DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

MEDICARE/MEDICAID PROVIDER NO.(L1) 245417						
2. STATE VENDOR OR MEDICAID NO (L2) 516842200		3. NAME AND ADDRESS OF FACILITY (L3) ROBBINSDALE REHAB & CARE C (L4) 3130 GRIMES AVENUE NORTH (L5) ROBBINSDALE, MN			(L6) 55422	4. TYPE OF ACTION:7(L8) 1. Initial
5. EFFECTIVE DATE CHANGE OF OWN (L9) 07/01/2015		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 02/01/2 8. ACCREDITATION STATUS: 0 Unaccredited	016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	07 X-Ray	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
11LTC PERIOD OF CERTIFICATION From (a): To (b):		10.THE FACILITY X A. In Complia Program Re Compliance	equirements Based On:	S:	2. Technical Personnel 3. 24 Hour RN	7. Medical Director
12.Total Facility Beds 13.Total Certified Beds	75 (L18) 75 (L17)	B. Not in Com	cceptable POC ppliance with Progra and/or Applied Wa		4. 7-Day RN (Rural SN_X 5. Life Safety Code * Code: A,5*	NF) 8. Patient Room Size 9. Beds/Room (L12)
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 75 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARK CCN 24-5417Documentation supporting the facili17. SURVEYOR SIGNATURE	·			·	peing recommended and forwa	**
Gloria Derfus, Unit Supervisor 02/26/2016 (L19)					Kamala Fiske-Downing,	Enforcement Specialist 02/26/2016 (L2
PART 19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Partic 2. Facility is not Eligible		20. COM	BY HCFA REC PLIANCE WITH OUTS ACT:			ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513)
OF PARTICIPATION	3. LTC AGREEN BEGINNINC		LIC AGREEME		26. TERMINATION ACTION VOLUNTARY 00	0 <u>INVOLUNTARY</u>
03/01/1987 (L24) 25. LTC EXTENSION DATE: 27		VE SANCTIONS n of Admissions:	(L25)		01-Merger, Closure 02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	on <u>OTHER</u>
(L27)		uspension Date:	(L44) (L45)			00-Active
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
31. RO RECEIPT OF CMS-1539	(L28) 32	DETERMINATION 02/04/2016	OF APPROVAL D		DETERMINATION APPR	



Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245417

February 26, 2016

Ms. Kathleen Pankratz, Administrator Robbinsdale Rehab & Care Center 3130 Grimes Avenue North Robbinsdale, MN 55422

Dear Ms. Pankratz:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 26, 2016 the above facility is certified for:

75 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 75 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K67.

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

Kumalu Fiske Downing

Minnesota Department of Health

Robbinsdale Rehab & Care Center February 26, 2016 Page 2

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697



Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered February 26, 2016

Ms. Kathleen Pankratz, Administrator Robbinsdale Rehab & Care Center 3130 Grimes Avenue North Robbinsdale, MN 55422

RE: Project Number \$5417025

Dear Ms. Pankratz:

On January 4, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 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 February 1, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 22, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 17, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 26, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 17, 2015, effective January 26, 2016 and therefore remedies outlined in our letter to you dated January 4, 2016, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K67 at the time of the December 17, 2015 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION			DATE OF REVIS	IT
IDENTIFICATION NUMBER	A. Building				
245417 _{Y1}	B. Wing	Yz	2 2	2/1/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
ROBBINSDALE REHAB & CAF	RE CENTER	3130 GRIMES AVENUE NORTH			
		ROBBINSDALE, MN 55422			

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

ITE	M	DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix	F0176	Correction	ID Prefix F028	57	Correction	ID Prefix	F0278		Correction
Reg. #	483.10(n)	Completed	Reg. #	15(h)(6)	Completed	Reg.#	483.20(g) - (j)		Completed
LSC		01/26/2016	LSC		01/26/2016	LSC			01/26/2016
ID Prefix	F0282	Correction	ID Prefix F030	09	Correction	ID Prefix	F0312		Correction
Reg. #	483.20(k)(3)(ii)	Completed	Reg. #	25	Completed	Reg. #	483.25(a)(3)		Completed
LSC		01/26/2016	LSC		01/26/2016	LSC			01/26/2016
ID Prefix	F0314	Correction	ID Prefix F032	22	Correction	ID Prefix	F0323		Correction
Reg. #	483.25(c)	Completed		25(g)(2)	Completed	Reg. #	483.25(h)		Completed
LSC		01/26/2016	LSC		01/26/2016	LSC			01/26/2016
ID Prefix	E0320	Correction	ID Prefix F033	32	Correction	ID Prefix	E0333		Correction
Reg. #	483.25(I)	Completed		25(m)(1)	Completed	Reg. #	483.25(m)(2)		Completed
LSC		01/26/2016	LSC		01/26/2016	LSC			01/26/2016
ID Prefix	F0371	Correction	ID Prefix F042	28	Correction	ID Prefix			Correction
Reg. #	483.35(i)	Completed	Reg. #	60(c)	Completed	Reg. #	483.60(b), (d), (e	e)	Completed
LSC		01/26/2016	LSC		01/26/2016	LSC			01/26/2016
REVIEWE STATE AC		REVIEWED BY (INITIALS) GD/kfd	DATE 02/26/2016	SIGNATURE	OF SURVEYOR	23		DATE	/2016
REVIEWS	ED BY	REVIEWED BY (INITIALS)	DATE	TITLE	100	<u> </u>		DATE	2010

POST-CERTIFICATION REVISIT REPORT

	ER / SUPPLIER CATION NUMBE	ER A.	ULTIPLE CON Building Wing	STRUCTIO	N			Y2	DATE OF REVISIT 2/1/2016 _{Y3}
	FACILITY SDALE REHA	B & CARE	CENTER			STREET ADDRESS, (3130 GRIMES AVENU ROBBINSDALE, MN 5	IE NORTH	, ZIP CODE	
program corrected provision	, to show those d and the date	e déficiencie such corre he identific	es previously ctive action v	reported ovas accom	on the CMS-25 plished. Each	Medicaid and/or Clinica 67, Statement of Defic deficiency should be fi the CMS-2567 (prefix	iencies and ully identifie	Plan of Correct d using either th	ion, that have been ne regulation or LSC
ITEI	М		DATE	ITEM		DATE	ITEM		DATE
Y4			Y5	Y4		Y5	Y4		Y5
ID Prefix	F0441	(Correction	ID Prefix	F0456	Correction	ID Prefix	F0465	Correction
Reg. #	483.65	(Completed	Reg. #	483.70(c)(2)	Completed	Reg. #	483.70(h)	Completed
LSC		C	01/26/2016	LSC		01/26/2016	LSC		01/26/2016
ID Prefix	F0468		Correction						
	483.70(h)(3)								
Reg. #			Completed						
LSC			01/26/2016	<u> </u>					
REVIEWE		REVIEWE		DATE	SIGNAT	URE OF SURVEYOR			DATE
STATE AC	GENCY	(INITIALS)) GD/kfd	2/26/20	016	18623			2/1/2016
REVIEWS CMS RO	ED BY	REVIEWE (INITIALS)		DATE	TITLE				DATE
FOLLOW 12/17/20	UP TO SURVE	Y COMPLET	TED ON			NCORRECTED DEFICIENTIES (CMS-2567)			YES NO
				<u> </u>					

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PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 245417 Y1 B. Wing DATE OF REVISION A. Building 01 - MAIN BUILDING 01 B. Wing 2/22/2016 NAME OF FACILITY ROBBINSDALE REHAB & CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422 This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have becorrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or Liprovision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement the survey report form).	245417 YOUNGER NAME OF FACILITY	CATION NUMBER A. Building 01 Y1 B. Wing				DATE OF REV	ISIT
ROBBINSDALE REHAB & CARE CENTER 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422 This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have becorrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or Liprovision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement the survey report form).						_{Y2} 2/22/2016	Y3
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 Liprovision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement the survey report form).				3130 GRIMES AVENU	E NORTH	·	
ITEM DATE ITEM DATE ITEM DATE	program, to show those defici- corrected and the date such o provision number and the ider	to show those deficiencies previous d and the date such corrective action number and the identification prefix	ly reported on the CMS-256 was accomplished. Each d	 Statement of Deficition Efficiency should be full 	encies and Plan of Co Illy identified using eith	rrection, that have t er the regulation or	LSC
	ITEM	VI DATE	ITEM	DATE	ITEM	DATE	
Y4 Y5 Y4 Y5 Y4 Y5	Y4	Y5	Y4	Y5	Y4	Y5	
ID Prefix Correction ID Prefix Correction ID Prefix Correction Correctio	ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Corre	ction
Reg. # NFPA 101 Completed Reg. # Completed Reg. # Completed Reg. # Completed	Reg. #		Reg. # NFPA 101	Completed	Reg. #	Comp	leted
LSC K0066 01/26/2016 LSC K0067 01/26/2016 LSC		K0066 01/26/2016	LSC K0067	01/26/2016	LSC		

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Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 3020 0001 8869 0725

February 16, 2016

Ms. Kathleen Pankratz, Administrator Robbinsdale Rehab & Care Center 3130 Grimes Avenue North Robbinsdale, MN 55422

Subject: Robbinsdale Rehab & Care Center - IDR

Provider # 245417 Project # S5417025

Dear Ms. Pankratz:

This is in response to your letter of January 8th, 2016, in regard to your request of an informal dispute resolution (IDR) for the federal deficiencies at tag F225 and F226 issued pursuant to the survey event B1TG11, completed on December 17, 2015.

The information presented with your letter, the CMS 2567 dated December 17, 2015, and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F225, D-S/S 42 CFR § 483.13 Staff Treatment of Residents F225 The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, uncluding 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.)

F226, D-S/S 42 CFR § 483.13 Staff Treatment of Residents F226 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property.

Summary of the facility's reason for IDR of this tag.

The facility indicated a report to the State agency (SA) was submitted on 12/17/15, when the facility was notified of R4's allegation of potential resident to resident abuse. The facility conducted a thorough investigation and the result of the investigation was submitted to the SA within the required 5 working days. On 1/6/16, the facility submitted a copy of a facsimile transmittal sent to facility on

Robbinsdale Rehab & Care Center February 16, 2016 Page 2

12/18/15, at 6:35 a.m. tracking identification number 90981, which indicated an incident report had been recieved at the Office of Health Facility Complaints (OHFC) and the facility investigative report of the incident was due within 5 working days of the incident. A second facsimile dated 12/23/15, sent to the facility titled Disposition Letter from MDH, indicated the facility had submitted a report of possible maltreatment from the facility on 12/17/15, with a tracking ID of 90981. The facsimile further listed the information submitted had been reviewed and it was determined that no further action by the OHFC was necessary at that time.

Summary of facts: An incident of potential resident to resident abuse was reported by R4 to the survey team during survey. Interviews revealed the facility was not aware of the incident and the director of nursing (DON) was notified of the report. After survey, on 12/21/15, the facility informed the survey team an investigation of the incident had been done, however, the report had not indicated a report of the incident of potential abuse had been submitted to OHFC prior to initating an investigation. On 1/6/16, the facility sent copies of a facsimile dated 12/18/15, at 6:35 a.m. which indicated an incident had been reported of potential resident to resident abuse involving R4. In addition, a copy of the investigation done by the facility and a facsimile of submission of the investigation to OHFC was submitted.

This in not a valid example of a deficient practice under these regulations, F225 and F226, and will be removed from the Statement of Deficiencies.

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Gail Anderson, Unit Supervisor Licensing and Certification Program

Health Regulation Division

Telephone: 218-332-5140 Fax: 218-3325196

Sail anderson

cc: Office of Ombudsman for Long-Term Care Pam Kerssen, Assistant Program Manager

Licensing and Certification File

Gloria Derfus, Metro Team C Unit Supervisor

PRINTED: 02/16/2016 FORM APPROVED OMB NO. 0938-0391

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (PLETED
		245417	B. WING		12/1	7/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CAP	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 000		of correction (POC) will serve	F 00			
	Department's acception enrolled in ePOC, year the bottom of the	of compliance upon the otance. Because you are your signature is not required if first page of the CMS-2567 nic submission of the POC will tion of compliance.				
F 176 SS=D	an on-site revisit of conducted to valida with the regulations accordance with yo 483.10(n) RESIDER	NT SELF-ADMINISTER	F 170			1/26/16
	if the interdisciplina	ent may self-administer drugs ry team, as defined by as determined that this				
	This REQUIREMENT by: Based on observative review, facility failed (R82, R87) who we self-administer medium.	tion, in view, and document d to ensure of 2 of 2 residents re assesses not to		The submission of this plan of corre is not an admission by the provider fact or conclusion set forth in the Statement of Deficiency. This Plan Correction is being submitted because	of any	
	have a clear plastic in front of R82 with were two blue and colored capsule and	on 12/14/15, at 7:03 p.m. to medication cup on the table four medications in it. There white capsules, one dark d a white oval that had the vent hypocalcemia-low levels		is required by law. However, eviden Robbinsdale Rehabilitation and Car Center good faith, the facility offers following plan of correction and has achieved substantial compliance in of the areas addressed by January 2016.	cing e the each	

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

Electronically Signed 01/12/2016

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

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245417	B. WING			12/1	7/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROBBIN	SDALE REHAB & CAI	RE CENTER			130 GRIMES AVENUE NORTH OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 176	of calcium in the both three other residen medication cup rem the evening meal umedications at 7:25 nurse (LPN)-D was room area at the tirnot in a location who self-medication and assessment dated 5/11/13, was marker resident requested Quarterly Nursing Dassessment dated "self-medicates/des" R82's quarterly Min 10/6/15, indicated Facognitively impaired dementia, diabetes stage 4 on dialysis. Nursing Comprehe 12/6/15, indicated reself-administer the The Hennepin Cou orders printed 12/6 one Nephrocap (a cused to treat or prepoor diet, certain ill capsule by mouth in capsules (used to treat or prepordication of the self-administer the cused to treat or prepoor diet, certain ill capsules (used to treat or prepordication).	ddy) printed on it. There were its seated at the table. The nained at the table throughout ntil R82 self-administered the p.m. Licensed practical noted to leave the dining me of the observation and was itere able to visualize R82. d Data Collection and 8/31/12, and reviewed and not applicable and indicated staff to administer medication. Data Collection and 10/5/15, indicated no for sires to self-medicate." Simum Data Set (MDS), lated R82 was moderately and had diagroses of and chronic in liney alsease	F1	176	A Self Medication and Data Collect and assessment was completed for on 1/5/2016 in order to evaluate Reability to safely self-administer her medications. The results were reveloped by the aterdiscip pary team (IDT) implementation to letermine if the practice is rafe. Lice ced Practical Nurse (LPN) Devided aucation on 12/15/2015 to self-administer drug management and part of the practice is referred by the administer drug management recedure to ensure LPN -D followed recet procedure when administer and assessment was completed from 1/5/2016 in order to evaluate Reability to self-administer her medications. A Self Medication and Data Collect and assessment was completed from 1/5/2016 in order to evaluate Reability to self-administer her medications. The results were reviewed by the I determine if the practice is safe. LPN-D was provided education on 12/15/2015 related to self-administer management procedure when administering medications. All residuate the potential to be affected by same deficient practice. A facility wide audit was completed 12/17/2015 and 19 residents were identified with current self- administer of medications and will be re evaluated.	r R82 32's sewed prior to was related of the serion serions. DT to ration dents with the contration of the serion serion of the contration of the serion of the contration of the contration of the serion of the contration of the	
	each three times a	day with meals and Renvela hree times daily with meals.			Measures and systematic changes to ensure that the deficient practice		

