourage fluids, and decline.	to call back if there was a				
	decline.					
	- On 8/17/15, at 11:10	p.m. noted resident was				
		ered nurse in his room at				
	approximately 7:25 p.					
		and slurring his words."				
	•	36. Blood pressure 94/59				
		notified and orders received				
		nd encourage fluids. Call				
		at 10:00 p.m. blood pressure				
		ted at this time to be more				
		ords, and drinking fluids. idence the Gazebo policy				
	was followed.	defice the Gazebo policy				
	- On 8/18/15, at 2:57	a.m. noted at approximately				
		npted to obtain vital signs,				
	and resident was incr	easingly agitated, using foul				
		f obtaining frequent checks				
	on resident every one	to two hours for safety.				
	A Dhysician Progress	Note dated 9/21/15				
	A Physician Progress	Note dated o/21/15,				

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Minnesota Department of Health STATE FORM

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NAME OF PROVIDER OR SUPPLIER  A. BUILDING:  B. WING  O5/17/2016  STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE		
	NAME OF PROVIDER OR SUPPLIER	
MISSION NURSING HOME 3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441	MISSION NURSING HOME	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETI TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE  DATE	PREFIX (EACH DEFICIENC	
identified a review of the incident [dated 8/17/15] where resident returned to the facility and had a breathalyzer of 0.33. The note indicated the vital signs were now normal and resident is back to his baseline. During interview with the physician, R51 stated he was "angry that the social worker can not allow him to bring his own "Booze' into the facility. He was also angry that he will be off the Gazebo program for 3 days since he got himself intoxicated." The progress note identified no education and no orders were provided for increased monitoring when R51 was intoxicated. Then note indicated nursing was to continue to monitor for any signs or symptoms of withdrawal.  - On 9/28/15, at 10.36 p.m. resident returned to the facility via taxi at approximately 6:00 p.m. and was met at the door by the SSD. He turned in his alcohol bottles, and breathalyzer was 0.141. Resident was informed by the SSD he will not be attending Gazebo thomorow.  On 5/11/16, at 3:02 p.m., the SSD stated R51 liked to go out and drink with his meals. She verified the Gazebo policy identified that drinking outside the program would result in a one week suspension, which had not been enforced in this case.  - On 10/24/15, at 1:33 p.m. notes indicated R51 had refused to shower the evening before, and had been informed he could not attend the Gazebo program, so had become very upset and angry.  - On 11/5/15, at 11:24 p.m. identified R51 had returned at 5:35 p.m. from going out on a visit with his brother [left at 12:05 p.m.] The note indicated he was drunk and went to his room after being searched. The record lacked evidence the	identified a review of where resident return breathalyzer of 0.33. signs were now norm baseline. During inte R51 stated he was "can not allow him to facility. He was also Gazebo program for intoxicated." The proeducation and no ordincreased monitoring Then note indicated monitor for any signs - On 9/28/15, at 10:3 the facility via taxi at was met at the door alcohol bottles, and Resident was inform attending Gazebo to On 5/11/16, at 3:02 pliked to go out and diverified the Gazebo outside the program suspension, which his case.  - On 10/24/15, at 1:3 had refused to show had been informed his Gazebo program, so angry.  - On 11/5/15, at 11:2 returned at 5:35 p.m. with his brother [left indicated he was druited to show had been informed for the residual structured at 5:35 p.m. with his brother [left indicated he was druited to show had been informed the gazebo program, so angry.	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SI COMPLE	
		00235	B. WING		05/1	7/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MISSION NURSING HOME		MEDICINE LA H, MN 55441	KE BOULEVARD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
21495	Continued From page	82	21495			
	Gazebo policy having	been implemented.				
