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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: B08E
Facility ID: 00144

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245187**

2. STATE VENDOR OR MEDICAID NO.
(L2) **276542000**

3. NAME AND ADDRESS OF FACILITY
(L3) **TEXAS TERRACE CARE CENTER**
(L4) **7900 WEST 28TH STREET**
(L5) **SAINT LOUIS PARK, MN** (L6) **55426**

4. TYPE OF ACTION: 7 (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2015**

6. DATE OF SURVEY **11/2/2015** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12. Total Facility Beds **118** (L18)

13. Total Certified Beds **118** (L17)

10. THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	118			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jessica Sellner, HFE NE II 11/17/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/17/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06301
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 17, 2015

Mr. Reid Hewitt, Administrator
Texas Terrace Care Center
7900 West 28th Street
Saint Louis Park, MN 55426

RE: Project Number S5187024

Dear Mr. Hewitt:

On October 1, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 17, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 2, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 17, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 27, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 17, 2015, effective October 27, 2015 and therefore remedies outlined in our letter to you dated October 1, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245187

November 17, 2015

Mr. Reid Hewitt, Administrator
Texas Terrace Care Center
7900 West 28th Street
Saint Louis Park, MN 55426

Dear Mr. Hewitt:

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 October 27, 2015 the above facility is certified for:

118 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 118 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245187	A. Building B. Wing	11/2/2015

Name of Facility	Street Address, City, State, Zip Code
TEXAS TERRACE CARE CENTER	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0155** Reg. # **483.10(b)(4)** LSC	**10/27/2015**	ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	**10/27/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	**10/27/2015**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	**10/27/2015**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	**10/27/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	**10/27/2015**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	**10/27/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**10/27/2015**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	**10/27/2015**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	**10/27/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**10/27/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	**10/27/2015**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	**10/27/2015**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	JS/kfd	11/02/2015	29249	11/02/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/17/2015			

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Facility ID: 00144

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(L2) **276542000**

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(L3) **TEXAS TERRACE CARE CENTER**
(L4) **7900 WEST 28TH STREET**
(L5) **SAINT LOUIS PARK, MN** (L6) **55426**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2015**

6. DATE OF SURVEY **09/17/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
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04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **118** (L18)

13.Total Certified Beds **118** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

And/Or Approved Waivers Of The Following Requirements:

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	118			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Christine Bodick-Nord, HFE NE II 10/16/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/20/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06301
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0003 4738 3100

October 1, 2015

Mr. Reid Hewitt, Administrator
Texas Terrace Care Center
7900 West 28th Street
Saint Louis Park, Minnesota 55426

RE: Project Number S5187024

Dear Mr. Hewitt:

On September 17, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 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.

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:

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
jessica.sellner@state.mn.us
Telephone: (320)223-7365
Fax: (320)223-7365

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 27, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 27, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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 remedies be imposed:

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 17, 2015 (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 March 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. Gary Schroeder, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
gary.schroeder@state.mn.us
Telephone: (507) 361-6204

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Enclosure

cc: Licensing and Certification File

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

RECEIVED PRINTED: 10/01/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245187	A. BUILDING ____ OCT 14 2015 B. WING ____ MN Dept of Health St.Cloud	09/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEXAS TERRACE CARE CENTER	**7900 WEST 28TH STREET** **SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider to the accuracy of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.	
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced	F 155	1. Resident #111 has been provided an in-depth review of risks and benefits regarding use of indwelling catheters by both facility staff and attending NP. After explanation of risk and benefit resident has chosen to continue use of catheter. approved J Sellum 10/16/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: NHA (X6) DATE: 10/13/15

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245187	A. BUILDING ____ B. WING ____	09/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEXAS TERRACE CARE CENTER	**7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 1 by: Based on observation, interview, and document review, the facility failed to provide risks and benefits for continued use of an indwelling urinary catheter for 1 of 1 residents, (R111) who did not have medical justification for ongoing use of a indwelling catheter. Findings include: R111 was observed on 9/16/15, at 8:35 a.m. laying in bed. An indwelling urinary foley catheter bag was observed hanging on the side of the bottom of the bed frame about 1/4 full of urine. R111's quarterly Minimum Data Set (MDS) dated 7/3/15, indicated the resident had no cognitive impairment, had no behaviors, required extensive assistance with all activities of daily living (ADL's), and had an indwelling urinary catheter. R111's current Physician Orders dated 8/17/15, included diagnoses of generalized muscle weakness, knee pain, and unable to ambulate. The physician orders indicated the resident used a indwelling Foley catheter. R111's Catheter Plan of Care dated 7/3/15, indicated the resident had a indwelling catheter with diagnoses of spinal cord disease and urinary retention that cannot be corrected surgically or medically. A Hospitalist Progress Note from Fairview Hospital dated 5/24/14, indicated R111 had been admitted to the hospital for cervical decompression and fusion. The Discharge Summary Note dated 5/25/14, indicated R111 had a diagnoses while in the hospital of urinary	F 155	2. All residents whom currently have an indwelling catheter have diagnosis indicating medical necessity or have received risk and benefits explanation if no diagnosis is assigned. 3. All licensed nurses will be provided with education regarding appropriate diagnosis related to catheter use by 10/27/15. 4. DON/designee will audit 3 residents per week for medical justification or completion of risk and benefit for catheterization for 1 month. Continued audits of 3 residents will be completed	

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F 155	Continued From page 2 retention, and instructed, "Discharge the patient [R111] home with a Foley catheter as she is unable to void independently... Foley catheter in place and discharge instructions is make an appointment with urology associates within a week for further evaluation for urinary retention." A Physician Telephone Order dated 6/9/14, indicated, "Concern retention [urine], discontinue urology follow up appointment." There was no corresponding documentation regarding why the urology appointment was canceled, and if the appointment was to be rescheduled. A Physician Telephone Order dated 2/2/15, directed staff to remove R111's Foley Catheter on 2/9/15, and update physician on status. R111's Treatment Record dated 2/9/15, indicated to remove Foley catheter on 2/9/15. R111's Treatment Sheet indicated next to the treatment order, "Refused." Review of R111 Progress Notes indicated the following: 4/1/15- "Resident continues to be unhappy and possibly somewhat in denial about her medical and physical decline; resident refused to allow catheter to be removed per physician order because she feels she will soon be able to transfer without a mechanical lift and will allow her to get to a commode or toilet quicker. Resident is tearful she will have increased incontinence and it will lead to skin breakdown if catheter is removed too early. Resident has been working with physical therapy for transfer, though their reports show a [mechanical] lift is still required."	F 155	monthly until discontinued by QAPI. Results of audit to be shared at QAPI.	

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6/29/15- "Resident continues to have catheter in place, refusing to allow discontinuing..."

During interview on 9/14/15, at 4:55 p.m. Registered Nurse (RN)-D stated R111 used an indwelling Foley catheter since having spinal stenosis surgery in May 2014.

During interview on 9/16/15, at 8:35 a.m. R111 stated she had an indwelling catheter because she, "Can't spend all day waiting to get to the bathroom." R111 thought it would just be "easier" to keep the catheter in place until she can regain strength so she can get to the bathroom on her own. R111 stated she did not want the catheter in place forever, and was not aware there were any risks with keeping the catheter in place.

During follow up interview on 9/16/15, at 2:07 p.m. RN-D stated there is no documentation regarding the facility following up with a urology/ physician appointment regarding R111 continuing to use the indwelling catheter. RN-D stated R111 required extensive assistance using a mechanical lift to use the bathroom, and the resident told staff it was just easier to leave the catheter in, and since R111 had returned to the facility following spinal surgery in 5/2014, there is no documentation the facility had attempted to removed the indwelling catheter. RN-D stated there is no documentation R111 had been informed of the risks and benefits of continuing to use the indwelling urinary catheter without medical justification.