-	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY
		245417	B. WING			12/1	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH COBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 176	There was no phys R82 to self-adminis R87 was observed have a clear plastic in front of R87 with were three other rethe medication cup throughout the eves elf-administered the LPN-D was noted that the time of the old location where ables on 12/16/15, at 2:00 powder (used to tree observed on an endouserved on an endouserved on an endouser was sessment dated applicable and indinursing staff administrationally and control of the control of the Physicians of demonstration of the Physicians of demonstration of the Physicians of the	on 12/14/15, at 7:03 p.m. to emedication cup on the table two white tablets in it. There sidents seated at the table remained at the table ning meal until R82 ne medications at 7:20 p.m. to leave the dining room area observation and was not in a exto visualize R87. 77 p.m. a bottle of Nystatin the table in R87's room. d Data Collection and cated at the table ning at the dining room area observation.	F	1176	not re occure include reviewing net admissions prior to the plan of care (POC) meeting, held within 21 day admissioni. Current in house resid will be reviewed during the facility comprehensive sare plan review meetings per the assigned schedu Registe ad Nurses (RN) and LPN's ir service on policy and procedure //26/2/16. Audis will be completed weekly x weeks by the DON and/or designed will not for identified residents for a lility to self-administer drugs. The ad/or her designee will complete with RN's and LPN's related to self medication. Audits will be reviewed the quality Assurance (QA) meeting determine if any trends are identified recommendations made for continuations/monitoring needs.	s of lents weekily le. All s will be e by 4 lee that the e DON audits - I during g to ed, and	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		245417	B. WING			12/17/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 3130 GRIMES AVENUE NORTH	CODE	
ROBBIN	SDALE REHAB & CAI	RE CENTER		ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD I HE APPROPR	BE COMPLÉTIC
F 176	self-administer med During interview on LPN-D stated, "Yes last night for them. pills with meals. If y they are in their rood dining room. I do not self-administration verified the medical Phoslo capsules, on Nephrocap. LPN-D R87 were two Tyler On 12/17/15, at 12: (RN)-B verified R82 self-administration plans. The nurse she medications with the During an interview when asked would cup of medications resident who does of medication order (IDON) said, "No, the assessment, an ord IDON verified R82 self-administer medication and Asserved the Collection and Ass	dications. 12/15/15, at 11:55 a.m. If I left the pills on the table on they both like to take their rou give them their pills when they will bring it to the of know if they have of medication orders." LPN-Dottons left for R82 were two notes a tablet and one verified the medication left for notes of the medication left them. If on 12/17/15, 12:07 m. If you expect he seed a leave a on the dialog round table of a not have a suff-adhance at one of the medication of the medication. The note in the many a safe plan." The and R87 called not safely	F1	76		

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, REHAB & CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	1	DATE SURVEY COMPLETED
ROBBINSDALE REHAB & CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422			245417	B. WING		12/17/2015
F 176 Continued From page 4 a. Resident able to safely self-administer medications. * All questions must be marked "able" for resident to self-administer medications at this time. Document the reason and plan for re-evaluation as appropriate." F 257 SS=E The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, interview and documents review, the facility failed to ensure comfortable temperature was maintained in 1 1 3 ming rooms (Three South). This be 1 the prential of affect 25 of 26 residents yield the timp g in			RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH	
a. Resident able to safely self-administer medications. * All questions must be marked "able" for resident to self-administer b. Resident unable to self-administer medications at this time. Document the reason and plan for re-evaluation as appropriate." F 257 SS=E The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure comfortable temperature was maintained in N 3 a ring rooms (Three South). This better tential of affect 25 of 26 residents and used the birshing in	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
All residents have the potential to be affected. Staff will be in-serviced on actions they can take when residents verbalize concerns related to temperatures, e.g. statements such as, "It's hot in here" by 1/26/2016. The pnuematic thermostats observation 11 residents were in the dining room (DR) waiting for the food and then they got served. As residents waited for food, R46 and R61 were seated at the far table, close to door and were overheard to state the room was very hot. All residents have the potential to be affected. Staff will be in-serviced on actions they can take when residents verbalize concerns related to temperatures, e.g. statements such as, "It's hot in here" by 1/26/2016. The pnuematic thermostats are being re-calibrated to create a more comfortable environment for the residents. Audits will be completed by the Director of Maintenance and/or designee 3 times a week times 2 weeks, then weekly times 2	F 257	a. Resident ablamedications. * All questiveresident to self-admedications at this Document the re-evaluation as ap 483.15(h)(6) COMFTEMPERATURE LITTHE facility must protemperature levels after October 1, 199 temperature range. This REQUIREMED by: Based on observative review, the facility for temperature was moreoms (Three Sout affect 25 of 26 resident unit. Findings include: 3rd floor North dinimal Con 12/14/15, at 6:3 dining room observation 11 resident (DR) waiting for the served. As resident R61 were seated a and were overhear.	e to safely self-administer ons must be marked "able" for ninister able to self-administer time. The reason and plan for propriate." FORTABLE & SAFE EVELS Tovide comfortable and safe Facilities initially certified The reason and plan for propriate. FORTABLE & SAFE EVELS Tovide comfortable and safe Facilities initially certified The reason and plan for propriate. The reason and plan f		Staff offered to remove the sweater of R61, which was declined. The fan mounted on the wall in the dining room was cleaned immediately during the environmental tour on 12/16/2015. All residents have the potential to be affected. Staff will be in-serviced on actions they can take when residents verbalize concerns related to temperatures, e.g. statements such as, "It's hot in here" by 1/26/2016. The pnuematic thermostats are being re-calibrated to create a more comfortable environment for the residents. Audits will be completed by the Director Maintenance and/or designee 3 times a	r of

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER SDALE REHAB & CA			STREET ADDRESS, CITY, STATE, ZIP CO 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
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F 257	meal R165 was on DR was hot which DR. R13 nodded if forehead with her R13's Minimum Daindicated had impalated and unders R61's Minimum Daindicated had impalated had impalated and usually R165's Minimum Daindicated had mochowever, R61 had needs and usually R165's Minimum Daindicated had mochowever, R165 haneeds and unders R13's MDS dated having intact cognitheir needs. On 12/16/15, at 7: have removed her brought into the Dexercises R61 kep a.m. restorative stillyou look tired do or go take a nap" I hot in here." Restot to the table offered completely but R6	25 a.m. during the breakfast verheard to indicate to R13 the was the other side of the split her head as she wiped her napkin. ata Set (MDS) dated 10/22/15, aired cognition impairment the ability to express their tand others. ata Set (MDS) dated 11/25/15, aired cognition impairment the ability to express their understand others. Data Set (MDS) dated 12/9/15, derate cognition impairment of the ability to express their understand others.	F 2	weeks to monitor air temper various locations. The dining will be audited by the house supervisor or designee to er cleaned per the cleaning sch results will be aviewed at the QA metaling to determine if a identifite it and recommendate continued audits/monitor	g room fans keeping nsure they are nedule. The monithly any trends are tions made	

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	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 1130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 257	maintenance super housekeeping super training and housel During the tour, the cracked open. Ever open, the temperate 82.7 degrees. In act temperature was restated it was hard to the building with the temperatures. MS at temperature was how the more than the period thought the DR room in addition a fan me was observed to have build-up on the one the fan was noted to the dining room direction residents sat during often the fan was claundry manager so when asked when cleaned last house stated she was not was responsible for done. Housekeeping she had not been as	was conducted with the rvisor (MS), executive director, ervisor, executive director in keeping and laundry manager. DR window had been in with the window cracked ture reading of the DR was addition, the other split DR side eading 81.5 degrees and MS or regulate the temperature in the fluctuating outside acknowledged the igh. When asked to close the S declined to close the window lents in the DR and MS	F2	257			
F 278 SS=D	policy was requested 483.20(g) - (j) ASS	56 a.m. a copy of the facility ed but not provided. ESSMENT RDINATION/CERTIFIED	F 2	278			1/26/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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F 278	Continued From	page 7	F 2	78		
	The assessment resident's status.	must accurately reflect the				
	each assessmen	e must conduct or coordinate t with the appropriate ealth professionals.				
	A registered nurs assessment is co	e must sign and certify that the mpleted.				
		tho completes a portion of the tsign and certify the accuracy of assessment.				
	willfully and know false statement ir subject to a civil r \$1,000 for each a willfully and know to certify a materi resident assessm	and Medicaid, an individual who ringly certifies a material and a resident assessment is money penalty of not me than assessment; or an individual wringly causes an oner individual all and false statement in a tent is subject to accordingly or than \$5,000 for each				
	Clinical disagreer material and false	ment does not constitute a e statement.				
	by: Based on intervious facility failed to en	ENT is not met as evidenced ew and document review, the nsure 1 of 3 residents (R98) et (MDS) was coded accurately ary incontinence.		R98 Quarterly MDS ARD was reviewed on 12/17/20 modification was complet Resident was discharged All residents have the pot affected by this practice.	015 and a ed on 1/6/16. on 11/1/2015.	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245417	B. WING			12/ ⁻	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CAI	RE CENTER		31	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH OBBINSDALE, MN 55422		
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F 278	R98's admission M resident had been of incontinent and on MDS dated 10/23/1 frequently incontine in bladder continen. The Urinary incontine (CAA) dated 7/27/1 occasional bowel a admission, had sev such as being new major surgery and increased the chan had also indicated and was able to asl potential for indepeas continence of both R98's care plan dath had an alteration in plan directed staff to three-day elimination voiding pattern, corrupt assessment and R98's diagnoses in cerebrovascular ac replacement, and nobtained from quark R98's undated Black Assessment indicated and on the undated	DS dated 7/25/15, indicated coded as occasionally the subsequent quarterly 5, had been coded as being ent which indicated a decline ce. Thence Care Area Assessment 5, indicated resident had and bladder incontinence since eral aspects that played into it to facility, had recently had a cook a diuretic which ce of incontinence. The CAA R98 was alert and oriented a for assistance and had the indence with toileting as well owel and bladder. The definition of the determination of the second of the care acker on tracking to determine a hole of the care acker on tracking to determine a hole of the care acker on tracking to determine a hole of the care acker on tracking to determine a hole of the care acker on tracking to determine a hole of the care acker on tracking to determine a hole of the care acker on tracking to determine a hole of the care acker on tracking to determine a hole of the care acker on tracking to determine a hole of the care acker on tracking to determine a hole of the care acker on tracking to determine a hole of the care acker on tracking to determine a hole of the care acker on tracking to determine a hole of the care acker on tracking to determine a hole of the care acker on tracking to determine a hole of the care acker on tracking to determine a hole of the care acker on tracking to determine a hole of the care acker on tracking to determine a hole of the care acker on tracking to determine a hole of the care acker on the care acker on the care acker on the care acker on the care acker of the care acker on the ca	F2	78	The IDT will receive the re-education MDS accuracy standards per the Finanual by 1/26/2016. Re-education be conducted by the Regional Director Revenue Integrity and/or designeed DON and by the regional Director of Revenue nursing staff by 1/26/16 on resident documentation. The Regional Director of Revenue integrity and presignee will audit MDF is per month for a period of the naths travalidate accuracy. The fartity's IDT weekly comprehensive plan review (CCPR) meeting the lized to validate accuracy of MDF adding after the MDS has been completed. Results of audits will be reviewed at the facility's QA meetin monthly until resolved.	RAI n will ctor of . The the t t three ree ensive will be	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING	(X	(3) DATE SURVEY COMPLETED
		245417	B. WING			12/17/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATI	E, ZIP CODE	
ROBBIN	SDALE REHAB & CA	RE CENTER		3130 GRIMES AVENUE NOR ROBBINSDALE, MN 5542		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIA	
F 278	On 12/17/15, at 12: the MDS coordinate used to code the M admission MDS withough 7/25/15, Rincontinence during why he was coded. The quarterly MDS assessments dates R98 to have had si which put him to be incontinent. The MI had a surgery on 1 facility on 10/12/15 done within two we asked about the unindicated R98 was coordinator stated acknowledged she stated was going to practical nurse-C if toileting program. -At 2:34 p.m. the R the quarterly MDS data that nursing accare tracker and didata at the time and supposed to have be incontinent as the acknowledged the coded inaccurately with the consultant modified. -At 3:03 p.m. interir stated the nurses we data and follow up make sure the data.	is 52 registered nurse (RN)-E, or, after she pulled the data IDS's stated during the th assessment dates 7/19/15 98 had three episodes of the time frame and that was as occasionally incontinent. dated 10/23/15, with 10/17/15 to 10/23/15, noted ax episodes of incontinence ecoded as frequently DS coordinator stated R98 0/9/15, and came back to the and the quarterly MDS was eks post surgical. When indated assessment which continent the MDS she was not sure and had co-signed them and had co-signed them and had co-signed them and had been concerned as a consistent of the sistents had documented in the data and a second to see if MDS and been and stated would follow up to see if MDS could be with data and ask questions to a was accurate if there was a	F2	278		
	change and then fo	ollow up with a notation the				