	should have been a rethe gazebo contract.  On 12/4/15, at 10:26 R51 had gone out at 6:00 p.m. a call had been sent to the hosp dated 12/4/15, indicated ambulance. "Report to liquor store in Plymouwere called. Arrives wintoxication and slurri wheelchair bound. Redetox center." Further "Patient was conversiloss of consciousness 30 seconds. Patient Came to after 30 seconds incoherently." The latidentified "Pt [patient]	ng words. Patient is eportedly lives at Mission or information included, ng in room when he had s on the cart lasting about curresponsive to sternal rub. onds and started yelling est note from this visit increasing agitation; or his belongings and to be				
	On 5/11/16, at 3:02 p had called the facility incident. The SSD als to eat, and the restau liquor store. The SSD restaurant and gone the liquor store had sipolice, reporting some stated the facility did report. The DON state	regarding the 12/4/15 to stated R51 had gone out rant was across from a stated R51 had left the the liquor store. Staff at subsequently called the eone intoxicated. The SSD not have a copy of the police ed she'd instructed dispatch spital for evaluation. Upon				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE S COMPLI		
		00235	B. WING		05/1	7/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
MISSION	NURSING HOME		MEDICINE LA I, MN 55441	KE BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
21495	refused the breathaly said R51 had been do police and hospital to calmed him down and The DON stated no a available from the hosi if a physician was cor increased monitoring expectation that incre completed as well as also stated R54 had pstating he was not to for the gazebo. The Slunch, or he would no gazebo program and serious lately because - On 12/5/15, at 1:47 indicated R51 had no Gazebo for breaking (drinking alcohol outs - On 12/5/15, at 6:49 had not been allowed program until re-evaluation. When interviewed on SSD stated at that tim from the Gazebo progverified did not correla Program Contract why violation for drinking oprogram.  A Psychology Progresidentified R51 had be mood and alcohol use want [sic?] to control	iter six hours, R51 had zer or vital signs. The DON emanding staff call the return his alcohol. Staff had d R51 returned to his room. Ilcohol levels or reports were spital. There was no record ntacted for any orders of an incident report. The DON confirmed her ased monitoring would be an incident report. The DON costed a note on his door be disturbed unless it was a sSD stated R51 had to eat the added, "He is taking it more exit is important to him."  p.m. documentation the been allowed to attend the rules yesterday [12/4/15] ide the Gazebo program).  p.m. notes indicated R51 to attend the Gazebo uated after the weekend.  5/11/16, at 3:02 p.m. the ne R51 had been restricted gram for one day, which she atte with the Gazebo Alcohol ich directed a one week	21495			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		RVEY [ED
			R WING			
		00235	B. WING		05/17/	/2016
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
MISSION	NURSING HOME		ST MEDICINE LA TH, MN 55441	AKE BOULEVARD		
(V4) IB	SLIMMADV ST.	ATEMENT OF DEFICIENCIES	<u>,                                      </u>	PROVIDER'S PLAN OF CORRE	CCTION	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21495	Continued From page	e 84	21495			
	of recently." Previous dated 11/17/15.	s visit with psychology was				
	quickly returned from receiving ice from sta coffee cup noted behi asked if staff could ch stated "yes" it was no cup was taken, and the around the front lobby SSD had been notifie from the Gazebo the rules. The record lact policy was followed, with violation for drinking oprogram.  - On 2/3/16, at 4:53 p	p.m. notes indicated R51 the Gazebo program after ff. There was a covered ind the resident. R51 was leck the cup, and after R51 ted to smell of alcohol. The ne resident chased staff y. The note indicated the d and R51 was restricted following day for breaking ked evidence the Gazebo which directed a one week outside of the Gazebo  .m. R51's quarterly note rticipated in programs after				
	the gazebo program, inappropriately/makin	he was noted to be talking g sexual comments.				
	Keppra level drawn, a aggressive with the p indicated R51 had co	hlebotomist. The notes me to nursing station later, yelling he did not want to				
	a history of only want Gazebo program, staneeded to eat lunch be program, and had bee SSD stated there had gazebo program for re	en compliant with this. The been no restriction from the efusing therapy/services, or ing at staff when they enter				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _	DING:		ETED
		00235	B. WING		05/-	17/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		3401 EAS	T MEDICINE LA	KE BOULEVARD		
MISSION	NURSING HOME	PLYMOUT	H, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21495	Continued From page	e 85	21495			
	been yelling at staff in administer insulin, and door indicated to never gazebo program.  - On 3/13/16, at 9:41 had again stated staff	.m. notes indicated R51 had his room for waking him to d had stated the sign on his er wake him except for the p.m. notes indicated R51 f should only wake him for				
	the Gazebo program.  - On 3/14/16, at 2:49 a.m. resident was noted to be offered insulin prior to lunch. The notes indicated R51 had stated, "NODO NOT EVER WAKE MEONLY WAKE ME FOR GAZEBO."  - On 3/31/16, at 5:45 p.m. Therapy discontinued					
	, ,	resident either refusing or after the gazebo program.				
	an emergent call from	a.m. R51 was informed of n his son. R51 stated "I do ergency. I only want to be )."				