The facility policy titled Indwelling Urinary Catheters dated July 2015, indicated a comprehensive assessment includes underlying

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F 155	Continued From page 4 factors supporting medical justification, determination of which factors can be reversed, and development of a plan for appropriate indications for continuing use of an indwelling catheter beyond 14 days. Residents admitted to the center with an indwelling catheter that was placed elsewhere need a provider order and medical justification for the catheter to remain in place.	F 155		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure timely/ thorough investigations were conducted and resolutions were provided for resident grievances for 2 of 3 residents (R71 and R32) who reported lack of staffing grievances to the facility. Findings include: R71's Admission Record (face sheet) dated 9/8/15, identified diagnoses including generalized pain and diabetes. R71's quarterly Minimum Data Set (MDS) dated 8/31/15, identified the resident had no cognitive impairment and required extensive assistance with bed mobility, dressing, and personal hygiene. R71's Care Plan dated 8/31/15, identified R71 was chair-fast (self-imposed), continent of urine, and independent with toileting. The care plan also indicated R71 reported inaccurate information	F 166	1. The outcomes of the investigations regarding resident's #71 and #32 grievances have been discussed with each resident. 2. All resident allegations are being documented, investigated, and outcomes discussed with resident; referrals to outside agencies will be completed as required.	

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F 166	Continued From page 5 regarding her own health and diet, and staff were directed to validate her feelings, allow time for her to express her thoughts and feelings, and investigate the residents concerns. A Resident Concern Report dated 6/10/15, indicated the following grievance: "[R71] is concerned of the call light response times. [R71] states that she [and] her roommate would like to be checked on in the morning. [R71] states aides wait for call lights [and] should be proactive." The facility administrator conducted an investigation of facility acuity reports and total cares per aide on 6/10/15. The administrator directed continued call light audits and unit meetings were to include discussions regarding hourly rounding and implementation strategies. The investigation lacked interviews with staff or other residents on call light response times and staff's ability to respond to resident needs in a timely manner. The disposition for this grievance dated 7/24/15, indicated, "Continue call light audits, encourage [nursing assistants (NAs)] to anticipate res [resident] needs and round on floor. Resident [checks] in AM focus on resident need and level of assistance. Meals and orders are taken by [NAs] prior to each meal. For breakfast, this would be around 8:00 a.m. Follow up hourly rounds ongoing." The report lacked evidence of having followed-up with R71 to inquire on her sense of resolution to this matter. No further evidence of investigation or resolution for this grievance was provided. During interview on 9/17/15, at 2:18 p.m. R71 stated she did not feel her grievance was resolved, and she had raised her concerns again stated the grievances are not always written up when complaining. R71 stated, "We wait 45 minutes to one hour at times [for call light responses]." R71 stated when turning on the call	F 166	3. All staff will be educated and trained on expectation of investigating and communicating resident grievances by 10/27/15. 4. NHA/Designee to audit 3 resident grievances per week to ensure timely investigation and communication with resident for 1 month. Continued audits of 3 resident grievances will be completed monthly until discontinued by QAPI. Results will be shared in QAPI.	

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F 166	Continued From page 6 light she has to wait for long periods of time and staff will walk right by the room without stopping to see what she needed. R71 stated there is not enough staff to provide the cares the residents need, and stated she does not hear back on the concerns (grievances) she informs the facility about, and does not feel like they are resolved. R32's Admission Record (face sheet) dated 7/8/15, identified diagnoses including chronic pain and pressure ulcer of the lower back. R32's quarterly MDS dated 9/4/15, identified the resident had no cognitive impairment, required extensive assistance for most activities of daily living, reported experiencing pain frequently, was on a scheduled pain management regimen with use of as needed pain medications, utilized a urinary catheter, and was always incontinent of bowel. R32's Care Plan dated 9/4/15, identified R32 had bilateral lower extremity contractures with decreased upper extremity strength, was bedfast (self-imposed), had a stage four pressure ulcer to her coccyx, and required her incontinent product be changed as needed. The care plan indicated R32 had persistent pain related to neuropathy, contractures, and muscle spasms. The care plan also indicated, "Inappropriate/ excessive use of call light." A Resident Concern Report dated 8/20/15, indicated the following grievance: "On 8/18/2015 [R32] stated during AM's [at] approximately 8:30 she had a fever, she was experiencing diahrea [sic] and she had experienced a long call light time." The facility's investigation included a review of random call light audits, which included two call lights audited on the Garden Terrace unit (where R32 resided). One of the audits took place on 8/17/15, at 1:20 p.m. (the day before the resident made the complaint) and the other was	F 166		

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F 166	Continued From page 7 on 8/18/15, at 10:32 a.m. The audits indicated the call lights were on approximately six and eight minutes. The investigation also included a nursing review of R32's record signed 9/11/15, which indicated the resident received antibiotics on 8/17/15, and on 8/19/15, and the physician was notified of symptoms, with a resulting new order for antibiotics. The investigation noted, "...may have had episode of loose stool," but "diarrhea was not for longer than 24 hours." The investigator's conclusion noted, "No further f/u [follow-up] needed. Loose stools and hydration status were not ongoing to the point of [increased] concern other than interventions done." The administrator's follow-up dated 9/16/15, indicated, "See attached call light audits from August. No discernable trends of long wait times. See above nurse's statement re: [regarding] clinical concerns... No further concerns have been appreciated." The follow-up from this grievance did not take place for nearly one month after the grievance was submitted. Also, the investigation lacked focus on the concern of a long call light wait, with no review of the staffing coverage at the time of concern, interviews with staff or other residents on call light response times, and staff ability to respond to resident needs in a timely manner. The report lacked evidence of following up with R32 to inform her of the outcome and to get her sense of resolution to her grievance. During interview on 9/15/15, at 10:03 a.m. R32 stated the facility needed more staff, and during the evening shift she had to wait for long periods of time before the call light is answered. R32 stated, "They need more staff... The evening is the worst... About an hour I've had to wait for pain medication." During interview on 9/17/15, at 2:43 p.m. the	F 166		

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F 166	Continued From page 8 director of nursing (DON) stated when residents brought forward a concern a grievance process was utilized to follow-up on those concerns. The DON stated upon conclusion of an investigation of the resident concern/ grievance, facility management should return to the resident who filed the grievance to inform the resident the outcome of the grievance concern, and determine if the resident is satisfied. DON stated there was no additional information or follow-up from the grievance reports to indicate if R71 and R32 were interviewed after the initial reports were submitted, nor to identify if the residents were informed of the outcome of the investigation and if they felt the grievance was resolved. The facility's Resident Rights policy/ procedure dated 7/15, directed staff to involve residents in resolving conflicts about care decisions. The policy identified all staff were responsible for documenting resident concerns. The policy included a Resident Bill of Rights which noted, "You have the right to prompt efforts by the facility to resolve grievances you may have...."	F 166		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	F 225	1. Resident #161, #76, #57 grievances have been reviewed and reported to state agency.	

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F 225	Continued From page 9 The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident allegations of abuse/ neglect/ mistreatment were reported immediately to the state agency and investigated for 2 of 8 residents, (R161 and R76), who reported allegations of staff mistreatment. In addition, the facility failed to ensure bruising of unknown origin was immediately reported to the state agency and investigated for 1 of 4 residents (R57) reviewed with bruising of unknown origin. Findings include:	F 225	2. All resident allegations are being reported immediately to the NHA, DON, and reported to the State Agency as required. All allegations are being thoroughly investigated. 3. All staff will be re-educated regarding reporting and investigating allegations of abuse, neglect, misappropriation of property, mistreatment, resident to resident altercations, and injuries of unknown origin by 10/27/15.	

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F 225	Continued From page 10 R161 admission Minimum Data Set (MDS) dated 6/28/15, indicated the resident had no cognitive impairment, and required extensive assistance with all activities of daily living (ADL's). A Resident Concern Report dated 1/29/15, indicated R161 had complaints of, "Staff being rude, sarcastic, not offering assist... denying patient requests, unwilling to provide assist of 2 as patient requires; telling her to do it herself... Wednesday 1/28/15, afternoon shift." R161 Progress Note dated 1/31/15, indicated the resident required assistance of 2 staff with cares and transfers. The follow up facility investigation of R161's allegations of staff neglect was not completed until 2/6/15, 8 days after R161 complained of staff mistreatment. During interview on 9/17/15, at 11:25 a.m. director of nursing (DON) stated the staff who spoke with R161 regarding her concerns on 1/29/15, did not feel it was actual abuse or neglect, so the facility felt they could wait a few days to begin the investigation. DON stated R161 allegations should have been investigated sooner, and verified the residents allegations of staff mistreatment was not reported to the state agency. R76's quarterly MDS dated 7/17/15, identified the resident had no cognitive impairment and was independent with ADL's. A Resident Concern Report dated 5/6/15, indicated, "Nursing aides (NA) being disrespectful	F 225	4. NHA/Designee will audit up to 2 allegations per week for implementation and investigation per policy for 1 month. Continued audits of 2 allegations will be completed monthly until discontinued by QAPI. Audit results will be reviewed at QAPI.	