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F 278	information was a was going to be r up with the nurse	accurate. IDON stated the MDS nodified and was going to follow.	F 2			1/00/10
F 282 SS=E	The services provided must be provided	ERVICES BY QUALIFIED CARE PLAN vided or arranged by the facility by qualified persons in each resident's written plan of	F 2	82		1/26/16
	by: Based on observerview, the facility care was implemented for ADL reviewed for report (R72) for standard	ration, interview, and document failed to ensure the plan of ented for 1 of 3 residents (R91 ls; for 1 of 3 residents (R14) sitioning; for 1 of 3 residents d of tube feeding and for 1 of eviewed for non dressures.		having: .91 was given extensive shaving needs on 12/18/2 A facility wide audit was of 12/18/2015 and seventee are noted to require extenshaving needs.	2015. completed on on male residents nsive assist with	
	care. R91 was observe	ved according to the plan of d to be sitting in the wheelchair on 12/14/15, at 3:52 p.m. and		In-servicing will be provided 12/26/2016 that address to provide services by qualification accordance with each residence (POC). Staff in-service address direct observation be taken if residents are counshaven.	the need to ied persons in sidents plan of icing will also n and actions to	
	the resident face When R91 was a stated "I shave ev him to be seen by 12/16/15, at 8:49 room (DR) eating	was covered with facial hair. sked about be shaved, he very morning" and "it disturbed a young lady unshaven." On a.m. R91 was in the dining breakfast and still was		Audits will be completed by a designee that will more residents requiring assist three times a week for two weekly. The weekly audit completed during facility or rounds. Audits will be reviewed.	nitor identified with shaving o weeks, then ts will be caring partners	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
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	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
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F 282	a.m. and 1:07 p.m. lounge and remain R91's care plan darequired extensive hygiene which includressing and undre On 12/17/15, at 12 (RN)-B was intervinot look like he got the care and servic care for personal hunshaved from 12/2 Repositioning: Physician's Order were to "Repositioning: Physician's Order were to "Repositioning every 1 hour in characteristic with the left side while it to turn R14 with two W/c positioning per R14 was not repositioning to the plong of the plong	R91 was seated in the area led unshaven. Ited 10/25/15, indicated R14 assist of two with personal uded combing of hair, shaving, essing. Item 143 p.m. registered nurse lewed and indicated R91 did a shaved. R91 did not receive less according to the plan of laygiene as he remained laygiene as he remained lay 12/17/15. Isigned 11/30/15, indicated staff in every 2 hours in bed and lair." If a Assessment: Plevention and land undated, in fruct laff to lair. If ye has now at all times, and lo pillous lightly high on side. If medical loctor (MD) order. Isitioned even two hours an of care.	F2	the QA meeting to determine are identified, and recomment made for continued audits/ moneeds. Repositioning. R14 elocted host be services POC at Uphsiciar orders were and updated on 15/2016. A facility wide audit was completed audit elocation and in the earlier assist with reposition and the earlier an	and the e reviewed leted on ts identified ioning ndations. to all t addresses ualified ach iceing will kin integrity am and e DON tor assist with eek for two ll be surance any trends dations nitoring	

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245417	B. WING			12/1	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH COBBINSDALE, MN 55422	•	
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F 282	- At 12:25 p.m. R14 table in the DR At 1:32 p.m. R14 went for three and repositioned. On 12/16/15, at 12: and was asked if sl "I have not been to have preferred to s dice game. They sa - At 12:30 p.m. nursinterviewed and stadown yet At 12:31 p.m. a se NA-H, remarked, "I she was playing dic - At 1:32 p.m. RN-E bed between break only keep her up a have not seen her up a have not see	4 was asleep in w/c in DR. 4 was awake sitting at the was placed in her bed. R14 45 minutes without being 25 p.m. R14 was interviewed he had laid down. R14 replied, bed. I did not refuse. I would leep in my bed. I did enjoy the haid I need to eat." sing assistant (NA)-G was hated, "I have not laid her [R14] econd NA was interviewed and No, I have not laid her down he and it is lunch now." 3, stated, "[R14] did her to to hat and just now we idean, house to lay down." 38 a.m. NA-1 state LR 4 hand when the needs to use hes. R 14 as to be how hour from left to right huse to bed. H stated R14 was to be how hours and sometimes he chair the aide(s) would lay	F 2	282	placement, medication administration nutritional formula tube feeding administration. Resident recieves be feedings, which he tolerates without or symptoms of adverse affects, to him increase dependence rather have accontinuous tube feeding for administration. RN-D has presided re-education at relates to bolus tube feedings, g-tup acement verification and G-tube metrics on administration on 12/28. A acility wide audit was completed 2/17/2015 and four residents were identified that have the potential to affected by this practice. In-servicing will be provided to staff 1/26/2016 that addresses standard practice as it relates to G-tubes and feedings. Audits will be completed by the DC and/or designee that will monitor identified residents requiring G-tub placement checks, medication and feeding administrations, three times week for two weeks, then weekly. Will be reviewed during the quality assurance (QA) meeting to determ any trends are identified, and recommendations made for continuaudits/monitoring needs. Skin alteration: An assessment was completed and	oolus at signs allow r than mula s it be 8/2015. on e be f by ls of d tube N e tube s a Audits ine if ued	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING			12/ ⁻	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER	STREET ADDRESS, CITY, STATE, ZIP COE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		DDE		
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F 282	indicated the wound three months. During interview or interim director of resident who has a tendon, joint capsultracts also may be pressure ulcers] to physician recommed MDS and care planshould not have stap.m. without being staff to follow the corders." G-tube placement: R72's gastrostomy checked for placement R72's medication and enteral feeding via from 8:34 a.m. untitiobserved to flush to centimeters (cc) of placement. RN-D to medications via drawing them administering med G-tube with 50 cc of Jevity (a calorically tube feeding) 1.5 winto the G-tube. RN 225 cc of Jevity has the G-tube with 50.	in 12/17/15, at 2:07 p.m. the nursing (IDON) stated, "A stage 4 pressure ulcer [e.g., ale. Undermining and sinus associated with Stage 4 be repositioned based on endations, what is on their n." The IDON stated, "R14 ayed up from 9:45 a.m. to 1:30 repositioned. I would expect are plan and physician	F 2	monitoring was put into place 12/16/2015 for R61 related non-pressure skin issues. All residents have the potent affected by the ame practice. Education will be provided to provide the necessivities by 1/26/2016. Audits will be completed by a d/or designee weekly for dentified to have non-pressissues to ensure monitoring. Audits will be reviewed during assurance (QA) meeting to any trends are identified, and recommendations made for audits/monitoring needs.	to identing the DOI resident sure skin is in plant determined	e N ts n ace. pulity ne if	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
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F 282	reflux disease-GER with 50 cc of water. The Nutrition Risk (listed as nutritional disease, risk of deh R72 typically consupercent (%) of measquamous cell cand tube feedings. The check for tube plac medication administ R72's diagnoses list Physician Orders in neoplasm of the meaddition, the orders G-tube placement predication administ On 12/17/15, at 9:2 gastrostomy tube placeding. RN-D state gastrostomy tube no gravity through a synthemal consumption on IDON stated, "I won prepare the medical explain what they are Check placement as separate the plunger tube and then pour into the syringe flus done flush the tube hands. You can mix	Care Plan dated 10/8/14, risk factors were cardiac hydration, low sodium levels, amed approximately 10 ls, swallowing difficulty due to cer of the throat, and requires interventions directed staff to ement prior to feeding and stration. Steed on the December 2015 included dysphagia, malignant outh, GERD, and stroke. In a directed staff to check for prior to feeding and stration.	F	282			

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		245417	B. WING			12/ ⁻	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH COBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	g-tube. Skin alteration: R61's skin alteration according to the plate of the plate	n was not monitored an of care. ed on 12/14/15, at 1:52 p.m. rview R61 pulled up her left at two old bruises were sked if someone had abused added the staff rushed sting her. 0 a.m. R61 was observed at atter on seated on the w/c to the day room. When asked R61 stated good but he arm ime and thought was from the far experience to the table oved her swetner. The recivered on the rich at arm. In orative as istant (RA) affered to join the exercise and	F 2	282			
		ent at the table eyes closed.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING		12	/17/2015	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIF 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 282	and treatment ca resident was at ri impaired/decreas bowel and bladded due to the use of moderate pain ar inflammation). Thinspect the skin fobreakdown. An Occurrence R concern had been facility staff by the several bruises/s. The note indicate bruises/skin concern had been facility staff by the several bruises/s. The note indicate bruises/skin concern had been facility staff by the several bruises/s. The note indicate bruises/skin concern had been facility staff by the several bruises/s in concern had been facility staff by the several bruises/skin concern resembled at Pight posterior of the purple in color and Pight forearm part of the purple and the several bruises	ty assessment: preventation re plan dated 8/14/14, indicated sk related to ed mobility, was incontinent of er and was at risk for bruising Aspirin (used to treat mild to do to reduce fever or see care plan directed staff to or signs and symptoms of eport dated 12/16/15, (after no brought to the attention of exurveyor), indicated R61 has kin conditions to both arms. do the measurements of the litions were as follows: forearm 2 centimetr (cm) x 1. Foruise; atteral forearm to 5 cm x 0.8 cm in; distal upper and 1.4 cm x 1.4 cm do scal forearm 0.8 cm x 0.6 cm pink and forearm 0.6 cm x 0.1 cm arm 0.6 cm x 0.4 cm irregular on; oximal forearm 0.8 cm x 0.4 cm irregular on; oximal forearm 0.8 cm x 0.4 cm	F2				
		report any changes in skin					

OLIVIE	TO TOTA MEDICATE	a medicinib delititided			011	ID 110. 0000 0001
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	_	(X3) DATE SURVEY COMPLETED
		245417	B. WING			12/17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, ST 3130 GRIMES AVENUE NO ROBBINSDALE, MN 55	ORTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI' CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD I ED TO THE APPROPR FICIENCY)	BE COMPLÉTION
F 282	condition to the number of the pure when asked if it income. Surveyor and approached R61 wheelchair in her relook at R61's arms get them because the bruises on both old bruises and wathe changes. On 12/17/15, at 7:5 investigation had be 12/16/15, after the the facility attention prone to bruising reuse, the way reside when in the common around. When asked identified possible is supposed to be involved bruising due to when positioning self as investigation of the nurse as soon and the nurse need the nurse as soon and the nurse need the care plan for sobservation of the wound Preventation Program Manual et "Monitor area(s) of abrasion, bruise, but the nurse is the program of the solution of the solution, bruise, but the nurse is the program of the solution, bruise, but the nurse is the program of the solution, bruise, but the nurse is the program of the solution, bruise, but the nurse is the program of the solution, bruise, but the nurse is the program of the solution, bruise, but the nurse is the program of the solution, bruise, but the program of the solution of the solution of the solution, bruise, but the program of the solution of the solution of the solution of the solution, bruise, but the nurse is the program of the solution of the sol	rse if identified with cares sluded any bruising. At 2:35 RN-B went to room ho was seated on her from. When RN-B started to R61 stated "the kids make me they grab me." RN-B verified a arms stated the bruises were is not able to describe some of a some of the started yesterday concern had been brought to a and she thought resident was elated to prophylactic Aspirir and she though staff had been though staff had been though staff had been though staff had beet gated she if dicated "Yes." It can be caused if still any fruising we settigated she if dicated "Yes." It can be caused the cause of the started that a settigated she is dicated the settigated she is dicated. The settigated she is dicated the settigated she is dicated the settigated she is dicated. The settigated she is dicated the settigated she is d	F 2	282		

STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION (X3) DATE SURVEY COMPLETED
		245417	B. WING		12/17/2015
	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	
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SS=D F	HIGHEST WELL E Each resident mus provide the necess or maintain the hig nental, and psych accordance with the and plan of care.	at receive and the facility must sary care and services to attain hest practicable physical, osocial well-being, in he comprehensive assessment	F 309		1/26/16
biling representation of the control	Based on observative eview, the facility oot cause and properevent bruising for eviewed for non-principles. It is a second propered to the facility of the fac	10 a.h. R6 was served all eater on trated on the heeling her slf into the day I how she had slept R61 stated was hurting at the time and	C.	A assessment was completed and onitoring was put into place on 12/16/2015 for R61 related to identifinon-pressure skin issues. All residents have the potential to be affected by the same practice. Education will be provided to staff as relates to monitoring and reporting observations related to skin alteration to the team member qualified to provide the necessary services by 1/26/2016. Audits will be completed by the DON and/or designee weekly for residents identifed to have non-pressure skin issues to ensure monitoring is in plantal Audits will be reviewed during the quassurance (QA)meeting to determine any trends are identified, and recommendations made for continue audits/monitoring needs.	s it n(s) vide 5. N s ce. uality e if