	- On 5/6/16, at 8:55 p be awakened for anyt	.m. R51 requested to never thing but the Gazebo.				
	and stated he had be year and a half, and he program ever since. He to this nursing home and smoke." R51 state the program, but was specified. "I didn't reasign to participate." Fealcohol was purchase locked up. "I have been year and a half program of the program, but was specified." I didn't reasign to participate." Fealcohol was purchase locked up. "I have been year and a half program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the	a.m. R51 was interviewed en at the facility for about a had been part of the Gazebo He said he'd agreed to come "because I was able to drink ted he signed a contract for not exactly sure what it ad it thoroughly. I had to Further, R51 stated the ed by the SSD, and it was en restricted on one or two ank more than I should				

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AND DI AN OF CORRECTION IDENTIFICATION NUMBER:		[ · · · ·			(X3) DATE SURVEY COMPLETED	
70001 2700	or connection	IDENTIFICATION NOMBERS	A. BUILDING: _		OOWII EETEB	
		00235	B. WING		05/1	7/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
MISSION	NURSING HOME	3401 EAS	MEDICINE LA	KE BOULEVARD		
MISSION	NUKSING HOWE	PLYMOUT	H, MN 55441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21495	Continued From page	e 86	21495			
	have." R51 stated wh had only been restrict drink on outings anyn to take me on outings	en he was hospitalized, he ted for 1-2 days. "I don't nore. I have nobody locally s. I would if I could." The ut "I am probably gonna				
	When interviewed about the facility's Gazebo program on 5/11/16, at 4:05 p.m., the SSD stated residents need to ask to be on this, and are then evaluated by the interdisciplinary team (IDT). The SSD said she evaluates whether the resident is appropriate behaviorally to be on the Gazebo program, and then nursing and the physician evaluate if they are appropriate medically. The SSD stated, "if a resident drinks outside the gazebo program, the policy spells out the consequences", and that her hope was that the policy would be followed.					
	Use, identified: "Purp Mission Nursing Hom residents who are chridependent. While end the efforts of resident facility also recognize relapse or continue to This policy is adopted use of alcohol and drand healthy environm supporting and encounthe policy included:  1. Mission Nursing Hefforts at sobriety and assistance at all times  2. In order to particip	couraging and supporting s to maintain sobriety, the set that some persons will o use alcohol and drugs. It to provide guidelines on the ugs, with the goals of a safe tent in mind, while also uraging sobriety." In addition some will support any and all it is available to give you so ate in the Gazebo program, seessed by therapy, nursing, magement committee.				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND I LAN	SI SOMMEDION	BENTI TOATION NOWIDER.	A. BUILDING: _	A. BUILDING:			
		00235	B. WING		05/1	7/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE			
TO UNIC OT T	NOVIDEN ON OUT FEET		, ,	KE BOULEVARD			
MISSION	NURSING HOME		TH, MN 55441	THE BOOLEVARD			
	OUR MAN DV OT		<u> </u>	DD0//DDD0/D144/05/00DD507/0			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE	
21495	Continued From page	e 87	21495				
	building is not permitt searches are conduct alcohol in the building 4. Inappropriate beha of alcohol will not be a addressed according management policy.  An undated facility poindicated "violent, crin behavior in public will Nursing Home. Resid behavior in public will facility." Examples of assault (including threalso identified other in affecting the health, s resident and/or the coallowed. "Residents win public and who republe discharged from the such behavior includes SUGGESTED METHOTHE Social service diresystems to ensure resident rights and the related to the ongoing could educate all apponthese systems. The committee could mon compliance.	ed. Random room ted to ensure there is no playior resulting from the use allowed and will be to the facility behavior  dicy titled Behavior Policy, minal or inappropriate sexual not be tolerated by Mission ents who engage in such be discharged from the such behavior included eats of assault). The policy mappropriate behavior in rafety, or welfare of the mmunity would not be who engage in such behavior eat the behavior twice will me facility." Examples of ed self-endangerment.  OD OF CORRECTION: ector (SSD) could develop sidents have their needs ent options and availability . This could include their e rights of other resident g use of alcohol. The SSD ropriate staff and residents					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING			