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to her [R76] in the dining room. Gives examples of NA serving her spaghetti and when she told them she was allergic to it they responded, 'If you die, you die.' Resident unable to identify who stated this to her. Resident reports most issues are with evening NA. Reports being frustrated and not wanting to come out to dinner meal. Stated she did not come out for dinner yesterday."

The follow up investigation/ Disposition was dated 5/26/15, and indicated, "Reminded resident if she has any concerns that her floor nurses are unable to assist her with, to talk to PM (evening) nurse supervisor... Unable to investigate 'if you die you die' statement due to missing information. PM supervisor to oversee meals starting 5/26/15."

During interview on 9/17/15, at 11:25 a.m. DON stated she was not aware why R76's alleged staff mistreatment was not reported, or why it was not investigated until 20 days after the allegation was made by R76, and verified R76's allegation should have been reported to the state agency and investigated. DON stated she would talk to the nurse manager and obtain more information.

DON provided a handwritten, untitled document signed by the administrator dated 9/17/15, regarding R76's allegation of staff mistreatment on 5/26/15. The documented identified the administrator spoke to R76 and, "Questioned if she remembers any problems with dietary aides she said 'nope, cant remember.' When asked if anyone in dietary hurt her feelings/ was rude she stated she cant remember. resident obviously has no long standing mental anguish resulting from resident concern... Administrator uncertain why investigation was not documented more

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F 225	Continued From page 12 thoroughly. Leadership change did occur in dietary department on 7/1/15. Best guess is that either documentation has been lost or Registered Dietician (RD) immediately unsubstantiated report of 'If you die you die.' R57's quarterly MDS dated 8/14/15, indicated the resident had severe cognitive impairment, and had behaviors of rejection of care 4-6 days in the 7 day look back period; but less than daily. An Occurrence Report dated 4/5/15, regarding R57 indicated, "Bruise found below resident eye after being combative during am (morning) cares, NA reported bruise below residents left eye before lunch. Resident is known to be combative during cares and had probably raised his arm resulting in him hitting himself in the face." The Conclusion/ Investigation dated 9/16/15, (over 5 months after the injury of unknown origin occurred), documented by DON indicated, "Resident observed rubbing eyes frequently which has resulted in bruising below eye. Continues to be combative during cares- striking out at staff and accidentally and unintentionally striking self. Nails noted to be long." A Progress Note dated 4/6/15, indicated, "IDT (interdisciplinary team) reviewed patient bruise under right eye. Upon further investigation area appears to look as if pinched. This staff did observe him rubbing his mouth, nose, and eyes with his left hand. Patient may have rubbed area under eye and pulled it causing a bruise." During interview on 9/17/15, at 11:25 a.m. DON stated she was not sure why the investigation regarding R57's bruising of unknown origin was	F 225		

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F 225	Continued From page 13 not reported to the state agency, and why there was not an investigation of the bruise documented which included staff and/ or resident interviews regarding incident. The facility policy titled Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property dated July 2015, instructed all allegations of resident mistreatment will be reported to the state agency immediately, and staff is directed to report all alleged violations to the executive director (administrator) and DON/ designee immediately.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident allegations of abuse/ neglect/ mistreatment were reported immediately to the state agency and investigated according to the facility policy for 2 of 8 residents, (R161 and R76), who reported allegations of staff mistreatment. In addition, the facility failed to ensure bruising of unknown origin was immediately reported to the state agency and investigated according to the facility policy for 1 of 4 residents (R57) reviewed with bruising of unknown origin.	F 226	1. The facility has implemented its abuse prevention policy including immediate notification to the administrator and State Agency, as required, as well as completing a thorough investigation of potential allegations.	

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F 226	Continued From page 14 Findings include: The facility policy titled Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property dated July 2015, instructed all allegations of resident mistreatment will be reported to the state agency immediately, and staff is directed to report all alleged violations to the executive director (administrator) and DON/ designee immediately. R161 admission Minimum Data Set (MDS) dated 6/28/15, indicated the resident had no cognitive impairment, and required extensive assistance with all activities of daily living (ADL's). A Resident Concern Report dated 1/29/15, indicated R161 had complaints of, "Staff being rude, sarcastic, not offering assist... denying patient requests, unwilling to provide assist of 2 as patient requires; telling her to do it herself... Wednesday 1/28/15, afternoon shift." R161 Progress Note dated 1/31/15, indicated the resident required assistance of 2 staff with cares and transfers. The follow up facility investigation of R161's allegations of staff neglect was not completed until 2/6/15, 8 days after R161 complained of staff mistreatment. During interview on 9/17/15, at 11:25 a.m. director of nursing (DON) stated the staff who spoke with R161 regarding her concerns on 1/29/15, did not feel it was actual abuse or neglect, so the facility felt they could wait a few days to begin the	F 226	2. All potential allegations are being reported to the NHA promptly and reported to State Agency as needed. 3. All staff will be educated regarding policy implementation by 10/27/15. 4. NHA/Designee will audit up to 2 allegations per week for implementation and investigation per policy for one month. Continued audits of 2 allegations will be reviewed monthly until discontinued by QAPI. Results of audit will be reviewed at QAPI.	

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

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F 226	Continued From page 15	F 226		

investigation. DON stated R161 allegations should have been investigated sooner, and verified the residents allegations of staff mistreatment was not reported to the state agency according to the facility policy.

R76's quarterly MDS dated 7/17/15, identified the resident had no cognitive impairment and was independent with ADL's.

A Resident Concern Report dated 5/6/15, indicated, "Nursing aides (NA) being disrespectful to her [R76] in the dining room. Gives examples of NA serving her spaghetti and when she told them she was allergic to it they responded, 'If you die, you die.' Resident unable to identify who stated this to her. Resident reports most issues are with evening NA. Reports being frustrated and not wanting to come out to dinner meal. Stated she did not come out for dinner yesterday."

The follow up investigation/ Disposition was dated 5/26/15, and indicated, "Reminded resident if she has any concerns that her floor nurses are unable to assist her with, to talk to PM (evening) nurse supervisor... Unable to investigate 'if you die you die' statement due to missing information. PM supervisor to oversee meals starting 5/26/15."

During interview on 9/17/15, at 11:25 a.m. DON stated she was not aware why R76's alleged staff mistreatment was not reported to the state agency, or why it was not investigated until 20 days after the allegation was made by R76, and verified R76's allegation should have been reported to the state agency and investigated according to the facility policy. DON stated she would talk to the nurse manager and obtain more

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F 226	Continued From page 16 information. DON provided a handwritten, untitled document signed by the administrator dated 9/17/15, regarding R76's allegation of staff mistreatment on 5/26/15. The document identified the administrator spoke to R76 and, "Questioned if she remembers any problems with dietary aides she said 'nope, cant remember.' When asked if anyone in dietary hurt her feelings/ was rude she stated she cant remember. Resident obviously has no long standing mental anguish resulting from resident concern... Administrator uncertain why investigation was not documented more thoroughly. Leadership change did occur in dietary department on 7/1/15. Best guess is that either documentation has been lost or Registered Dietician (RD) immediately unsubstantiated report of 'If you die you die." R57's quarterly MDS dated 8/14/15, indicated the resident had severe cognitive impairment, and had behaviors of rejection of care 4-6 days in the 7 day look back period; but less than daily. An Occurrence Report dated 4/5/15, regarding R57 indicated, "Bruise found below resident eye after being combative during am (morning) cares, NA reported bruise below residents left eye before lunch. Resident is known to be combative during cares and had probably raised his arm resulting in him hitting himself in the face." The Conclusion/ Investigation dated 9/16/15, approximately 5 months after the occurrence was reported, the DON documented, "Resident observed rubbing eyes frequently which has resulted in bruising below eye. Continues to be combative during cares- striking out at staff and	F 226		

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F 226	Continued From page 17 accidentally and unintentionally striking self. Nails noted to be long." A Progress Note dated 4/6/15, indicated, "IDT (interdisciplinary team) reviewed patient bruise under right eye. Upon further investigation area appears to look as if pinched. This staff did observe him rubbing his mouth, nose, and eyes with his left hand. Patient may have rubbed area under eye and pulled it causing a bruise." During interview on 9/17/15, at 11:25 a.m. DON stated she was not sure why the investigation regarding R57's bruising of unknown origin was not reported to the state agency according to facility policy, and why there was not an investigation of the bruise documented which included staff and/ or resident interviews regarding incident.	F 226		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident choice of daily schedule, for 1 of 4 residents (R46) reviewed for choices. Findings include:	F 242	1. Resident #46 has his activities, interests, and schedule documented and honored per his plan of care.	