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245417	B. WING _		12	2/17/2015
NAME OF PROVIDER OR SUPPLIER ROBBINSDALE REHAB & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	look tired do you we take a nap?" The It's hot in here." The It's hot in here. The It's here. The It's hot in here. The It's here. The It	he group. approached asked R61 "You want to stay for breakfast or go resident stated "What time is it? he RA then wheeled R61 to the move her sweater completely d "just leave it." Bruises were dent at the table eyes closed. 50 a.m. observed resident 51 a.m. observed nursing eel resident out of the dining en NA-C stated "I will see you led "thank you" as resident oner room." erved resident open the door the me out. Theard resident callout "please between do to the please of the please o	F 30			
	and treatment can resident was at ris impaired/decrease bowel and bladde due to the use of A moderate pain and	y assessment: preventation e plan dated 8/14/14, indicated k related to ed mobility, was incontinent of r and was at risk for bruising Aspirin (used to treat mild to d to reduce fever or e care plan directed staff to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245417	B. WING		12/	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
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F 309	inspect the skin for breakdown. R61's Pressure ulc dated 3/19/15, indipressure related is in mobility and active. R61's diagnoses in non-Alzheimer's diagnoses in non-Alzheimer's diagnoses, depreted in the quarterly Minim 11/25/15. In additions severely impaired of the quarterly Minim 11/25/15. In additions severely impaired of the quarterly Minim 11/25/15. In additions severely impaired of the quarterly Minim 11/25/15. In additions severely impaired of the graph of the several bruises/skin conditions are also be a proposed in color and a purple in color and a Right forearm prox 0.6 cm purple and a Left lateral distal forears; Left posterior mid scabbed lesion; Left lateral upper purple discoloration	er Care Area Assessment cated R61 was at risk for sues due to being dependent vities of daily living. cluded dementia sease, seizure anxiety, osteoarthritis, essive disorder obtained from turn Data Set (MDS) dated in, the MDS indicated R61 had cognition. port dated 12/16/15, (after brought to the attention of surveyor), indicated R61 had cognitions to be a arms. The measurements of the sons were as 1 llows rearm 2 contiments (cm) × 1.6 uise; the rearm 1.6 cm × 0.8 cm scally; ximal posterior lateral 0.6 cm dirregular shape; forearm 0.8 cm x 0.6 cm pink forearm 0.6 cm x 0.1 cm arm 0.6 cm x 0.4 cm irregular arm 0.6 cm x 0.4 cm irregular				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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	NAME OF PROVIDER OR SUPPLIER ROBBINSDALE REHAB & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	,	age 21 30 p.m. NA-C was unavailable	F3	09		
		termine if the bruises were				
	(RN)-B stated he wany changes in skidentified with care bruising. At 2:35 proom approached wheelchair in her look at R61's arms get them because the bruises on bot	33 p.m. registered nurse would expect the staff to report in condition to the nurse if es when asked if it included any o.m. surveyor and RN-B went to R61 who was seated on her room. When RN-B started to a R61 stated "the kids make me they grab me." RN-B verified h arms stated the bruises were as not able to describe some of				
	nursing (IDON) staprone to bruising ruse, the way residuhen in the commaround. IDON indicated R61's risk to	56 a.m. the Interim director of ated she thought resident was related to prophy actic Aspirin lent would position he self non area and when ing self acted the Pressure Nor CAA for brusing die to wheeling self oning suffer indicated by the				
	expect the NAs to the nurse as soon	00 p.m. IDON stated she would report any change in skin to as they are done with cares eds to follow the facility protocol.				
	Program Manual e "Monitor area(s) o abrasion, bruise, b	on and Management Clinical effective July 2015, directed f skin impairments e.g. purn, excoriation, or rash daily ent Administration Record until				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING		12/	17/2015	
	NAME OF PROVIDER OR SUPPLIER ROBBINSDALE REHAB & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 309 F 312 SS=D	A resident who is daily living receive maintain good nu and oral hygiene. This REQUIREM by: Based on observe review, the facility facial hair was proreviewed for active dependent on state Findings include: R91 was observe in his room on 12 resident face was R91 was asked a shave every more seen by a young 8:49 a.m. R91 was breakfast and still On 12/17/15, at 7 seated in the area unshaven. The Nursing Note	unable to carry out activities of es the necessary services to trition, grooming, and personal ENT is not met as evidenced ration, interview and document ration, interview and document ration, interview and document ration and for 1 of 3 residents (R(1) ratios of daily living and who was fit for shaving. In the dining room eating a was observed to be unshaven. The county and the lady unshaven. The county are in the dining room eating and was observed to be unshaven. The county are in the dining room eating and the lady unshaven are in the dining room eating and the lady unshaven. The lady unshaven are in the dining room eating and the lady unshaven are in the dining room eating and the lady unshaven. The lady unshaven are in the dining room eating are unshaven. The lady unshaven are un	F3	312 F) 1 was given extensive shaving needs on 12/18/2 A facility wide audit was of 12/18/2015 and 17 male in noted to require extensive shaving needs. In-servicing will be provided 1/26/2016 that addresses provided to all staff by 1/2 addresses need to provided qualified persons in accorresidetn's POC. Staff in-saddress direct observation be taken if residents are considered to and/or designee that will indentified residents requires shaving three times a weak weeks, then weekly. The	assist with his 2015. completed on residents are e assist with ed to all staff by a need to 26/2016. that le services by rdance with each ervicing will also n and actions to observed to be by the DON monitor ring asssit with ek for two weekly audits		
	of any refusals of	d the Nursing Notes were void care. ated 10/25/15, indicated R14		will be completed during f Partners rounds. Audits w during the quality assurar meeting to determine if ar	vill be reviewed nce (QA)		

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	PROVIDER OR SUPPLIER SDALE REHAB & CA			STREET ADDRESS, CITY, STATE, ZIF 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
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F 312	required extensive which included cordressing and undr. The Minimum Data indicated R91 receassist for personal R91 had no behave cognition level was On 12/17/15, at 10 stated, "told the mand do it." On 12/17/15, at 12 was interviewed a like he got shaved and services for personal R91 had no behave the stated of the mand the	assist with personal hyigene mbing of hair, shaving,	F3	identified, and recommer for continued audits/mon		
	interiem director o is asked about bei requests to be sha attempt to do it the changes their mindocument if the re 483.25(c) TREATM PREVENT/HEAL I Based on the com resident, the facilit who enters the factorical does not develop individual's clinical	In 12/17/15 et 2:0 o.m. the finursing stated, "If the denting shoved as a says yes or eved, I say ct the staff to exame de unless the resident d. I would except them to sident refused when asked." MENT/SVCS TO PRESSURE SORES prehensive assessment of a y must ensure that a resident cility without pressure sores oressure sores unless the condition demonstrates that able; and a resident having	F 3	14		1/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
	245417	B. WING		12/	17/2015
NAME OF PROVIDER OR SUPPLIE ROBBINSDALE REHAB & C			STREET ADDRESS, CITY, STATE, ZIP 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
This REQUIREMI by: Based on observereview, facility fail residents who had pressure ulcers rerepositioning. Findings include: R14's Minimum Dindicated R14 wadue to impaired by transfer. The MDS unstageable Stage thickness skin lost tissue necrosis, of supporting structured Undermining and associated with Strequired two persons mobility and had a According to the work of the covered by sloughthe true depth of the estimated until the	ceives necessary treatment and one healing, prevent infection sores from developing. ENT is not met as evidenced ration, interview and document ed to ensure 1 of 3 (R14) dibeen identified at risk for eceive assistance with Pata Set (MDS) dated 12/8/15 at high risk for pressure ulce sed mobility and impaired further noted R14 has a see 4 pressure ulcer utill swith extensive restruction, ridamage to make let one, or ares (e.g., tendon, ant capalle, sinus tracts and make tage coressy a ulcers) R14 on assist for transiers and bed no behaviors of refusing care. Wound sheets the following was estageable ulcer (full-tissue which the base of the ulcer was nor an eschar and, therefore, the damage cannot be less are removed) measured 2.8 X 1.4 cm X 0.4 cm and healing	F3	F314 P34 elect 1 Hospice serv	completed on ents identified positioning mendations alcers. ed to nursing ldresses a y assessment reatment POC th repositioning nent needs. by the DON monitor ring assist with re ulcer week for two its will be ty assurance if any trends mmendations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245417	B. WING		12	/17/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
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F 314	cm X 1.4 cm X 0.4 week On 12/9/15, unstacm X 0.6 cm X 0.4 slough noted On 12/15/15, unsacm x 0.6 cm x 0.4 on drainage. Pink in Treatment Care Plimplement an indivapplicable "q [everthe left side while it to turn R14 with two Wheelchair (w/c) p (MD) order. Physician's Order were to "Reposition every 1 hour in characteristic and the following were to "Reposition every 1 hour in characteristic and the following were to "10.30 a.m. the in the w/c At 10:45 a.m. the dice At 12:17 p.m. R1 table in the DR At 1:32 p.m. R14 went for three and repositioned.	cm and no change from last ageable ulcer measured 2.4 cm and healing well with no stageable ulcer measured 2.4 cm and granulation noted with in color. y Assessment:Prevention and an undated, instruct staff to vidualized turning schedule in y] 2 hrs [hours]", to lay R14 on n bed but not at all times, and yo pillows slightly high on side. To pil	F3			

<u> </u>	to i oit willbior at	- CHILDIOTHD CLITTICLE				····	0000 0001
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245417	B. WING			12/	17/2015
	NAME OF PROVIDER OR SUPPLIER ROBBINSDALE REHAB & CARE CENTER			31	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	"I have not been to have preferred to s dice game. They sa - At 12:30 p.m. nursinterviewed and sta down yet At 12:31 p.m. a sa NA-D, remarked, "I she was playing dic - At 1:32 p.m. regis "[R14] did not go to just now. We ideall hours at a time. I hadown." On 12/17/15, at 10 would ask for assist the bathroom facilit repositioned every and she did not ref - At 10:52 a.m. NA-repositioned every when R14 was in the down after mea - At 12:33 p.m. RN-here and the docto RN-B remarked, "S reposition her ever with turning and rejudicated the wount three months and the wound weekly. During interview or	the had laid down. R14 replied, bed. I did not refuse. I would leep in my bed. I did enjoy the aid I need to eat." sing assistant (NA)-B was ated, "I have not laid her [R14] econd NA was interviewed and No, I have not laid her down be and it is lunch now." Itered nurse (RN)-B stated, bed between breakfast and by only keep her up a couple of ave not seen her refuse to lay at a couple of ave not seen her refuse to use the couple of the couple of the couple of a couple of	F	314			
		ng shaved and says yes or					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245417	B. WING _		12/17/20	15	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMP	(5) LETION ATE	
F 314 F 322 SS=D	attempt to do it the changes their mind document if the reseason of the comparent of the co	aved, I expect the staff to e same day unless the resident d. I would expect them to sident refused when asked." REATMENT/SERVICES - G SKILLS prehensive assessment of a y must ensure that has been able to eat enough stance is not fed by naso is the resident 's clinical rates that use of a naso gastric able; and is fed by a naso-gastric or receives the appropriate vices to prevent aspirance, and naso-pharmageal ore, if possible, a proportion eating.	F 31		1/26/	16	
	by: Based on observareview, the facility checked placemer (G-tube) prior to in	Ation, interview, and document failed to ensure nursing staff of a gastrostomy tube fusing medication and formula (R72) observed to have a tube survey.		F 322 R72's Order and POC was reviewed 12/17/2015 as it relates to G-tube placement, medication administration nutritional formula tube feeding administration. Resident recieves be feedings, which is tolerated without	on and		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A BUILDING 245417 NAME OF PROVIDER OR SUPPLIER ROBBINSDALE REHAB & CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH REGULATORY OR LSC IDENTIFYING INFORMATION) FOR SUPPLIER F 3222 Continued From page 28 Findings include: During medication administration observation and enteral feeding via R72's G-tube from 8:34 a.m. until 9:27 a.m. registered nurse (RN)-D was observed to flush the G-tube with 100 cubic centimeters (cc) of water without first checking placement. RN-D the continued to administer medications via drawing them up into a syringe and pushing them into the G-tube. After administering medications RN-D flushed the G-tube with 50 cc of water and refer wup 50 cc of Jevity (a calorically dense nutritional formula for tube feeding) 1. Sivil a syringe and pushed it into the G-tube. RN-D repeated that action until 225 cc of Jevity had been given. RN-D flushed the G-tube with 50 cc of water and reflex disease-GERD) and flushed the grisk of dehydration, low spurum yvelss 82 of typically consumed approximately 10 percent (%) of meals, swallowing difficult for the check of tube placement prior to feeding and medication administration. Nutritional Status care area assessment dated 8/18/15, incicated R72 received the majority of nursifion or keldyn tube as a trisk for unsafe weight changes, dehydration and aspiration or choking.	CENTER	RS FOR MEDICARE	: & MEDICAID SERVICES			Ü	MR NO.	0938-0391
ROBBINSDALE REHAB & CARE CENTER (A) DEPRETEX (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) FAST (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOR TAG (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOR TAG (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOR TAG (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOR TAG (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOR TAG (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOR TAG (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOR TAG BINSDALE, MN 52422 ID PROVIDERS OR JOINT OF CORRECTION OF COMMENTION (EACH CORRECTIVE ALTO PROPRIATE DEPICIENCY) FOR TAG BINSDALE, MN 52422 FOR SIMBS AVENUE NORTH (CORRECTIVE ALTO PROPRIATE DEPICIENCY) FOR SIMBS ALE, MN 52422 THEN TAG BINSDALE, MN 52422 THEN TAG BINSDALE, MN 52422 FOR SIMBS ALE, MN 52422 FROWIDERS CHAIN OF CORRECTION OF COMMENTION (EACH CORRECTIVE ALTO PROPRIATE DEPICIENCY) FROWIDERS CHAIN OF CORRECTION OF COMMENTION (EACH CORRECTIVE ALTO PROPRIATE DEPICIENCY) FROWIDERS CHAIN OF CORRECTION OF COMMENTION (EACH CORRECTIVE ALTO PROPRIATE DEPICIENCY) FROWIDERS CHAIN OF CORRECTION OF COMMENTION (EACH CORRECTIVE ALTO PROPRIATE DEPICIENCY) FROWIDERS CHAIN OF CORRECTION OF COMMENTION (EACH CORRECTIVE ALTO PROPRIATE DEPICEMENT OF THE APPROPRIATE DEPICEMENT OF THE APPROPR	. ,							
CALL DEPICE No.			245417	B. WING			12/ ⁻	17/2015
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 322 Continued From page 28 Findings include: During medication administration observation and enteral feeding via R72's G-tube from 8:34 a.m. until 9:27 a.m. registered nurse (RN)-D was observed to flush the G-tube with 100 cubic centimeters (cc) of water without first checking placement. RN-D then continued to administer medications via drawing them up into a syringe and pushing them into the G-tube. After administering medications RN-D flushed the G-tube with 50 cc of water and drew up 50 cc of Jevity (a calorically dense nutritional formula 225 cc of Jevity had been given. RN-D flushed the G-tube with 50 cc of water than gave the medication or prezace (for gastroesophageal reflux disease-GERD) and flushed the g-tube with 50 cc of water. The Nutrition Risk Care Plan dat 109 14, listed as nutritional risk factors can be disease, risk of dehydration, low sprum evels. R2: y typically consumed approximately 10 percent (%) of meals, swallowing diffin, lift due to squamous cell cancer of the throat, and requires tube feedings. The interventions on such staff to check for tube placement prior to feeding and medication administration. Nutritional Status care area assessment dated 8/18/15, indicated R72 received the majority of nutrition via feeding ube and was at risk for unsafe weight changes, dehydration and	NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX TAG					3	130 GRIMES AVENUE NORTH		
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R72's quarterly Minimum Data Set dated	F 322	Findings include: During medication and enteral feeding a.m. until 9:27 a.m. observed to flush the centimeters (cc) of placement. RN-D the medications via dra and pushing them in administering medications with 50 cc of Jevity (a calorically tube feeding) 1.5 without the G-tube. RN 225 cc of Jevity has the G-tube with 50 medication omeprate reflux disease-GEF with 50 cc of water. The Nutrition Risk of Isted as nutritional risk of dehydration, typically consumed of meals, swallowing cell cancer of the the feedings. The intercheck for tube place medication administration via feeding unsafe weight charaspiration or choking and the state of the control of the c	administration observation yvia R72's G-tube from 8:34 registered nurse (RN)-D was ne G-tube with 100 cubic water without first checking nen continued to administer awing them up into a syringe into the G-tube. After cations RN-D flushed the of water and drew up 50 cc of dense nutritional formula for with a syringe and pushed it I-D repeated that action until dense given. RN-D flushed cc of water than gave the izole (for gastroesophageal RD) and flushed the grate in a grate for a guidant and the grate in a guidant and the grate weeks (R72) approximately 10 percent (%) and difficult due to squamous moat, and requires tube wentions directed staff to ement prior to feeding and stration. Are area assessment dated R72 received the majority of guidant was at risk for negs, dehydration and ng.	F	3322	or sympotms of adverse affects, to increased independence rather that a continuous tube feeding formula administered. RN-D was provided re-education as it relates to bolust feedings of the placement verification and G abe medication administration 12/28/2 15. A facility with radiit was completed 12/1 /2015 and four residetns were notified at have the potential to affect by by this practice. In servicing will be provided to nursuaff by 1/26/2016 that addresses standards of practice as it relates to G-tubes utilizing facility policies and procedures as well as the CMS tulfeeding status critical element path tool. Audits will be completed by the DC and/or designee that will monitor identified residents requireing G-tuplacement checks, medicaiton and feeding administrations, three times week for two weeks, then weekly will be reviewed during the quality assurance (QA) meeting to determany trends are identified, and recommendations made for continuations.	an have tube ation tion on I on e be sing o d be nway DN abe I tube es a Audits aine if	