		00235	B. WING		05/1	7/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MISSION NURSING HOME			MEDICINE LA I, MN 55441	KE BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21510	Continued From page	e 88	21510			
21510	MN Rule 4658.1200 SpecializedRehabilita	Subp. 2 A.B. tive Services; Provision	21510			
	rehabilitative services resident's comprehen nursing home must:  A. provide the requirequired services from according to part 465.  This MN Requirement by: Based on interview and facility failed to ensure plan was included as care planning process reviewed for Preadming Resident Review (PAFINDING).  Findings include:  R66's admission Mini 3/10/16, indicated R6 R66's Order Summar	red services; or obtain the n an outside source 8.0075.  It is not met as evidenced and document review, the e an individualized service part of the assessment and so for 1 of 1 resident (66) ssion Screening and				
	and anxiety disorder. 3/11/16, indicated R6	isorder, conduct disorder R66's care plan dated 6 had an alteration in ed to a diagnosis of mental				
	R66 was evaluated of date of admission to the Level II PASRR was concentrated and R66's medical neservices. The Level II	ort Level II PASRR indicated in 8/8/14. R66's proposed the facility was 2/3/11. The completed by Hennepin R66 had mental retardation seds required nursing facility PASRR further indicated quire active treatment. The				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED	
		00235	B. WING		05	5/17/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MISSION	NURSING HOME			KE BOULEVARD		
040.45	CLIMMA DV CT	ATEMENT OF DEFICIENCIES	ΓH, MN 55441	DDOVIDED'S DI AN OF CODD	FCTION	2/5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21510	Continued From page	89	21510			
	needs have been spe	and will be met while this				
	R66's medical record plan (ISP) by the loca	lacked an individual service I agency.				
	medical record coordi Level II PASRR was a R66's previous facility not repeat Level II PA	5/12/16, at 7:54 a.m. the nator stated that R66's accepted as it was from and that the county does SRR's unless the resident conton a community setting.				
	R66's PASRR was co not have an annual re determine individual s see what issues the re a referral to psychiatry were reviewed by the committee for approp stated currently staff of	r (LSW)-B verified that mpleted on 8/8/14 and did eview. LSW-B stated to services the facility waited to esident had and then made y. In addition, medications interdisciplinary team (IDT) riate medications. LSW-B				
	facility did not have a R66 does not have ar	p.m. LSW-B verified the current ISP and stated that a ISP because he resided in not a group home setting.				
	he had contacted the not have an active so and did not have an a updating their softwar R66 was last assesse the facility did not hav	.m. the LSW-B stated that county today and R66's did cial worker with the county ctive ISP. The county was e. LSW-B further stated by the county in 2015 and the the most recent				

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Minnesot	a Department of Healtr	1				
		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00235	B. WING		05/4	7/2016
		00235			05/1/	7/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		3401 EAS	T MEDICINE LA	AKE BOULEVARD		
MISSION	NURSING HOME	PLYMOU1	H, MN 55441			
()(4) ID	SLIMMADV STA	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTION	N.	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
21510	Continued From page	<u> 90</u>	21510			
	. •	. 00				
	from the county.					
		most recent Evaluative				
	•	R to the facility, which				
		evaluated on 7/1/15. R66's				
		nission to the facility was				
		ASRR was completed by				
		I indicated R66 had mental medical needs required				
		es. The Level II PASRR				
		s person does require active				
		igency assures that all				
		Is have been specified in				
		al service plan and will be				
		resides in the nursing				
		included in the information				
	from the county.					
	A policy for Level II P	ASRR was requested and				
	none was provided by	·				
	·	•				
	SUGGESTED METH	OD FOR CORRECTION:				
	The director of social	services (SSD) could				
	develop and impleme	nt policies and procedurse				
	related to residents w	ith Level II PASRR				
		active treatment needs are				
		educate all appropriate staff.				
		or all residents with a Level				
	•	o ensure needs were met				
	and report results to t	he quality assurance				
	committee.					
	TIME DED. 00 - 6-	20000001011				
		CORRECTION: Twenty-one				
	(21) days.					

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