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F 242	Continued From page 18 R46's Admission Record (face sheet) dated 8/8/15, identified diagnoses including quadriplegia, spinal neoplasm, malaise/ fatigue, and chronic pain. R46's quarterly Minimum Data Set (MDS) dated 8/7/15, indicated the resident had no cognitive impairment and required extensive assistance to get in and out of bed. R46's Care Plan dated 8/5/15, identified the resident frequently refused cares from certain caregivers, and required the assistance of two people with the use of a mechanical lift for transfers. The care plan indicated the resident was unhappy with his cares and placement. Interventions included setting limits as needed, being clear with interactions and intentions, and allowing him to maintain a sense of control. The care plan indicated R46 was verbally abusive and demanding toward staff, demanding to use commode when staff are serving lunch, and refuses other times when offered. Interventions for this included clear direction about the care that was provided and his schedule of cares. The care plan also identified, "Excessive call light use... Threatening to transfer self [with] Hoyer [mechanical lift] independently- observed moving lift into his room." During interview on 9/15/15, at 10:11 a.m. R46 stated, "There is not enough staff available to lay me down in the afternoon... If I do [lay down] they will not get me back up for dinner so they bring the food in here [room] for me." During a follow up interview on 9/17/15, at 3:22 p.m. R46 stated he typically chooses not to lay down in the afternoon because if he did, he would not be able to get back up for supper and would have to stay in bed to eat. R46 stated if he would be able to receive assistance to lay down and get up when he wanted to, he would like to lay down	F 242	2. All residents will be interviewed regarding their preferences related to their care by 10/27/15. 3. All staff will be re-educated regarding resident right of choice and providing health care consistent with resident choice by 10/27/15.	

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F 242	Continued From page 19 in the afternoons, but than get up at supper time. During interview on 9/17/15, at 3:34 p.m. nursing assistant (NA)-C and NA-D stated R46 did ask to lay down sometimes in the afternoon to early evening hours. NA-D stated he usually asks around the time they are serving dinner, and then he doesn't like that they are not able to assist him right away. NA-C and NA-D both stated R46 was a demanding resident who expected assistance immediately upon asking for it. NA-D stated staff were not always able to help R46 until after the meal was over, so the length of time he had to wait for assistance in or out of bed was dependent upon the time he requested for help, and stated if the resident asked for help at the start of the meal service, he might have to wait longer. The facility's Resident Rights procedure dated 7/15, directed a resident's right to quality of life, including independent choice and decision making was to be recognized, respected, and supported. The Personal Needs procedure dated 7/15, directed each resident's care plan was to address individual needs and preferences.	F 242	4. ETD/designee to interview 3 residents per week relating to their choices being honored for 1 month. Continued audits for 3 residents will be completed monthly until discontinued by QAPI. Audits to be reviewed at QAPI.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309	1. Resident #17 is receiving services per the plan of care. 2. All dialysis residents will be receiving services per their plan of care.	

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F 309	Continued From page 20 by: Based on interview and document review, the facility failed to ensure coordination of care with an outside dialysis unit for 1 of 1 resident (R17) who received hemodialysis. Findings include: R17's admission Minimum Data Set (MDS) dated 5/8/15, identified diagnoses including end-stage renal disease. R17 had no cognitive impairment, required extensive assistance for most activities of daily living, and received special treatments of oxygen therapy and dialysis. R17's Care Area Assessment (CAA) dated 5/8/15, noted R17 previously lived in a group home in the community, but had experienced numerous hospitalizations related to chest pain, shortness of breath, and other co-morbidities which lead to nursing home admission. R17's Hemodialysis Plan of Care dated 9/15/15, identified the resident refused to attend dialysis on 7/18/15, 8/11/15, 8/15/15, and 9/15/15. The care plan directed staff to send and complete a Dialysis Center Communication Record form along with R17 to each appointment and document information exchanged after each dialysis treatment. The care plan directed staff to monitor for fluid retention and to report pertinent lab values to the dialysis center. R17 was prescribed a 1500 cubic centimeters (cc) per day fluid restriction. A risk/benefit acknowledgement regarding the residents refusals to attend dialysis and/or adhere to dietary and fluid restrictions was signed by R17 on 7/8/15. Review of R17's nursing Progress Notes from 7/18/15, through 7/23/15, identified the following: R17 chose to skip his dialysis appointment on 7/18/15. On 7/22/15, R17 was admitted to the hospital for chest pain and hypercalcemia (high calcium level). Registered nurse (RN)-E	F 309	3. Staff will ensure dialysis communication sheets are provided to dialysis location before appointment and received after each resident's dialysis appointment by 10/27/15. 4. DON/designee to audit completion of dialysis communication sheets for 5 residents per week for 1 month. Continued audits of 5 residents will be completed monthly until discontinued by QAPI. Results will be shared at QAPI.	

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F 309	Continued From page 21 contacted the social worker at R17's dialysis center to update them on the residents hospitalization, and at this time RN-E was informed R17 had a shortened dialysis treatment on 7/21/15, due to fistula (the dialysis access) infiltration. The progress note indicated the facility was not aware the resident did not receive the whole dialysis treatment that day, nor did the dialysis center communicate with the facility to reschedule R17 to return earlier than his typical schedule in response to the shortened run. On 7/23/15, R17's interdisciplinary team met to review his admission to the hospital, and according to the progress notes, the team determined R17 having canceled his own treatment on 7/18/15, along with the lack of communication from the dialysis center on 7/21/15, related to the shortened dialysis run, could have contributed to R17's condition and subsequent hospitalization. R17's Dialysis Post Treatment report from the dialysis treatment on 7/21/15, which was not printed until 8/6/15, indicated R17 had received only 90 minutes of the prescribed 240 minute run, due to fistula infiltration. The report identified the volume removed as 1.5 liters (L), with a calculated target removal of 9.10 kilograms (kg) and an actual target removal of only 4.00 kg. During interview on 9/17/15, at 11:16 a.m. RN-E stated there were concerns with the lack of communication with R17's dialysis unit. RN-E stated he was not informed of R17's shortened dialysis treatment on 7/21/15, until he requested the dialysis treatment information be faxed on 8/6/15, and if he had known about the missed dialysis treatment time, he would have been even more vigilant with encouraging R17 to adhere to his fluid restrictions. RN-E stated the facility's typical process for communication with dialysis	F 309		

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F 309	Continued From page 22 centers were to use communication sheets that were sent back and forth with the resident, however, R17 either refused to take the communication sheets with him, refused to return the sheets to the facility, or the dialysis center failed to return the sheets. RN-E stated he will call the dialysis center generally on a weekly basis to request the post-run reports be faxed. During interview on 9/17/15, at 2:38 p.m. the director of nursing (DON) stated she was aware the communication with the dialysis center does not always occur timely regarding R17's treatments. The DON agreed a system for consistent, on-going communication that was not dependent upon R17's follow through, was important for the coordination of his care. The facility's Dialysis Management (Hemodialysis) policy dated 7/15, directed staff to use the Dialysis Center Communication Record for continuity of care between the facility and dialysis unit. A post-dialysis assessment was to be included on this communication form. The facility's contractual agreement with dialysis units included an interchange of information useful/ necessary for the care of a resident.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	1. Nurse Practitioner met with resident #11. Resident refused discontinued use of catheter. NP did address risks associated with continued catheter use.	