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F 322	and received "51 % through the feeding R72's diagnoses list Physician Orders in neoplasm of the mobstructive pulmon addition, the orders G-tube placement medication administration admini	I R72 was cognitively intact 6 or more" of his total calories g tube." sted on the December 2015 included dysphagia, malignant outh, GERD, chronic hary disease, and stroke. In structured staff to check for prior to feeding and	F3			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,) MULTIPLE CONSTRUCTION BUILDING		E SURVEY MPLETED
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F 323 SS=E	medication into the meds. When done and wash hands. have a doctor's or Enteral Tubes proinstructed staff to: "10. Verify tube plana install 10-2 tube while simultate left upper quadrar stethoscope to vastomach and b. Aspirate 2-reinstall." "13. Remove plunto tube pour medito flow by gravity." 483.25(h) FREE CHAZARDS/SUPE The facility must environment remains is possible; and	pour each individual e syringe flushing between e flush the tube, remove gloves You can mix all the meds if you der." cedure dated July 2015 accement. O mL [milliliters] of air into the neously auscultating over the at of the abdomen with a lidate air movement in the 10 mL of gastric contents and ger from syringe, attach syring cation(s) into syringe, and allow DF ACCIDENT RVISION/DEVICES ensure that the respent ains as five on cicide the zards deact reside a receives sion and posistance devices to	F3			1/26/16
	by: Based on observ review, the facility smoking materials residents (R167, I	ENT is not met as evidenced ation, interview and document failed to ensure supervision for was provided for 9 of 16 R43, R31, R41, R72, R68, R8, ddition, the facility failed to		F 323 Smoking: On 12/22/2015 the smoking saf collection and assessment was completed for R167 and resider		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 2/	1772010
ROBBIN	SDALE REHAB & CA	RE CENTER			130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
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F 323	residents (R13) where Findings include: During the evening 12/15, 12/16, and 1 observations were (three sided tent) in Ave entrance. Their three wooden bence cigarette butts streefront door to the smooth butts were observed the smoking recept policy directed smooth in a locked drawer assessed as depermaterials secured in R167 was identified and was admitted the diagnosis of right lust (spread) to brain where the smoking secondary. The care plan date would provide smooth smoking secondary. The Smoking Safet Assessment dated could not light his contraction.	of 12/14, and the days of 12/17/15, of the survey, made of the smoking structure of the parking lot on the Grimes are were burn marks in three of these in the smoking area, and who on the ground from the noking structure. Cigarette do in the garbage can, next to acle. The facility smoking obsers assessed as keep their smoking material in their room. Smokers and the medication some. If by the facility as a moker, of the facility on 110/15 with large carser with measurement of the brain of the b	F3	323	has improved and R167 is now ass as an independent smoker. R167's and the POC were updated. On 12/22/2015 the smoking policy and procedure was reviewed with R167. On 12/24/2015 the smoking policy procedure was reviewed with R43 or ardian and the OC was update on 12/24/2015 the smoking policy procedure was reviewed with R31, N2, and x68. On 2/24/2015 the smoking policy procedure was reviewed with R118 the resident is identified as R8 on the statement of deficiencies, but upon this is a typo and should read "R11 there is no R8 on the listing provide the survey team member. R168 was discharged; however, a smoking safety data collection and assessment was completed as well review of the smoking policy and procedure prior to discharge. R135 was discharged. A facility wide audit was completed 12/17/2015 and fifteen residents has potential to be affected by this practical to be affected by this practical to be affected by this practical field residents on 12/31/2015. staff will be in-serviced by 1/26/2015 smoking policy and procedure as well as well as the serviced by 1/26/2015 smoking policy and procedure as well as well as the potential to be affected by this practical to be affected by this practical to be affected by 1/26/2015 staff will be in-serviced by 1/26/2015 smoking policy and procedure as well as the potential to be affected by 1/26/2015 smoking policy and procedure as well as the potential to be affected by 1/26/2015 smoking policy and procedure as well as the potential to be affected by 1/26/2015 smoking policy and procedure as well as the potential to be affected by 1/26/2015 smoking policy and procedure as well as the potential to be affected by 1/26/2015 smoking policy and procedure as well as the potential to be affected by 1/26/2015 smoking policy and procedure as well as the policy an	and and d. and R41, and s. Note he review 8" as ed by I as a on ave the stice. with all All 6 on	
	was windy, due to was not able to let	igarette independently if it use of only one hand. R167 go of cigarette and then eakness. R167 was assessed			smoking policy and procedure as v interventions in place for identified residents. Audits will be completed by the Dir		

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F 323	as a dependent sm family, who visited On 12/15/15, at 1:5 his cigarettes and I easy retrieval. R16 his family outside, I cigarettes and light he knew they shou station. On 12/15/15, the first facility and also ide smoking area, and reassess all resides On 12/16/15, at 9:5 nurse (LPN)-C stat secured in the 4th 1 cigarettes were obs On 12/16/15, at 10: social worker came night. With permission checked, the cigaret longer in the pocket R43's quarterly Mir 9/11/15, indicated F cognition. Elopeme indicated resident his moking program afloor/unit/room after R43's diagnoses in depressive disorder.	oking and would smoke with daily. 55 p.m. R167 stated he kept ighter in his coat pocket for 7 stated he only smoked with he just liked to keep the er in his pocket, even though do be kept at the nursing. The marshal surveyed the ntified the issues with the directed the facility to not for safe smoking. The ann. licensed practical ed R167's cigarettes were floor medication room. The served in the medication room is served in the medication room. The served in the medication room is served in the medication room. The served in the medication room is served in the medication room. The served in the medication room is served in the medication room. The served in the medication room is served in the medication room. The served in the medication room is served in the medication room. The served in the medication room is served in the medication room.	F3	323	Social Services and/or designee the monitor random identified residents times a week for one week, then the times a week for one week, and we thereafter. Audits will aslo include the cigaretter are using properly disposately and the casurance (QA) meeting to determ any trends are identified, and recombened is made for continuated a combened. Sanctrusfers: In 12/28/2015 Director of Rehabili (LOR) completed a clinical review assist in modifications to R13's PO relates to transfers and toilet use. POC was updated. A facility wide audit was completed 12/17/2015 and twenty residents he potential to be affected by this practive which staff use the mechanical lift. In-servicing will be provided to nurs staff by 1/26/2016 that addresses standards of practice as it relates to transfer techniques. Audits will be completed by the DC and/or designee that will monitor identified residents requiring transfassist, including those residents where the use of a mechanical lift times a week for two weeks, then we assurance (QA) meeting to determing any trends are identified, and recommendations made for continuant recommendations made for conti	tation to C as it R13's on ave the ctice for sing three weekly. Quality ine if	

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F 323	The Smoking Safe Assessment dated independent smoking not indicated slighters had been understood where policy. On 12/15/15, at 93 smoking area local entrance door surgarbage with the instationed outsides a clear plastic bage cigarette butts we can. Right next to cigarette receptace filled and cigarette receptace hole. A cigarettes butts in way to the entrance benches located in observed with bur At the time of observed with bur At the time of observed with ereceptacle by left the area after and went into the R43's clothing ches on 12/16/15, at 33 residents inside the smoke receptacle observed to be full of the served to be full or the served to be full or the served serve	ety Data Collection and de 12/09/15, indicated R43 an eter, however the assessment storage of the cigarettes, and reviewed to ensure R43 to store them per the facility. 11 a.m. during a tour to the sted to the left side of the veyors observed a concert inside made of hard plastic the tent. The can was lined with and trash with multiple re observed disposed in the garbage can was a black le that was observed to be a butts were seated on all the area on the loor all the ce past the yellow line and the enside the smoking ent we can marke along the sking ent we can be sking ent to the station of the sking at the time. The stationed by the garbage can at the time. The stationed by the garbage can at the time.	F3	323	audits/monitoring needs.		

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F 323	cushion was obsert lighter stored when out of the room to be the executive direct management staff. On 12/15/15, at 1:: (HKA)-A stated "I at the smokers go out and has not seen the she could do if she around the room. In the find cigarettes for a around the room shourse to make sure have the cigarettes around the room and this it and goes out to sin the third floor she ask." When asked cigarettes and light them not stored pro "On the residents would not take it ou have their families would be begging for told not to give the care tech were bott facility smoking pol residents who are cable to keep all the and for those who were care tech were would the second	can a.m. during the ender R43's wheelchair wed two cigarettes and a staff brought the wheelchair per eviewed. During the tour tor and several other were present. On p.m. housekeeping aide ctually do not see that many as they go when they want hem stored" when asked what saw the cigarettes stored all the saw the cigarettes stored all the further stated if she would a resident who left them lying the would bring them to the the resident was supposed to	F	323				

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F 323	facility smoking pol sure at this time an When asked specific being locked both and would be gettir. Both indicated residuance with oxygen the front of the build they are done smoked with oxygen the facility for five yout smoking with oxygen the facility for five yout smoking with oxygen the facility for five yout smoking policy ED orientation. ED stated flag as not being sate the assessment an would help and in thad to swap cigare the past they have had been very reliate expect all the staff stated she would notice the safety but the answers exactly about storage of cigED stated if resider would be safe like it been assessed to but the supplies. ED all take cigarettes and on the bed it would re-assessed. When	if either of them knew the icy both stated they were not d would get back to surveyor. ically about smoking supplies stated they were neither sure ng back to surveyor about it. dents were not supposed to and would have the tank at ding and would not get it after	F	323			

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F 323	through with the poaudits and would clany concerns would further stated she had during her audits at of the best smoking. On 12/16/15, at 7:3 and HKA-A approach would be able to ke also have them sto rooms which they had be assessment/plan or indicated resident strict floor. Interventificated and remind on the wearing a jacket rules and consequently and consequently for the Care Area Assindicated cognitive 5/15/15, indicated processes and the smoking policy and him of the smoking onto can for resident request assist. R31's smoking safe assessments dated an independent smoking part and the smoking safe assessments dated an independent smoking safe assessments dated an independent smoking safe assessments dated an independent smoking part and the smoking safe assessments dated an independent smoking safe assessments dated an independent smoking part and the smoking safe assessments dated an independent smoking part and the smoking safe assessments dated an independent smoking part and the smoking safe assessments dated an independent smoking part and the smoking safe assessments dated an independent smoking part and the smoking safe assessments dated an independent smoking part and the smoking safe assessments dated an independent smoking part and the smoking safe assessments dated an independent smoking safe assessments dated an independent smoking safe assessments and the smoking safe assessmen	oblicy ED stated she did do heck and if she had noticed did address it immediately. ED had not seen any concerns and thought the facility had one grograms. By a.m. both the floor care tech ched and stated residents eep the cigarettes on them and red in the cabinets in their had a key to. Behavior symptom of care rewritten 5/8/15, smoking in-between door or some included offer to get for risks and consequences of ear. Re-direct and reministed ences. Bessment (CA) data 25/18/15, impairment CAA data	F 32				

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F 323	goals and intervent Smoking assessm 2/6/15, indicated resmoker and the asson the plan of care. The quarterly MDS moderate cognitive included hypertens disease. The comprehensive dated 11/18/15, incomprehensive dated 11/18/15, at 11 cigarettes observed and updated. On 12/15/15, at 11 cigarettes observed R31 in hall toward his root and had a pack of R31 indicated her had done that for the shoppers get materies received some took which was used as table was a rolling approximately four lighter fluid bottle of which stated flamm stated the Zippo stated other reside they ask permission.	tions on the plan of care. ent dated 8/27/15, 5/8/15, and esident was an independent esessment would be addressed	F3				

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		245417	B. WING _		12	/17/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	Continued From p (RN)-A stated he was lighter fluid. R31 s RN-A stated it was p.m. RN-A stated director, indicated their shop to lock and their shop their shop to lock and their shop their shop their shop to lock and their shop to lock and their shop to lock and their shop	rage 38 was not aware of the Zippo stated it should be tossed and ald be tossed. At 12:17 p.m. s disposed of properly. At 12:57 he gave it to the maintenance they had a locked place in flammables. ssessment: prevention and of care dated 5/14 indicated in cigarettes occasionally. fety data collection and ad 1/6/15, 4/17/15, and 10/5/15 an independent smoker and dinterventions on the plan of d. On the 7/10/15, assessment eviewed 10/6/15-no y [RN-A]." S dated 10/5/15 hindicated R41 tact and diagnose include	F 3:	DEFICIENCY)		
	and updated. On 12/15/15, at 11 in her room and st today. R41 opene drawer and showed R41 had two pack drawer and half (1/2)	ated and care plan reviewed 1:51 a.m. R41 was lying in bed tated she was not feeling well d her bedside dresser's second ed me a pack of 18 cigarettes. Its of cigarettes in the top locked (2) carton in the bottom drawer. Ept a lighter in her jacket and				