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F 315	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medical justification for ongoing use of an indwelling urinary catheter for 1 of 3 residents, (R111) who had an indwelling catheter. Findings include: R111 was observed on 9/16/15, at 8:35 a.m. laying in bed. A Foley catheter bag was observed hanging on the side of the bottom of the bed frame about 1/4 full of urine. R111's quarterly Minimum Data Set (MDS) dated 7/3/15, indicated the resident had no cognitive impairment, had no behaviors, required extensive assistance with all activities of daily living (ADL's), and had an indwelling urinary catheter. R111 Care Area Assessment (CAA) for Urinary Incontinence and Indwelling Catheter dated 1/13/15, indicated the resident had a Foley catheter related to, "Urinary retention and had two pressure ulcers on buttocks, had urinary incontinence if no Foley (catheter) in place to assist with healing of pressure ulcers." R111's current physician orders dated 8/17/15, included diagnoses of generalized muscle weakness, knee pain, and unable to ambulate. The physician orders indicated the resident used a indwelling Foley catheter. R111's Catheter Plan of Care dated 7/3/15, indicated the resident had a indwelling catheter	F 315	2. All residents with catheters have medical justification. 3. All nurses will be educated regarding need for medical justification for catheterization of resident by 10/27/15. 4. DON/designee to audit 3 catheterized residents for justification of use per week for 1 month. Continued audits for 3 residents will be completed monthly until discontinued by QAPI. Results shared at QAPI.	

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F 315	Continued From page 24	F 315		

with diagnoses of spinal cord disease and urinary retention that cannot be corrected surgically or medically.

A Hospitalist Progress Note from Fairview Hospital dated 5/24/14, indicated R111 had been admitted to the hospital for cervical decompression and fusion. The Discharge Summary Note dated 5/25/14, indicated R111 had a diagnoses while in the hospital of urinary retention, and instructed, "Discharge the patient [R111] home with a Foley catheter as she is unable to void independently... Foley catheter in place and discharge instructions is make an appointment with urology associates within a week for further evaluation for urinary retention."

A Physician Telephone Order dated 6/9/14, indicated, "Concern retention [urine], discontinue urology follow up appointment." There was no corresponding documentation regarding why the urology appointment was canceled, and if the appointment was to be rescheduled.

A Physician Telephone Order dated 2/2/15, directed staff to remove R111's Foley Catheter on 2/9/15, and update physician on status. R111's Treatment Record dated 2/9/15, indicated to remove Foley catheter on 2/9/15. R111's treatment sheet indicated next to the treatment order, "Refused."

Review of R111 Progress Notes indicated the following:

4/1/15- "Resident continues to be unhappy and possibly somewhat in denial about her medical and physical decline; resident refused to allow catheter to be removed per physician order

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F 315	Continued From page 25 because she feels she will soon be able to transfer without a mechanical lift and will allow her to get to a commode or toilet quicker. Resident is tearful she will have increased incontinence and it will lead to skin breakdown if catheter is removed too early. Resident has been working with physical therapy for transfer, though their reports show a [mechanical] lift is still required." 6/29/15- "Resident continues to have catheter in place, refusing to allow discontinuing..." During interview on 9/14/15, at 4:55 p.m. Registered Nurse (RN)-D stated R111 used an indwelling Foley catheter since having spinal stenosis surgery in May 2014, and R111 had no pressure ulcers. During interview on 9/16/15, at 8:35 a.m. R111 stated she had an indwelling catheter because she, "Can't spend all day waiting to get to the bathroom." R111 thought it would just be "easier" to keep the catheter in place until she can regain strength so she can get to the bathroom on her own. R111 stated she did not want the catheter in place forever, and was not aware there were any risks with keeping the catheter in place. During follow up interview on 9/16/15, at 2:07 p.m. RN-D stated there is no documentation regarding the facility following up with a urology/ physician appointment regarding R111 continuing to use the indwelling catheter, nor was their documentation R111 was informed of the risks of continuing to use the indwelling catheter without medical justification. RN-D stated R111 required extensive assistance using a mechanical lift to use the bathroom, and the resident told staff it	F 315		

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F 315	Continued From page 26 was just easier to leave the catheter in. RN-D stated since R111 had returned to the facility following spinal surgery in 5/ 2014, there is no documentation the facility had attempted to removed the indwelling catheter. The facility policy titled Indwelling Urinary Catheters dated July 2015, indicated a comprehensive assessment includes underlying factors supporting medical justification, determination of which factors can be reversed, and development of a plan for appropriate indications for continuing use of an indwelling catheter beyond 14 days. Residents admitted to the center with an indwelling catheter that was placed elsewhere need a provider order and medical justification for the catheter to remain in place.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329	1. A sleep assessment has been completed for resident #2. 2. All residents that have pharmacological sleep aides have sleep assessments that are current.	

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F 329	Continued From page 27 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess sleep patterns for medication effectiveness for 1 of 2 residents (R2) who received medication for sleep. Findings include: R2's annual Minimum Data Set (MDS) dated 6/27/15, identified R2 was cognitively intact, had no trouble falling or staying asleep, and had a diagnosis of insomnia. During observation on 9/16/15, at 7:11 a.m. R2 was lying in bed asleep. During observation on 9/16/15, at 11:21 a.m. R2 was in the wheelchair sleeping near the nurses station. R2's Physician Telephone Orders 2/17/15, indicated R2 received Trazodone (medication used to treat depression and insomnia) 50 milligrams (mg), every night for insomnia. R2's Care Plan dated 2/17/15, indicated the resident used Trazodone for insomnia and increased restlessness at night.	F 329	3. All nurses will be re-educated regarding the policy for sleep assessments by 10/27/15. 4. DON/designee to audit 5 residents per week to assure sleep patterns are being assessed for medication effectiveness for residents who receive pharmacological sleep aides. Weekly audits will be completed for 1 month. Continued audits of 5 residents will be completed monthly thereafter until discontinued by QAPI.	

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F 329	Continued From page 28 R2's Pharmacy Consultation Report dated 2/3/15, indicated R2 had been receiving Trazodone 75 mg at bedtime for insomnia since 6/5/14. The Pharmacist recommendations were to consider a dose reduction to Trazodone 50 mg at bedtime, while concurrently monitoring for re-emergence of target and/or withdrawal symptoms. R2's most recent 7 Day Sleep Diary completed 2/18/15 - 2/22/15, indicated R2's sleep was monitored from 11:00 p.m. - 7:00 a.m. The Sleep Diary indicated in the 4 days tracked, R2 was noted to be asleep with the exception of 2/20/15, R2 was noted to be awake at 11:00 p.m., and 2/21/15, 7:00 a.m. was not addressed if the resident was asleep or awake. The Sleep Diary was only completed for 4 days, and there was no assessment to summarize the data, nor was R2's daytime sleep patterns monitored or assessed. During interview on 9/17/15, at 1:52 p.m. registered nurse (RN)-D stated sleep assessments should be completed annually, with any concerns or changes in sleeping behaviors, or with a change in medication used for sleep. RN-D stated a seven day sleep diary had been completed for R2 after the decrease in Trazadone February 2015, however, RN-D stated the sleep diary was only data collection of night time sleep, and the facility did not monitor the resident during day time hours to assess if the medication dose was effective, nor was there an assessment completed of the data collected. RN-D was unable to provide any sleep assessment for R2 regarding a baseline of the residents sleep prior to the initiation of Trazadone in 2014, before the dose reduction was completed in February 2015, or since the dose reduction was implemented.	F 329		

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F 329	Continued From page 29 During interviewed on 9/17/15, at 2:01 p.m. director of nursing (DON) stated a sleep log was completed for R2 in February 2015, after the Trazodone was decreased from 75 mg to 50 mg. DON stated sleep assessments are to be completed initially, annually, with any change in sleeping patterns, and with any dose changes in hypnotic medications. DON was unable to provide any sleep assessment for R2. The DON provided a blank facility form titled Sleep Assessment, dated July 2015, which she identified should have been completed for R2. The Sleep Assessment form indicated the following was to be assessed when completing a sleep assessment: - Excessive sleepiness during the day - Waking up too early - Unable to sleep at the desired time - Can't fall back asleep once awake - Any daytime napping - What helps to sleep - Any medical concerns - Current medications - Environmental factors - Caffeine intake - A summary of the data above which was collected. The facility policy titled Sleep Assessment dated 7/15, indicated the assessment is to be completed for a resident experiencing difficulty sleeping or using a sedative/hypnotic (sleep aide). It may be used to reassess sleep patterns as needed. It also noted to complete the sleep assessment quarterly, if continued sleep disturbance.	F 329		
F 353	483.30(a) SUFFICIENT 24-HR NURSING STAFF	F 353		

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F 353 SS=E	Continued From page 30 PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure sufficient staffing was provided to meet resident needs in a timely manner for 14 of 23 residents (R111, R160, R90, R61, R17, R12, R112, R27, R32, R46, R42, R71, R87, and R114) with complaints of lack of staffing to provide timely assistance with cares. Findings include: R111's quarterly Minimum Data Set (MDS) dated 7/3/15, identified her cognition was intact and required extensive assistance for toileting and transfers.	F 353	1. Resident #111, #61, #17, #12, #112, #27, #32, #46, #42, #71, #87, and #114 and unable to identify #160 and #90 are all getting their needs met timely. 2. All residents are receiving care in a timely manner. 3. All staff will be re-educated regarding providing care in a manner that fits with the resident's plan of care by 10/27/15. 4. ETD to interview 5 residents per week regarding timeliness of needs being met for 1 month. Continued audits for 5 residents will be completed monthly until discontinued by QAPI. Results of audits will be reviewed at QAPI.	

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F 353	Continued From page 31 During interview on 9/14/15, at 5:23 p.m. R111 stated she needed to wait long periods of time for assistance to get off the toilet, and staff have come into her room and turned the call light off, said they would be right back, and then failed to return to assist her. R111 stated recently a TMA [trained medication aide] was the only nursing assistant (NA) on the shift and she was running around trying to provide cares, and had no patience because of being so overworked. R160's Care Plan dated 9/14/15, identified he was a recently admitted to the facility, had no cognitive impairment, and required assistance from one staff for transfers. During interview on 9/14/15, at 5:34 p.m. R160 stated there was not always sufficient staff available to assist residents in a timely manner. R160 stated staff response times of 45 minutes with use of his call light and calling out the door for staff for help. R160 stated the facility told him he was not allowed to get out of bed by himself so he needed to call for staff to assist him so he could go to dinner. R90's quarterly MDS dated 8/31/15, identified the resident had no cognitive impairment and required extensive assistance for most activities of daily living. During interview on 9/14/15, at 5:44 p.m. R90 stated he had submitted a letter to the facility ownership last fall regarding insufficient staffing concerns. R90 stated there are still not enough staff to assist residents with cares, and call light response times are very long, specifically on the Garden Terrace unit. R90 stated Garden Terrace used to have four nursing assistants (NAs), but now they only have three NAs, which was not enough to meet the needs of the resident population on this unit. R61's quarterly MDS dated 8/7/15, indicated	F 353		

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F 353	Continued From page 32 moderately impaired cognition and required extensive assistance for most activities of daily living. During interview on 9/14/15, at 7:17 p.m. R61 stated he had waited three hours for a call light about one week ago. R61 stated he turned the call light on to ask staff to empty the urinal. R61 stated, "There running with two people [nursing assistants] when they're supposed to have four... Staff are always running." R17's quarterly MDS dated 8/7/15, indicated the resident had no cognitive impairment and required extensive assistance for most activities of daily living. During interview on 9/14/15, at 7:37 p.m. R17 stated there was not enough staff to ensure assistance was provided without having to wait a long time. R17 stated staff will come into the room when the call light is on, turn it off, say they will be right back, and then not return for one to two hours. R12's annual MDS dated 6/19/15, identified her cognition was moderately impaired and required extensive assistance from staff for toileting, transfers, and bed mobility. During interview on 9/15/15, at 8:45 a.m. R12 stated there was not enough staff available for timely assistance, and it takes approximately 30 minutes to get assistance after turning the call light on. R112's quarterly MDS dated 7/24/15, identified the resident had no cognitive impairment, was independent with activities of daily living, and had no concerns of pain. During interview on 9/15/15, at 9:24 a.m. R112 stated when she asked staff for assistance, they say they would get back to her, but then never followed through. R112 stated she had to ask staff multiple times whenever she wanted	F 353		

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F 353	Continued From page 33 assistance with anything, and although she was independent with activities of daily living, had to wait up to two hours when she turned her call light on to request ice or water. R112 stated she had complained of the staffing concerns to the facility social worker. R27's annual MDS dated 8/21/15, identified the resident had no cognitive impairment, required extensive assistance for toileting, and was frequently incontinent of bladder. During interview on 9/15/15, at 9:32 a.m. R27 stated the facility did not have sufficient staffing for timely cares, and at times had to wait several hours for assistance. R27 stated there is a clock right in front of her bed, and if she puts her call light on at 2:00 p.m., it won't be answered until after 3:30 p.m. because of shift change. R27 stated she had been incontinent due to having to wait too long for toileting assistance. R32's quarterly MDS dated 9/4/15, identified the resident had no cognitive impairment, required extensive assistance for most activities of daily living, and reported experiencing pain frequently. During interview on 9/15/15, at 10:03 a.m. R32 stated the facility needs more staff to provide cares, and the evening shift is the worst. R32 stated she had to wait up to an hour to receive for pain medication. A Resident Concern Report dated 8/20/15, indicated R32 made the following grievance: "On 8/18/2015 [R32] stated during a.m.'s at approximately 8:30 a.m. she had a fever, was was experiencing diahrea [sic] and she had experienced a long call light time." The administrator's follow-up dated 9/16/15, noted, "No discernable trends of long wait times... No further concerns have been appreciated." The report lacked evidence of having followed-up with R32's complaints of not receiving timely care.	F 353		

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F 353	Continued From page 34 R46's MDS dated 8/7/15, identified the resident had no cognitive impairment and required extensive assistance to get in and out of bed. During interview on 9/15/15, at 10:11 a.m. R46 stated there was not sufficient staff in the facility to ensure timely assistance. He stated, "There is not enough staff available to lay me down in the afternoon... If I do [lay down] they will not get me back up for dinner so they bring the food in here for me." During a follow up interview on 9/17/15, at 3:22 p.m. R46 stated he typically chose not to lay down in the afternoon because if he did, he would not be able to get back up for supper, however, if he thought he would receive assistance to lay down and get up when he wanted to, he would like to lay down in the afternoons, but then get up at supper time. During interview on 9/17/15, at 3:34 p.m. NA-C and NA-D confirmed R46 did ask to lay down sometimes in the afternoon to early evening hours. NA-D stated R46 will sometimes ask to get up when staff is serving dinner, so they are not able to assist him right away. NA-D stated staff were not always able to assist R46 out of bed until after the meal was over so the length of time he had to wait for assistance in or out of bed, was dependent upon the time he requested assistance. R42's quarterly MDS dated 6/19/15, identified the resident had no cognitive impairment and required extensive assistance with activities of daily living. During interview on 9/16/15, at 2:25 p.m. R42 stated they did not have enough staff to provide cares timely. R42 stated the night shift was very short staffed and in the past there have been only two NAs and one nurse on the Garden Terrace unit. In addition, if the other units in the facility were short on NAs, she stated one of the NA's	F 353		

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F 353	Continued From page 35 that was assigned to Garden Terrace unit would be pulled to assist on the other unit. R71's quarterly MDS dated 8/31/15, identified the resident had no cognitive impairments, and required extensive assistance with bed mobility, dressing, and personal hygiene. During interview on 9/17/15, at 2:18 p.m. R71 stated she had to wait up to 45 minutes to one hour for assistance when putting on the call light for assistance. R71 stated staff will walk by the room and no one will stop to ask what you need assistance with. R71 stated Garden Terrace is the unit the facility will pull staff from when another unit had a sick call. A Resident Concern Report dated 6/10/15, indicated: "[R71] is concerned of the call light response times. [R71] states that she and her roommate would like to be checked on in the morning. [R71] states aides wait for call lights and should be proactive." The investigation for this grievance dated 7/24/15, indicated, "Continue call light audits, encourage [NAs] to anticipate resident needs and round on floor. Resident checks in AM focus on resident need and level of assistance. Meals and orders are taken by NAs prior to each meal. For breakfast, this would be around 8:00AM. F/U [Follow-up] hourly rounds ongoing." The report lacked evidence of having followed-up with R71 to ensure the staffing concerns were resolved. R87's significant change MDS dated 8/1/15, identified the resident had no cognitive impairment and required extensive assistance from staff for most activities of daily living. During interview on 9/17/15, at 2:29 p.m. R87 stated call lights were not answered timely, and had to wait up to 45 minutes for staff assistance. She stated, "I have to go out to the nurse to request things... The aides come in with an	F 353		