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	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 323	Continued From pa smoked outside.	age 39	F3	23		
	care plan dated rev	ehavior symptom assessment written 10/3/14, entry dated 2 started to roll his own				
	assessments dated and 11/12/15 indica independent smok	Tety data collection and d 2/14/15, 5/15/15, 8/12/15, ated resident was an er and address goals and e plan of care were checked.	C			
	management plan indicated R72 was	sessment: prevention and of care dated 8/12/15, independent with smoking.				
	cognitive impairme The quarterly MDS was cognitively into					
		e care plan sview summary licated R72 was a smoker.				
	room to have six end top of the refrigeration top of the dress cigarettes were obtained to cigarettes were a lighter on the bed	444 a.m. observed resident's mpty cigarette packages on for and three empty packages er table eight individual served on the bedside table, in a pack in his hat, along with diside table. R72 stated he was ide anytime and stated he had				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		TE SURVEY MPLETED	
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	PROVIDER OR SUPPLIER	RE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422			·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE , DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	Continued From pa no cigarettes in his		F 32	23			
	smoked and kept a lighter in her camp smoked about two and smoked about two and assessment in a goals and intervent checked. The quarterly MDS was cognitively intacerebrovascular accerebrovascular accerebrovas	56 a.m. R8 was not in his rved a pack of The garett's not on a bloom be reading was in the uning room and cigaret each a drawer in his y data collection and 11/11/15, indicated R8 was an					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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F 323	R168 On 12/15/15, at 12 dining room, state cigarettes and light have any extra cigarettes and independent srinterventions on the The Fall/injury assumanagement care fall/injury risk related. The undated comparts with the undated comparts for R168 On 12/15/15, at 12 (NA)-A stated if should report it to the There was no smore residents have to some times she sate usually a lighter, rulf they were not have to so and handed them services supplies are purchased with must go outside passumoke shack. Sore smoking times in the lighter at the deskipping and lighter at the deskipping shade shades.	2:25 p.m. R168 was in the d he had a half pack of ater in his jacket but did not parettes. afety data collection and 112/10/15, indicated R168 was moker and address goals and he plan of care was checked.	F 33			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245417	B. WING		12	/17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA			STREET ADDRESS, CITY, STATE, ZIP 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE
F 323	smoke and brough On 12/15/15, at 1:' smoking materials the nurse's station aware of the smok On 12/15/15, at 1:' know what he wou materials out and a want to leave smol They do not have p going into rooms a concerns with ciga a concern he woul locked up. RN-A st smoking policy tho dependent smoker were locked up, mo on their own. They they locked and dis had six cigarettes I avoid all her mone RN-A stated every smoker. He indicat smoking policy to r aware of who was they were ensuring R135 was admitted was identified by th Nursing Comprehe Collection an Asse Comprehensive Ac Assessment indica	In p.m. NA-B stated if she saw in rooms she would take it to a NA-B stated she was not ing policy. If p.m. RN-A stated he did not lid do if he saw smoking about. It is their home if they king materials on their table. The problems with other people and stated he did not have rette stealers. If they did have did suggest the cigarettes were did at the roughly. If a resident was a rette the had not read the roughly. If a resident was a rette the her cigarettes were did have one resident who stribute her cigarettes. She kept on the maltication cart to by being spent on garette. One elso was an incoordent red he would befer to the read it. NA a states he was not in charge of the policy or how go it. If to the facility on 7/23/15, and the facility as a smoker on the resident was a smoker on t	F3	23		

	OF DEFICIENCIES OF CORRECTION			E SURVEY PLETED			
		245417	B. WING			12/	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH COBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	R135 was cognitive assistance with act R135's admission I diagnoses of a stronon-dominate side cocaine abuse, introduced in the brain of the Progress Note R135 was found sr Note dated 7/31/15 was held and social smoking policy and with family to smok The Smoking Safe Assessment dated assessed as an incomplete R135's Fall/Injury A Management Care indicated "Assessment dated assessed as an incomplete R135's Fall/Injury A Management Care indicated "Assessment dated "Assessment dated "Assessment dated "Assessment dated assessed as an incomplete R135's Fall/Injury A Management Care indicated "Assessment dated assessed as an incomplete to smooth the progress of the	MDS dated 7/30/15, indicated ely intact and required tivities of daily living (ADLs). MDS indicated R135 had oke, hemiplegia (paralysis on), seizures, asthma, history of racranial hemorrhage ain), dated 7/30/15, indicated moking in his room. Progress 5, indicated a care conference al service reviewed the diprocedure. R135 would go se. Ity Data Collection and 7/30/15, indicated R135 was dependent smoker. Assessment: Prevention and Plan undated hage interpretate for indent) fool will demonstrate and plan undated page 4 ment Fall/Injury risk related to: indent) Goal Will demonstrate Intervention Monitor	F	323			

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F 323	Smoke, but family On 12/15/15, at 1: aware of the smokyes a resident can or room. On 12/15/15, at 1: facility enforces the we ensure the resident that the resident that the interiment of the	age 44 aff will not take resident to members can do so." 05 p.m. when asked are you sing policy? LPN-D answered not smoke in their bathroom 10 p.m. when asked how the e smoking policy? RN-B stated idents remain safe. If not we to allow them to smoke. We will have go out and smoke with at needs to be supervised. In 12/17/15, at 2:07 p.m. when of nurses (IDON) was asked in in room in July, IDON I have been an incident port. ocate it and proving to not provided when requested sted copy of stacking rogress notes for 23 through ctor of parsin (DON) stated is the moking assessments. Sident was a smoking leted DON stated, "talk to //-A], she will know what the end off until they want to smoke. By say they smoke but have not y have been in the hospital. It is upon admission about the	F3			

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F 323	regulations. I was of transitional care un worker will talk to the smoke in their room. MN (Minnesota) Sn 2014, directed: "1. All residents who upon admission, que change of conditions smoking needs and smoke independen 2. Results of the sn discussed with the addressed in the readdressed in the r	and let them know there are off on 7/23/15, and 7/24/15. If a it resident admits the social he resident. Residents can not a moking policy revised January on smoke will be evaluated uarterly, and with a significant and to assess their ability to a determine any special deto assess their ability to a tip. In the determine and special deto assess their ability to a determine any special deto assess their ability to a special deto assess and a special deto a s	F3	323		
	R13 was observed	on 12/16/15, at 7:38 a.m. for exares were completed NA-C.				

OLIVILI	10 I OIL MEDICANE	A MEDICAID SERVICES	T		Olvid i	110. 0930-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING			12/17/2015	
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIF 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	, CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 323	R13 indicated she was assisted to the assist. When the N around R13 the be "tight." The belt wa not fit. The Velcro's transfer R13 to the stand into the correthen R13 was lowed the toilet use R13 was lowed the toilet use R13 was accommodate the legs could not spread admission diagnose (loss of use of one (difficulty swallowing apraxia of speech (difficulty swallo	age 46 had to use the bathroom. R13 edge of the bed by two NA A-C went to put the safety belt it would not fit as it was too s adjusted and again it would safety straps were not used to toilet. NA-C assisted the ect position over the toilet and red to sit on the toilet. After was placed in the wheelchair ff tilt the w/c backwards to egs of the stand as the stand ad as wide as the w/c width. to the facility 5/31/14, with es of stroke with hemiplegial side of the body) dysphagial g food and liquids) and (difficulty with express) ated 3/6/15, in Scate R13 was ee in carea due to ody hantus e. R13 equin d assist at two esists at to to at was usually incomplant with toileting d 3/9/15, indicated assist of tand" [Stand Up Patient Lift] dated 11/13/15, indicated R13 act, moderately depressed and assist of two staff with lift for transfer and toilet use. Ills in the past tree months.	F3				

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F 329 SS=D	On 12/17/15, at 7:1 have to lift the w/c to because the legs of far enough to get or what we figured our the w/c." On 12/17/15, at 7:3 while since they have back far enough comfortable." On 12/17/15, at 2:0 and indicated the stand they should have (PT) lift assessment R13 "had not had a September 2014, so be accurate for the The manufacturers Patient Lift dated 20 attachments are no patient back onto the correct this problem damage may occur wear and damage to arm and any pivot fraying, deformation any defective parts that the lift is not us 483.25(I) DRUG RE	3 a.m. RN-B stated, the staff to get R13 far enough back, in the stand would not spread over R13's w/c. RN-B "That's it to get her far enough back in 3, NA-C stated "it's been a ve been lifting the chair to get in the chair that she was so to be a physical therapy of the state	F 323			1/26/16
	Each resident's dru unnecessary drugs drug when used in	g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or				

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F 329	indications for its adverse conseque should be reduced combinations of the Based on a compresident, the facility who have not use given these drugs therapy is necessed as diagnosed and record; and resided drugs receive grade behavioral interversidents.	monitoring; or without adequate use; or in the presence of ences which indicate the dose d or discontinued; or any	F 3:	29		
	did not ensure advass being complereviewed for unnership include: R68's Care Area Area and indicated R68 recommedications. The facility's considered Consultation Reports	w an document review, facility verse site anect meritoring ted for 1 15 residents (R68) cessary means ations. Assessment dated 4/24/15, eived antipsychotic ultant pharmacy report entitled, ort Omnicare of Minnesota luded: "receives an		F 329 Medication monitoring includir blood pressures, (e.g. orthosts pressures) for R68 was put in 12/28/2015. All residents have the potentia affected by this same practice a facility wide audit was comp 12/28/2015 and fourteen resididentified at risk for monitoring postural blood pressure needs Nursing staff will be in-service 1/26/2016 on policy and process.	atic blood to place on al to be ; however, leted on dents were g needs for s. d by	

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F 329	at high risk for falls postural blood presmonthly/assessing per facility policy (or The medical record irregularity having I facility's attention a orthostatic blood presmonthly facility's attention and included an order or blood pressures to utilizing an antipsy 2015 indicated morpressures had not the medical record Treatment Administ evidence of any orthaving been monith November of 2015. The facility provided dated 5/15/15. The interventions for action for R68's use of Sezoloft (an antidepresion opportunity to happropriate for sucof the plan remainer Repetitive physical sitting, hypotension unsteady gait, fall is 31-180 days, hip free weight loss and orthogogeneous processing the processing for the plan remainer Repetitive physical sitting, hypotension unsteady gait, fall is 31-180 days, hip free weight loss and orthogogeneous processing the processing for the plan remainer Repetitive physical sitting, hypotension unsteady gait, fall is 31-180 days, hip free weight loss and orthogogeneous processing for the plan remainer Repetitive physical sitting, hypotension unsteady gait, fall is 31-180 days, hip free weight loss and orthogogeneous processing for the plan remainer Repetitive physical sitting, hypotension unsteady gait, fall is 31-180 days, hip free weight loss and orthogogeneous processing for the plan remainer f	is reported to have fallen or be Please consider monitoring sures (BP) at least for orthostatic hypotension or as advised by prescriber)." I lacked any evidence of this been brought forward to the gain even though no ressures for R68 had been ay of 2015. ministration Record (MAR) lated 5/13/15, for orthostatic be completed monthly, if chotic. R68's MAR for May nitoring of orthostatic blood been completed. In addition, which included the MAR and tration Record, lacked chostatic blood pressures ored between lay and lacked any layerse ick effect monitoring groquel (a antipsychotic) or essant). Although there was ave selected interventions h monitoring, an entire section ad unchecked including: movement, balance while n, dizziness/vertigo, syncope, n past 30 days, fall in past acture, swallowing problem,	F3	329	psychoactive medication symptom assessment/care plan needs. Audits will be completed by the DC and/or designee for identified residensure at Equation monitoring is in pweekly. Audits whose reviewed durquality issurance QA) meeting to differmine fany tiends are identified recommendations made for continuation and a monitoring needs.	ents to lace ring the	

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F 329	11/27/15, indicated and had diagnoses accident, traumatic depression. R68 wa activities of daily liv and set up help onl MDS also indicated the facility on 4/16/ The signed Physici 2015, indicated R6 milligrams (mg) every evening for mood of monitor for the risk medications and if the information in the information in the medical doctor. documented "O" for psychopharmacolo there were no documented were no documented in accomplemented in ac	R68 was cognitively intact including: cerebrovascular brain injury, anxiety, and as independent with most ring and required supervision, y with locomotion off unit. The R68 had been admitted to 15. an Orders for December 8 received Seroquel 25 ery morning, and 50 mg every disorder. Staff were also to of psychopharmacological noted staff were to document the medical record and notify. The licensed nurses of monitoring for the risk of gical medications however, amented orthostatic blood mended by the pharmacist to ital adverse six efforts for the did not mented on the seed of the did not seed cating orthostatic blood and monitored. The IDON ected such monitoring to be cordance with the consultant	F3	329		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3)	DATE SURVEY COMPLETED
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F 329 F 332 SS=D	effects for Seroque The information inc advised of the risk of (symptoms include upon standing, white especially during the titration, and also a treatment or increa The facility's policy dated 7/15, directed side effects as indic Medication Sympto R68's care plan dat symptoms to monit 483.25(m)(1) FREE RATES OF 5% OR The facility must er medication error ra This REQUIREMEN by: Based on observar review, facility failer for 2 of 7 Residents medication adminis 7.7% medication er Findings include:	one of the adverse side I was orthostatic hypotension. Iluded; "Patients should be of orthostatic hypotension feeling dizzy or lightheaded ch may lead to falls), re period of initial dose t times of re-initiating ses in dose." Psychoactive Medication d staff to "Monitor regularly for cated on the Psychoactive m Assessment/Care Plan." red 5/15/15, was void any or for side effects. The OF MEDICATION ERROR MORE resure that it is free of tes of five perment or releater. NT Inot muchs evidenced tion, interview, and document d to prevent medication errors of (R72, R76) reviewed for stration. This resulted in a	F 32		and s jn
	R72's G-Tube med enteral feeding was	ication administration and sobserved from 8:34 a.m. until d nurse (RN)-D was observed		for increased independence rather that have a continuous tube feeding formuladministered. RN-D was provided	n

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
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	PROVIDER OR SUPPLIER SDALE REHAB & CAI	RE CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH COBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 332	to crush the listed ra blue plastic cup. The medications we 81 milligrams (mg) (a muscle relaxer) (an antidepressant) Finasteride (treatm hyperplasia (BPH) Norco (an analgesi Keppra (used to treatblet, and Calcium units (promote bone milliliters (ml) of om gastroesophageal ras ordered by the Dorders. RN-D put on gloves centimeter) syringe pushed it into the Go cc of water and RN-D then added 5the plastic cup contained for the foliations in the lumps in bottom of G-tube with 50 cc of Jevity (nutritional stand pushed it into the Jevity had been given with 50 cc of water and flushed the G-tube with 50 cc of water and flu	ere Aspirin (a mild analgesic) chewable one tablet, Baclofen 10 mg one tablet, Wellbutrin of 75 mg two tablets, ent of benign prostatic	F3	3332	re-education as it relates to bolus to feedings, g-tube placement verification and G-tube medication administration 12/28/2015. A facility face adit was completed 12/17/2015 and four residents were identified that have the potential to affected by this practice. In-servicing face provided to staff 1/20/2016 that addresses standard practice and relates to G-tubes and feeding administrations, three time week for two weeks, medication and feeding administrations, three time week for two weeks, the weekly. As will be reviewed durign the qulaity assurance (QA) meeting to determ any trends are identified, and recommendations made for continuations/monitoring needs. Insulin administration On 12/28/2015 R76's blood sugars reviewed and results were discussion the diabetic clinic with no new order noted. Resident is without any advertigation of the potential to be affected. Nursing staff will be in-serviced by 1/26/2016 and will include policies procedures related to insulin injection procedures related to insulin injection of the procedures related to insulin injection procedures related to insulin injection of the procedures of the proced	on en tion on on en tion	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY PLETED	
		245417	B. WING			12/ ⁻	17/2015
	PROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH COBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 332	R72's quarterly Min 11/12/15, indicated and was independ with the exception R72's diagnoses li Physician Orders i malignant neoplas orders read, "Ok to together, flush with (water) following mand "Check for G-1 and medication ad 250 ml of water at PM, 4 PM and 8 P At 12/17/15, at 9:2 medication powde bottom of the cup to RN-D verified that the crushed medication or tube acknowledged the should have been medication or tube never given gastrofeedings via gravity practice." During interview of stated a nurse shore iduals before gi gastrostomy tube, administers medication the G-tube worushed medication or worked medication or tube.	nimum Data Set (MDS) dated at R72 was cognitively intact ent with activities of daily living of eating. Sted on the December 2015 included dysphagia, and mof the mouth. In addition, the crush and give meds in 60 ML [milliliters] of H2O ineds," "Give all Meds via GT," tube placement prior to feeding ministration. Flush G-tube with 12 midnight, 9 AM, 12 PM, 2 M." 7 am RN-D verified there was an and fragments still left in the that the dissolved pills are in the medication of containing at medication in it. The medication current in the medication of gastronomy ube programment of feeding for in the steam of the programment of the distance of the giving the effective feeding for in the medications or yethrough a stringe, "that is old in 12/17/15, at 9:33 a.m. RN-A ould check placement and	F3	332	utilization of FlexPens, glucose monitoring and infection control. Audits will be completed by the DC and/or designee that will monitor identified residents requiring insuli injections are times a week for tweeks then weeky. Audits will be reviewed during the quality assura (6A) meeting to determine if any are identified and recommendation made for continued audits/monitoringeds.	in vo nce trends	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(XX	(X3) DATE SURVEY COMPLETED	
	245417	B. WING				12/17/2015
NAME OF PROVIDER OR SUPPLIER ROBBINSDALE REHAB & CAI	RE CENTER		3130 GRIME	DRESS, CITY, STATE, ZIP COI ES AVENUE NORTH DALE, MN 55422	DE	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EA	PROVIDER'S PLAN OF CORF ACH CORRECTIVE ACTION S DSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	
get it all the medical medications, rinse of the feeding tube. During interview on interim director of nexpect the nurses to into the room and ethe resident, Check residuals, if ok, sep syringe, flush the tuindividual medication between meds. Who remove gloves and the meds if you have the meds if you	to the cup to make sure you ation. You would then do liquid out cup. Then you would flush a 12/17/15, at 2:07 p.m. the tursing (IDON) stated, "I would to prepare the medications, go explain what they are doing to explain the syringe flushing the dotter while excultating over the law upper domen with a steroscopy. The law upper domen with a steroscopy. On the explain contents and the from syringe, attach syringe eation(s) into syringe, and allow R72 did not receive the full is as ordered by the physician.	F3	32			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	(X3) DATE COMP	SURVEY PLETED
		245417	B. WING _		12/1	7/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 332	2015, directed staf Flexpen (used to cunit/milliliter sliding with meals For blo 201-250=8 units 29 units, 351-400= 20 than 400 = 24 units During medication 12/16/15, at 12:18 (LPN)-B verbalized and would need eight attached the needlunits for administrative stopper of the liprime the pen. LPN alcohol wipe and given Novolog. Surveyor and had LPN-B con Flexpen. LPN-B die the Flexpen prior to R76's quarterly MER76 was cognitive on the MDS including interview or interview LPN-B st	der for the period December f to administer Novolog ontrol blood sugar) 100 gecale based three times a day bod sugar 150-200=4 units, 51-300= 12 units 301-350=16 general units, blood sugar greater g	F 33	Ý		
	said it would not hu	n 12/17/15, at 12:21 p.m. RN-B urt to wipe the stopper off with N-B verified you are supposed				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245417	B. WING			12/ ⁻	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH COBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE
F 332	to prime flex pens is medication. RN-B seducation on Flexpen During interview or IDON verified the prinsuling the prinsuling dial up the room, explain proof The IDON stated in result in the resider wiping the end of the infection. Discharged Resider printed 12/17/15, for as manufacture insultant and proparation from your healthcat product package." NovoLog Flexpen in April 2015, instruct "Step 1: Prepare your the pen cap. Wipe alcohol swab. Remait the needle and screen Step 2: Step 2: Doi injection: small amount cartridge during no and ensure proper to select 2 units. He needle pointing up few times, which me top. Press the push dose selector is barried.	before you dial up the stated I have not had en since I have been here. In 12/17/15, at 2:07 p.m. the process to give Insulin via a ne end of the pen with alcohol, and the pen with 2 units of dose required, take resident to ess, administer the insulin. The pen would not priming the pen would not not getting the full dose. Not ne pen off could result in an an ent Medication Transfer Recard or NovoLog Flexpen provided ert. It instructed residents to on and usage instructions are professional and the	F	3332			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		TE SURVEY MPLETED
		245417	B. WING _		/17/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	appears, change t not receive the full by the physician.	he needle and repeat." R76 did amount of insulin as ordered	F 33		
F 333 SS=D	The facility must e any significant me This REQUIREME	nsure that residents are free of	F 33		1/26/16
	review, the facility residents (R76) we medication errors	ation, interview, and document failed to ensure 1 of 4 ere free of significant related to insulin administration tial to affect 4 residents who insulin pens.	C	F 3 3 12/28/2015 R76's blood sugars were reviewed and results were discussed with the diabetic clinic with no new orders noted. Resident is without any adverse effects noted related to this practice.	1
	indicated R76 had R76's blood sugar 12/16/15, ranged f 316. The Physicians Or 2015, directed star	rder for the period December ff to administer Novolog		A facility wide audit was complted on 12/28/2015 and sixteen residents have a potential to be affected. Nurisng staff will be in-serviced by 1/26/2016 and will include policies and procedures related to insulin injections, utilization of FlexPens, glucose monitoring and infection control.	
	unit/milliliter sliding with meals For blood 201-250=8 units 2 units, 351-400= 20 than 400 =24 units During medication	control blood sugar) 100 g scale based three times a day bod sugar 150-200=4 units, 51-300= 12 units 301-350=16 0 units, blood sugar greater s. administration observation on p.m. licensed practical nurse		Audits will be completed by the DON and/or designee that will monitor identified residents requiring insulin injections three times a week for two weeks, then weekly. Audits will be reviewed during the quality assurance meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245417	B. WING		12	/17/2015	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIF 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 333	(LPN)-B verbalized and would need attached the need units for administ the stopper of the prime the pen. LF alcohol wipe and Novolog. Surveyor and had LPN-B of the Flexpen. LPN-B of the Flexpen prior R76's quarterly M 10/15/15, indicated Diagnosis identification. During interview interview LPN-B about priming a Fwipe the top. I the had a cap." During interview registered nurse wipe the stopper verified you are so before you dial uphave not had edubeen here." During interview interim director of process to give Ir end of the pen with dose required, ta	ed R76's blood sugar was 223 eight units of Novolog. LPN-B dle to the Flexpen and dialed 8 tration. LPN-B did not wiped off e Novolog Flexpen and did not PN-B wiped R76's abdomen with gripped skin to administer the prostopped the administration correctly prime the Novolog did not wipe off the stopper on to attaching the needle. Minimum Data Set (MDS) dated and R76 was cognitively intact. The don't he MDS include diabetes on 12/16/15, at 12:37 p.m. stated, "I have never head ought it was sterill because it	F3				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
		245417	B. WING		12/17/2	015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COM	(X5) MPLETION DATE
F 333		would result in the resident	F 333	3		
	pen off could result Discharged Reside	nt Medication Transfer Record				
	as manufacture ins	or NovoLog Flexpen provided ert. It instructed residents to on and usage instructions				
		re professional and the				
	April 2015, instruct "Step 1: Prepare you the pen cap. Wipe to alcohol swab. Rem the needle and screen Step 2: Step 2: Doi injection: small amount cartridge during not and ensure proper to select 2 units. However, we will be a supported to select 2 units.	our NovoLog Flexpen: Pull of the rubber stopper with an ove the protective tab from ew it onto your Flexpen tight ing the air shot before each ounts of air may collect in the rmal use. To avoid injecting air dosing: Turn the dose selector old your Flexpun with the	C			
F 371 SS=E	few times, which m top. Press the push dose selector is bac should appear at th appears, change th 483.35(i) FOOD PR	and tap the cantage get by a coves the air subble to me about an all the way in until the ck to a 4-drop or insulin e tip of the needle. If no drop e needle and repeat." ROCURE, //SERVE - SANITARY	F 37 ⁻	1	1/20	6/16
	considered satisfact authorities; and	om sources approved or story by Federal, State or local distribute and serve food ditions				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		E SURVEY PLETED
		245417	B. WING		12/	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CAP	RE CENTER	3	STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 371	Continued From pa	ge 60	F 371			
	by: Based on observatoreview, the facility for sanitary condition in preparation areas. It to ensure hair restratore potential to affect 7 who ate out of the left of the facility of the facility of the facility package, the package, the package without closure to proodles. During the entire to cooler, and freezer NSM was observed.	9 p.m. during kitchen tour wind anager (NSM), the following ainer of white rank and 4 quart ocolate milk, with no open for past mood's was observed. If you a sed by the action of the age of no siles were left open prevent continuation of the arrival to not be wearing a hair is beard. During the tour, NSM to bend down to lower yidual baking pans to inspect		F 371 No residents were ound to be affet the praction; how ver, this had the potential to a fact 71 of 72 resident facily on that day. All residents have the potential to a these practices that eat out of the chen. In-servicing will be provided to the staff related to food storage and so conditions and review policies and procedures related to infection conthe Nutrition Services Mangaer (Nand/or designee by 1/26/2016. Audits will be completed by the NS and/or designee that will monitor so storage in food prep areas, including wearing of hair nets, the cleaning schedule three times a week for two weeks, then weekly. Audits will be reviewed during the quality assurate meeting to determine if any trends identified and recommendations monitoring needs.	dietary anitary strol by sm anitary ng vo nce are nade for	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245417	B. WING			12/ ⁻	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH COBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE
F 371	was observed. The dishwasher dish traside on the floor in dietary aide remove from the floor, place and loaded it with the dishwasher coveray to the outside from the clean one. Sanitary to be done dietary aide. On 12/17/15, at 10 should have dates stated the pasta not tie on the bag and floor on the clean one working with food stated if they were was not necessary would wear a net if serving at the stear. The 2013 Food and Food Code under tread, "(A) Except a section, FOOD EM restraints such as heard restraints, ar hair, that are design keep their hair from clean EQUIPMENT and unwrapped SIN SINGLE-USE ARTI	re were three empty ays standing upright on their front of the dishwasher. The ed an empty dishwasher tray ed it on the dishwasher belt, dirty dishes. She then opened wer and pushed the clean dish by pushing the dirty dish tray. The NSM stated it was not that way and informed the edge. The NSM stated the milk when opened for use. He edges should have had a twist be closed. 32 a.m. NSM stated a sone should wear a beard net. He end was cooking with food it to wear one. The stated he he was cooking to dance in table. 34 Drug Ack Inistration (FDA) he section of Hair Restraints is provided (B) of this PLOYEES shall wear hair mats, hair coverings or nets, and clothing that covers body and worn to effectively a contacting exposed FOOD; T, UTENSILS, and LINENS; NGLE-SERVICE and	F	371			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
		245417	B. WING		12/	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA			STREET ADDRESS, CITY, STATE, ZIP CO 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	times Cover all of Beards must be co 483.60(c) DRUG F	d "3. Wear a hair restraint at all of hair, including facial hair. overed." REGIMEN REVIEW, REPORT	F 3			1/26/16
SS=D	reviewed at least of pharmacist. The pharmacist methe attending physical nursing, and these	of each resident must be once a month by a licensed ust report any irregularities to ician, and the director of reports must be acted upon.				
	by: Based on intervier facility failed to ensure recommendations residents (R68) remedications. Findings include:	w and document review, the sure consultant that facist were acted to point of 1 of viewed for unlecessors.		R68's consultant pharmacis recommendations to monitor blood pressures at least monobtained and put into place 12/28/2015. All residents have the potent affected by this same practice.	or postural onthly was on tial to be ice, however a	
	indicated R68 recemedications. The facility's consumption Consultation Report dated 5/12/15, inclination and at high risk for falls	ultant pharmacy report entitled, ort Omnicare of Minnesota uded: "receives an is reported to have fallen or be s Please consider monitoring ssures (BP) at least		facility wide audit was comp 12/18/2015 and fourteen re- identified at risk for monitori postural blood pressures. Nursing staff will be in-servi 1/26/2016 on policy and pro psychoactive medication sy assessment/ care plan need	sidents were ing needs for ced by ocedure for mptom ds.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245417	B. WING		12/	17/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 428	per facility policy (a The medical record irregularity having facility's attention a orthostatic blood p completed since M. The Medication Acincluded an order oblood pressures to utilizing an antipsy 2015 indicated mo pressures had not the medical record Treatment Administ evidence of any or having been monit November of 2015. The facility provided dated 5/15/15. The interventions for acfor R68's use of Sc Zoloft (an antideprian opportunity to happropriate for sucof the plan remained Repetitive physical sitting, hypotension unsteady gait, fall 31-180 days, hip from the plan remained R68's quarterly Min 11/27/15, indicated and had diagnoses and or R68's quarterly Min 11/27/15, indicated and had diagnoses.	or as advised by prescriber)." In disched any evidence of this been brought forward to the again even though no ressures for R68 had been lay of 2015. Iministration Record (MAR) dated 5/13/15, for orthostatic be completed monthly, if chotic. R68's MAR for May nitoring of orthostatic blood been completed. In addition, l, which included the MAR and stration Record, lacked thostatic blood pressures ored between May and let care plan lacked and and diverse side affect conitoring decorate and a tipsyle of longer or essay. Although there was have sended including: I movement, balance while in, dizziness/vertigo, syncope, in past 30 days, fall in past racture, swallowing problem,	F4	designee for identified resider adequate monitoring is in place Audits will be reviewed during assurance (QA) meeting to de any trends are identified, and recomme data as made for caudits anonitoring needs.	ce weekly. the quality etermine if	