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F 353	Continued From page 36 attitude, 'What do you want?' [when] all I want is ice... [It] makes me feel more frightened for others [who need more assistance] than myself." R114's quarterly MDS dated 8/13/15, identified the resident had severe cognitive impairment, required extensive assistance with toileting, and was frequently incontinent of bladder R114's family member (F)-A was interviewed on 9/15/15, at 10:56 a.m. and stated the facility did not have sufficient staff available to ensure residents received the care and assistance they needed without having to wait a long time. F-A stated R114 had to wait along time for assistance with toileting and/ or assistance changing his incontinent brief. During interview on 9/16/15, at 7:08 p.m. NA-E stated the facility does not have enough staff to provide timely care to the residents. NA-E stated, "There are continent residents who become incontinent all the time because after waiting for their lights for five to ten minutes, they wet themselves." NA-E stated staff hear from residents all the time they do not feel they are getting the care they need, especially in Garden Terrace. NA-E stated at times staff will have to skip a resident bath or shower because they don't have enough staff. During interview on 9/16/15, 7:37 p.m. NA-F stated there was not sufficient staffing in the facility to provide timely resident cares, and stated Garden Terrace unit was working one NA less than they had in the past. NA-F stated residents get frustrated when they have to wait to for cares. A Weekly Huddle report dated 5/19/15, indicated, "I have been asked to address the C/O [complaints of] staffing issues from TCU [Transitional Care Unit] staff members. We are advertising and working very hard to bring in new employees. I understand that it's frustrating to	F 353		

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F 353	Continued From page 37	F 353		

work with one nurse or only two NAs but please for the sake of the residents, let's keep the 'we are short staffed' or 'we don't have enough time' out of their daily lives. Venting is normal and healthy and my door is always open to express this frustration to. I have been guilty of it and let's face it, everyday isn't perfect. We should all keep each other accountable for keeping a positive attitude, we are here for the residents after all."
Review of the facility's NA care sheets and staffing schedules from 9/14/15, through 9/18/15, identified the Garden Terrace unit had four resident groupings/ teams. The care sheet for the fourth team noted the residents were to be divided among the other three teams when there were only three NAs working. Each team had five to nine residents, raising the workload to eight to twelve residents per NA when only three aides were scheduled. The schedule reflected routine scheduling of three NAs on the evening shifts and one to two NAs on the night shift. One licensed practical nurse was also scheduled for the unit on night shifts. Thirteen of the twenty-nine residents on the unit required two staff for assistance with transfers and an additional four residents required an assist of one staff for transfers. More than eighteen of the twenty-nine residents required staff assistance with toileting.
During interview on 9/17/15, at 2:43 p.m. the director of nursing (DON) stated the frequency of call-ins on the weekend shifts had caused some difficulty, but management staff had come in on weekends to work the floor as NAs to cover these responsibilities. The DON stated the facility was also having some difficulty filling open positions, but was utilizing pool nurses to help cover these responsibilities. The DON stated staffing was an agenda topic at every staff meeting, and the facility was aware of the resident and staff

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	245187	A. BUILDING ______ B. WING ______	09/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEXAS TERRACE CARE CENTER	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 38 concerns. The DON stated the facility had limited new admissions until another resident discharged as an additional effort to ensure sufficient staffing coverage until more open positions could be filled. The DON stated staffing was difficult in the facility at this time, however, the facility was attempting to ensure appropriate measures were being taken to ensure resident needs were met. DON stated random audits of call light response times were conducted and no patterns of unreasonable wait times were identified, however, she stated the facility did not have an automated system for tracking call light times, but had certain staff designated to do random observations of call lights. The facility's Personal Needs procedure dated 7/15, indicated, "The center strives to promote a healthy environment and prevent infection by meeting the personal care needs of the residents... Personal care and ADL support will be provided according to the resident's care plan. Compliance with care delivery needs and interventions will be determined by observation of care delivery..."	F 353		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	1. Resident #2 drug regimen has been reviewed by a licensed pharmacist. 2. All resident have a licensed pharmacist review their medication monthly.	

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F 428	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility consulting pharmacist failed to ensure sleep patterns were monitored to determine sleep medication effectiveness for 1 of 2 residents (R2) who received medication for sleep. Findings include: R2's annual Minimum Data Set (MDS) dated 6/27/15, identified R2 was cognitively intact, had no trouble falling or staying asleep, and had a diagnosis of insomnia. During observation on 9/16/15, at 7:11 a.m. R2 was lying in bed asleep. During observation on 9/16/15, at 11:21 a.m. R2 was in the wheelchair sleeping near the nurses station. R2's Physician Telephone Orders 2/17/15, indicated R2 received Trazodone (medication used to treat depression and insomnia) 50 milligrams (mg), every night for insomnia. R2's Care Plan dated 2/17/15, indicated the resident used Trazodone for insomnia and increased restlessness at night. R2's Pharmacy Consultation Report dated 2/3/15, indicated R2 had been receiving Trazodone 75 mg at bedtime for insomnia since 6/5/14. The Pharmacist recommendations were to consider a dose reduction to Trazodone 50 mg at bedtime, while concurrently monitoring for re-emergence of	F 428	3. All nurses will be re-educated regarding need for sleep assessment before and routinely thereafter for sleep aid use by 10/27/2015. 4. DON to audit 5 residents for sleep assessment completion per week for 1 month. Continued audits of 5 residents will be completed monthly until discontinued by QAPI. Results of audits will be reviewed at QAPI.	

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F 428	Continued From page 40 target and/or withdrawal symptoms. R2's most recent 7 Day Sleep Diary completed 2/18/15 - 2/22/15, indicated R2's sleep was monitored from 11:00 p.m. - 7:00 a.m. The Sleep Diary indicated in the 4 days tracked, R2 was noted to be asleep with the exception of 2/20/15, R2 was noted to be awake at 11:00 p.m., and 2/21/15, 7:00 a.m. was not addressed if the resident was asleep or awake. The Sleep Diary was only completed for 4 days, and there was no assessment to summarize the data, nor was R2's daytime sleep patterns monitored or assessed. During interview on 9/17/15, at 1:52 p.m. registered nurse (RN)-D stated sleep assessments should be completed annually, with any concerns or changes in sleeping behaviors, or with a change in medication used for sleep. RN-D stated a seven day sleep diary had been completed for R2 after the decrease in Trazadone February 2015, however, RN-D stated the sleep diary was only data collection of night time sleep, and the facility did not monitor the resident during day time hours to assess if the medication dose was effective, nor was there an assessment completed of the data collected. RN-D was unable to provide any sleep assessment for R2 regarding a baseline of the residents sleep prior to the initiation of Trazadone in 2014, before the dose reduction was completed in February 2015, or since the dose reduction was implemented. During interviewed on 9/17/15, at 2:01 p.m. director of nursing (DON) stated a sleep log was completed for R2 in February 2015, after the Trazodone was decreased from 75 mg to 50 mg. DON stated sleep assessments are to be completed initially, annually, with any change in	F 428		

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F 428	Continued From page 41	F 428		

sleeping patterns, and with any dose changes in hypnotic medications. DON was unable to provide any sleep assessment for R2. The DON provided a blank facility form titled Sleep Assessment, dated July 2015, which she identified should have been completed for R2.

The Sleep Assessment form indicated the following was to be assessed when completing a sleep assessment:
- Excessive sleepiness during the day
- Waking up too early
- Unable to sleep at the desired time
- Can't fall back asleep once awake
- Any daytime napping
- What helps to sleep
- Any medical concerns
- Current medications
- Environmental factors
- Caffeine intake
- A summary of the data above which was collected.

During interview on 9/17/15, at 2:48 p.m. the facility consultant pharmacist (CP) stated R2's Trazodone was last decreased in February 2015. CP stated he had recommended a dose reduction to the facility at that time, and would use the sleep log in making the recommendation of a dose change. CP stated if he had concerns regarding sleep assessments to determine medication effectiveness, he would review those concerns with nursing. CP was not able to recall specific concerns regarding R2's sleep assessments.

The facility policy titled Sleep Assessment dated 7/15, indicated the assessment is to be completed for a resident experiencing difficulty

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F 428	Continued From page 42 sleeping or using a sedative/hypnotic (sleep aide). It may be used to reassess sleep patterns as needed. It also noted to complete the sleep assessment quarterly, if continued sleep disturbance.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431	1. Medication rooms only to be entered by licensed nursing staff. All outdated lab tubes have been disposed of and all medication is labeled appropriately per policy. 2. All medication rooms and medication carts have been audited to assure lab tubes removed and medications dated with open dates. 3. All licensed nurses will be re-educated regarding proper med storage procedure and safe keeping of med room keys by 10/27/2015.	

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F 431	Continued From page 43 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure only licensed personal had access to the medication room on the Transitional Care Unit (TCU). In addition, the facility failed to ensure blood tubes were not outdated in 1 of 3 medication rooms observed. In addition, the facility failed to ensure medication was labeled and it the original packaging in 1 of 3 medication rooms. This had the potential to affect all residents residing on the TCU unit. Findings include: During observation of the TCU medication room on 9/17/15, at 10:30 a.m. with registered nurse (RN)-A the locked medication room door opened and physical therapy aid (PTA)-A entered and removed an ice pack out of the freezer. During interview on 9/17/15, at 10:30 a.m. PTA-A stated she goes into the locked medication room by using the medication room keys that are located in the top drawer at the nurses station. During interview on 9/17/15, at 11:15 a.m. director of nursing (DON) stated she was not aware nurses were allowing none licensed personal into the medication room, and only nursing should be going into the medication room. During continued tour of the TCU medication room on 9/17/15, at 10:30 a.m. six unlabeled medication dispensers were found in the cabinet.	F 431	4. DON/Designee to audit all medication carts and medication rooms to ensure proper storage procedure is being followed 1 time per week for 1 month. Continued audits of med storage will continue 1 time per month until discontinued by QAPI. Results to be shared at QAPI.	

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F 431	Continued From page 44 One of the dispensers had multiple pills inside, however, none of the pills were labeled, and there was not a date or name of a resident on the dispenser. Located in a drawer in the TCU medication room, 17 outdated green top lab blood tubes were found; 16 of them were dated with an expiration date of 1/2015, and one was dated 12/2014. During interview on 9/17/15, at 11:15 a.m. DON stated she did not know what the medication dispensers were used for, or who they belonged to. DON also stated the expired blood tubes should be disposed of and not available for patient use. The facility policy titled Storage and Expiration of Medication, Biological's, Syringes and Needles dated 1/1/13, instructed only authorized facility staff should have possession of the keys, access cards, electronic codes, or combinations which open medication storage areas. Authorized staff may include nursing supervisors, charge nurses, licensed nurses, and other personnel authorized to administer medications in compliance with applicable law. The policy also indicated medications and biological's have an expiration date on the label.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441	1. Staff will follow appropriate infection control guidelines for hand hygiene.	

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F 441	Continued From page 45 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate hand hygiene and infection control practices were utilized for 1 of 3 residents (R139) observed being provided personal cares. Findings include:	F 441	2. Identified NAR has completed one on one education regarding hand hygiene. 3. All nursing staff will be re-educated regarding changing gloves and washing hands per policy by 10/27/15. 4. ETD/Designee to observe 3 staff members weekly during resident cares to monitor appropriate infection control procedures relating to hand hygiene for 1 month. Continued audits for hand hygiene will be completed 3 times per month until discontinued by QAPI. Results to be shared at QAPI.	

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F 441	Continued From page 46 R139 was observed on 9/17/15, at 10:55 a.m. being assisted with cares by nursing assistant (NA)-A and NA-B. NA-A washed R139's face, removed his gown, washed R139's arms, and applied deodorant. NA-B assisted by washing R139's left arm and applying deodorant. NA-A and NA-B performed perineal care, and placed a clean incontinent pad on the resident. NA-A opened R139's bedside table drawer without removing the soiled gloves and removed a tube of barrier cream. NA-B then touched the bed remote and R139's hand without removing her soiled gloves. NA-B then removed her gloves, performed hand hygiene, and left the room. NA-A proceeded to assist R139 without removing the soiled gloves and put on the residents pants, touched R139's drawer, and rubbed R139's hand. At 11:22 a.m. NA-B returned to R139's room with a hoyer sheet. NA-A assisted R139 to turn with the same soiled gloves and touched R139's clean clothing and hoyer sheet, put R139's shoes on, touched the hoyer lift and remote, assisted R139 to the wheelchair, and unhooked the sling. NA-A proceeded to R139's drawer and removed the residents toothbrush and toothpaste to assist the resident with oral cares. At no time during the observation did NA-A change gloves or perform hand hygiene. During interview on 9/17/15, at 11:33 a.m. NA-A and NA-B both stated hand hygiene and glove change should be performed after providing peri cares, and when going from any dirty to clean task or body part. During interview on 9/17/15, at 1:50 p.m. registered nurse (RN)-D stated staff are expected to change gloves and perform hand hygiene	F 441		

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F 441	Continued From page 47 between dirty and clean tasks. The facility policy titled Hand Hygiene- Plain Soap and Water handwashing and Alcohol Based Hand Rub dated 7/15, indicated either handwashing or alcohol based hand rub is to be performed during resident care if moving from a contaminated body site to a clean body site and after removing gloves.	F 441		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure resident environment was maintained and in good repair for 5 of 7 resident rooms, room 1, 23, 17, 108, and 208, which were observed requiring repair. Findings include: On 9/17/15, at 8:12 a.m. an environmental tour was conducted with maintenance manager (MM)-A, housekeeping manager (HK)-A, and the administrator with the following findings: Room 1's closet door was observed leaning against the wall. R27, who occupied room one, stated the closet door had been off for over 3 weeks and had been leaned against the wall. R27 stated she had complained to maintance and	F 465	1. Room #1, #23, #17, #108, and #208 have been addressed and are in good repair. 2. All resident rooms have been observed by maintenance director and are in good repair. 3. All staff will be re-educated on using maintenance work orders to communicate areas of repair within facility by 10/27/15.	

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F 465	Continued From page 48 the nursing staff that she wanted the closet door back on so her belongings were safe, however, nothing had been done with the closet door, and she was not aware if anything was being worked on to get it fixed. R27 also stated the cold water in the bathroom did not work for almost a year, and she had requested it be fixed multiple times. The cold water in room one was tested, and the lever turned, however, no water came out of the faucet. MM-A stated he was aware the closet was broken in R1's room, and he had removed it and leaned it against the wall because the lock was broke. MM-A and administrator verified the faucet had no cold water. MM-A stated the facility had issues with the water at one time, and the water was shut off facility wide for a short time. When the water was turned back on the cold water would not turn off in room one, so staff turned off the water when they could not get the water to stop running. During inspection of the cold water lever, the administrator determined the lever was on the sink backwards. Room 1 also was noted to have the veneer missing from the front of a drawer and had no handle to open the drawer. MM-A stated he was not aware of the concerns with the drawer, and would get it fixed. Resident room 23 was observed to have a three inch circle of black on a ceiling tile with a larger, approximetly six inch brown ring located around the black ring. Resident room 17 was observed to have celiling tiles in the bathroom which were hanging down and falling downward out of the holder. One area	F 465	4. NHA/designee to audit 5 rooms per week to ensure rooms are in working order for 1 month. Continued audits of 5 rooms will be completed monthly until discontinued by QAPI. Results to be shared at QAPI.	

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F 465	Continued From page 49 on ceiling tiles had dark brown substance on, and there was also brown substance around the vent on the ceiling. Under the sink in the bathroom, the dry wall had a broken area approximetly five by two inches, and another area approximetly one by 1.5 inch's. Resident room 108 was observed to have a broken blind that was non-functioning. Resident room 208 was observed to have the telephone face plate broken off, and the paint on the wall around the faceplate was chipped off the wall. During interview on 9/17/15, at approximetly 9:00 a.m. MM-A stated if staff notices repairs are needed for resident rooms, nursing should fill out work orders for maintence. MM-A stated environmental inspections of resident rooms are done quarterly, however, besides room one, MM-A was not aware of the needed repairs identified during the environmental tour. A facility policy titled Work Orders, undated, instructed staff to implement a building services work order request to establish a written measns of communication between all disciplines for items to be repaired or replaced.	F 465		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245187	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 09/15/2015

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SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Texas Terrace Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid, 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Texas Terrace Care Center is 3-story building with no basement. The original building was constructed in 1972 and was determined to be of TYPE I(332) Construction. In 1995 an addition was constructed to the west and it was determined to be of TYPE I(332) Construction. It is automatic fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 118 beds. At the time of the survey the census was 85. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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