<u> </u>	TO TOTA MEDIOMILE	WINEDIO/ ND CERTIFICE					0000 0001
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		E SURVEY IPLETED
		245417	B. WING			12/	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CAI	RE CENTER		31	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	depression. R68 wa activities of daily livand set up help onl MDS also indicated the facility on 4/16/ The signed Physici 2015, indicated R6 milligrams (mg) every evening for mood of monitor for the risk medications and if the information in the information in the medical doctor. documented "O" for psychopharmacolo there were no documented were no documented in a compressure as reconnected in 12/17/15 at 9:39 (RN)-B stated they blood pressures. On 12/17/15 at 2:30 pharmacist stated is pressures to be more on 12/17/15 at 3:20 nursing (IDON) stated ocumentation indipressures were being confirmed she experimplemented in accompharmacist's recomplemented in accompharmacist's recomplemented in accomplemented in accompharmacist's recomplemented in accompharmacist's recomplemented in accomplemented in accompharmacist's recomplemented in accomplemented i	as independent with most ing and required supervision, y with locomotion off unit. The I R68 had been admitted to 15. an Orders for December 8 received Seroquel 25 ery morning, and 50 mg every disorder. Staff were also to of psychopharmacological noted staff were to document the medical record and notify. The licensed nurses of monitoring for the risk of gical medications however, amented orthostatic blood and adverse side effects for the 19 a.m., registe ad not see did not menitor anostatic blood entitored at least monthly. 3 p.m., the interim director of the she did not see cating orthostatic blood and monitored. The IDON ected such monitoring to be cordance with the consultant	F	128			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		245417	B. WING		12	/17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIDEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 431 SS=E	10/29/13, indicated effects for Seroque The information in advised of the risk (symptoms include upon standing, whi especially during the titration, and also a treatment or increase. The facility's policy dated 7/15, directe side effects as individual Medication Symptom R68's care plan da symptoms to monite 483.60(b), (d), (e) ILABEL/STORE DR. The facility must erral licensed pharmator of records of receip controlled drugs in accurate reconciliar records are in order controlled drugs is reconciled. Drugs and biological labeled in accordant professional principal appropriate accessinstructions, and the applicable. In accordance with	maceuticals, last revised I one of the adverse side I was orthostatic hypotension. Cluded; "Patients should be of orthostatic hypotension feeling dizzy or lightheaded ch may lead to falls), he period of initial dose at times of re-initiating ses in dose." Psychoactive Medication d staff to "Monitor regularly for cated on the Psychoactive om Assessment/Care Plan." ted 5/15/15, was void any or for side effects.	F 4	31		1/26/16

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	_	(3) DATE SURVEY COMPLETED
		245417	B. WING		_	12/17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, ST 3130 GRIMES AVENUE NO ROBBINSDALE, MN 55	ORTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BI ED TO THE APPROPRIA ICIENCY)	
F 431	controls, and perm have access to the The facility must pr permanently affixed controlled drugs lis Comprehensive Dr Control Act of 1976 abuse, except whe package drug districts.	nts under proper temperature it only authorized personnel to keys. rovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to n the facility uses single unit ibution systems in which the ninimal and a missing dose	F	331		
	by: Based on observareview, the facility of medications/treatm medications rooms outgoing (medication pharmacy or destrooms. This had the residents. The facil medication storage defrosted in 1 of 3 the facility did not expatches were accurately potential diversion R10). Also, the facility of the facility of the facility did not expatches were accurately diversion R10).	tion, interview, and document did not ensure excited tents were discurded in 3 of 3 it; the facility diamot a sure ons to be cent bactories to be cent bactories of 3 media tips of 3 media tips of a media tips of a media tips of a media tips of a refrigera or was cleaned and medication soms. In addition, ensure Fentanyl (narcotic) rately destroyed to prevent for 2 of 3 residents (R29, dity failed to ensure medication for 1 of 6 medications carts		The expired medical amedication rooms medications requiring the pharmacy or descompleted on 12/17 medication storage the second floor medication storage the second floor medication and defrost facility wide audit with 12/18/2015 to ensure the second floor medication with the second floor medication and feaculately destroyed diversion, no addition noted.	s were discarded ng to be sent bac estroyed was 7/2015. The refrigerator locate edication room wasted on 12/17/2015 as completed on the medication can entanyl patches wed to prevent pote	ed in as 5. A rts rere
	Findings include: Second floor medic			All residents have t affected. Nursing staff will be 1/26/2016 on the pe	e in - serviced by	

OLIVILI	COT OIL MEDIO/IIL	WINDOWN OF CELLANDER					0000 0001
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		SURVEY PLETED
		245417	B. WING	·		12/	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CAI	RE CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	storage tour was co (RN)-A who provide room. Upon opening shelves were observed to bottles, pill cards of treatments. A tote wobserved stored unto have dry water sof medications were brown drips on the substance was. In a observed: - 15 bottles of lodof packing stripes) stormedication room of and four loosely lying dried white soap so verified and stated, store them. We do - Three Zinc 50 mill tablets bottles with - Engerix B (hepatited drops and with ace stored together in a cone infusion ball of (an antibiotic) stored drawer with a discase on 12/17/15, at 1:5 expired medications supposed to be stored together in a coknowledged and that needs to be do medications were of pharmacy to be distime it had been do	of p.m. the medication room ompleted with registered nurse and access to the medication g, the second cabinet the rived overflowing with multiple is various medications and with multiple medications was ader the sink, which appeared tain and water damage. Some the observed to either have cap or side unsure what the addition, the following were some in a box and inside the sink in the which some were in a box and inside the sink that had sum all over the sink. RN-A "They is a better place to be have a supply room." In the indication of the sink in the	F.	431	related to receipt and disposition of controlled drugs, the storage of druprocess to discard expired drugs, or requiring to be returned to the pharmand the monitoring and care related medication from the process. As dits whose completed by the DC designate for Moff the medication medication and treatments carts to be ture as equate monitoring is in put that the process of the process of the process. In addition controlled drugs will be completed to ensure Fental atches were accurately destroyed prevent potential diversion three times weekly for one week, then weekly, will be reviewed during the quality assurance (QA) meeting to determine any trends are identified, and recommendations made for continuations made for continuations made for continuations made for continuations monitoring needs.	ugs, the drugs rmacy, d to the he DN or cooms, lace . then audits audits Audits ine if	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION ING		E SURVEY PLETED
		245417	B. WING		12/	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CAI	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		(X5) COMPLETION DATE
F 431	medication room R responsibility is mir medications were swith suppositories I been stored separal 2ND FLOOR REFF On 12/17/15, at 1:5 storage tour with R to have a two-three Three ice packs we frost. In addition, th have an orange disnurses on night shi cleaning and defrosonce a month. Fentanyl patches d Second Floor: On 12/17/15, at 2:0 medication cart was During the tour insi observed an opener R29. When asked with disposing used patchad to witness the were supposed to sa Administration Rec R29's MAR and na 12/16/15, it was reventanyl patch five	ations were not stored in the N-A stated "The final ne." When asked if supposed to be stored together RN stated they should have stely. RIGERATOR FREEZER 4 p.m. during medication N-A the freezer was observed inch thick build up frost. Here observed encased in the e thick frost was observed to coloration. RN-A stated the fit were supposed to be stell the refrigerator and freeze hisposal	F 4			

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(- /	DATE SURVEY COMPLETED
		245417	B. WING			12/17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422)DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 431	to the medication of During the tour, throwere observed stort When asked what it destroying the used nurse were supposed RN-F verified R10 destroyed six times which four times dissign off witnessing no nurse had signed destruction on 12/1 Third Floor medication on 12/1 Third Floor medication tour to the RN-F who provided observed: -Hemoccult (a test kit with expiration 5 Anticoat absorbent expiration 1/2014, a stored in a shelve it addition, the biohas with two inches buits stated would be clearesponsible for mal was free of expired stated was the nurse managers would he shelves of the refrigulation flex per store of the store of the per suppositories (bow with insulin flex per suppositories)	of p.m. RN-F provided access art and the narcotic box. see Fentanyl patches for R10 red inside the narcotic box. The facility policy was for d patches, RN-F stated two red to witness the destruction. The form 12/1/15, to 12/16/15, of d not have a second nurse the destruction and one time red off on the MAR the 6/15.	F4	31		

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245417	B. WING			12/·	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CAI	RE CENTER		31	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH COBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 431	nursing (IDON) stars supposed to be pull room for destruction supposed to be sto medications. IDON were supposed to find sign when the patch destruction and the follow the policy for Medications were medication cart and not properly stored in The medication cart and 19:55 a.m. with RI floor treatment cart nursing (DON). Both Santyl wound produte oral medication the Santyl was not only wound tube produced the oral medication the Santyl was not only wound tube produced the santyl was not only wound tube produced the santyl was of using the residents RN-B repmight take somethic another resident." A bottle of eye drop glaucoma) 1 % was RN-B stated [R87] treatment. RN-B stared in the suppose of the suppose	7 p.m. the interim director of red expired medications were led from cart and medication in and suppositories were red separately from other further stated the nurses collow the policy of two nurse res are removed and nurses were supposed to cleaning the refrigerators. of properly stored on one of two medication carts were diversed to the succession of the second of the succession of the second of the se	F	131			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING			12/ ⁻	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CAI	RE CENTER		31	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH COBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETION DATE
F 431	nurse (LPN)-B was nurses desk leaving unlocked At 11:56 a.m. LPN No resident, staff o cart At 12:05 p.m. the unlocked as LPN-B perform a blood surdoor to R76's room of sight At 12:08 p.m. the No resident, staff o cart while it remained and the resident, staff or cart while it remained unlocked as LPN-B medication cart unlocked as the resident, staff or viswhile it remained unlocked in tact, on to in dining room. The nurse's reach or vision and the resident in the r	on carts: 53 a.m. licensed practical observed to walk down to the great the medication cart I-B returned and locked cart. It is retained approached the medication cart was left walked into resident room to gar test. LPN-B closed the interest. The medication cart was out LPN-B returned to the cart. It is retained to the cart. It is ret	F	431			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY PLETED
		245417	B. WING _		12/	17/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 431	During interview or stated, "Med carts nurse is not there. [residents] get in the	n 12/17/15 at 2:07 p.m. IDON should be locked when the There is risk for injury if they	F 43			
	"2. Destroy used t Fentanyl), following a. Two licensed nu	ransdermal patches, (e.g. g removal from the resident. rses must sign for the used patch on the resident's stration Record"				
	Biologicals, Syring 1/1/13, directed: "3. General Storag 3.2. Facility should medications and bifrom internal use m 3.4. The facility should therapy products a separately from others."	ensure that external use ologicals are stored so, wately nedications and binogical. buld ensure that infusion and supplies an astorial appropriate to ppersour and				
F 441	manufacturer's or s 16. Facility should discontinued, outdomedications or biol pharmacy return/do Applicable Law,"	supplies a commendations. destroy a return all ated/expires or deteriorated ogical in accordance with estruction guidelines and other N CONTROL, PREVENT	F 44	1		1/26/16
55=E	The facility must es	stablish and maintain an rogram designed to provide a comfortable environment and				

CLIVILI	13 I OK WEDICAKE	. A MEDICAID SERVICES			OIVID IVC	7. 0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245417	B. WING			/17/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 3130 GRIMES AVENUE NORTH	ODE	
ROBBIN	SDALE REHAB & CA	RE CENTER		ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
F 441	Program under whi (1) Investigates, co in the facility; (2) Decides what p should be applied t (3) Maintains a recactions related to in (b) Preventing Spre (1) When the Infect determines that a r prevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each dihand washing is indeprofessional practic (c) Linens Personnel must ha	ease and infection. of Program stablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective infections. ead of Infection cion Control Program esident needs isolation to of infection, the facility mus t prohibit employees with a ease or infected skin is isons with residents or veir food, cansmit the discuse. t require staff was their irect resident con ct for valich dicated by at repter	F			
	by: Based on observareview, the facility f	NT is not met as evidenced tion, interview and document ailed to follow infection control f 8 residents (R13, R76, R1,		Diabetic care: R13, R 76, R1, R132, R75, R14 clinical records were r		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/16/2016 FORM APPROVED

CENTER	S FUR MEDICARE	& MEDICAID SERVICES			UI	VID INU.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		245417	B. WING			12/1	17/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DODDING	SDALE REHAB & CA	DE CENTED		3	130 GRIMES AVENUE NORTH		
KODDIN	SDALE REHAD & CAI	RE CENTER		R	OBBINSDALE, MN 55422		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	١	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		COMPLÉTION DATE
F 441	Continued From pa	ige 74	F 2	141			
	•	61, R14) reviewed for			1/5/2016 for infection control purpo	ses to	
	infection control.	or, icra) reviewed for			ensure each resident was without	363 10	
	iniootion control.				infections at the time this practice v	vas	
	Findings include:				observed. No infections were note		
					LPN-D, RN -G and RN-A verbalize		
	Diabetic care:				correct in control practice af		
	R13:				review a) completed after observat		
		4 p.m. licensed practical			were in the specific dates no		
		observed come out of R13's			A resident have the potential to be		
	room wearing a pair of gloves and had a glucometer in her hand. LPN-D disposed the				affected by his practice as it relate infection control, however a facility	S IO	
	lancet then grabbed the tip of the used stripe with			_ `	a vit was completed on 12/28/2019		
		the sharps container, then			sixt ar esidents with diagnosis of	Jana	
		ipe (germicidal disposable			aberes and who also have orders	to	
		top of the treatment cart			n pnitor their blood sugars have the		
	wiped the glucome	ter briefly wrapped it with whe			otential to be affected.		
		inside on the top drawer of			Nursing staff will be in -serviced by		
		ill wearing the same gloves		•	1/26/2016 and will include a review		
	picked a pen and d	ocumented in the treat ent			policies and procedures related to		
	sheets. LPN-D ther	n pulled the draw with same	3		of personal protective equipment (I		
	to R13's room pulls	insulin vial drawinsulin went ed the privacy virtai was			Hand hygeine including the use of sanitizer, glucose monitoring equip		
	overheard indicate	to R13 she was sting to the			disinfect/ decontaminate procedure		
	her insulin. LPN-D	then come out of recognition			bloodborne pathogens related to in		
	same gloves dispos	sed e syringe then went into			control standards of practice.		
	R13's wheeled resi	dent com to the			Audits will be completed by the DC	N or	
	hallway then proce	eded to leel the cart down			designee that will monitor infection	control	
		st room in the south hallway to			practices three times per week for		
		north hallway still with same			weeks, then weekly. Audits will be		
	gloves on.				reviewed during the quality assurate		
	The guestest Minin	our Data Cat (MDC) data d			(QA) meeting to determine if any tr		
		num Data Set (MDS) dated R13 was a diabetic and had			are identified, and recommendation made for continued audits/ monitor		
	no infections.	n 13 was a diabetic and fidd			needs.	iiig	
	no inicodona.				Peri Care:		
					NA-C verbalized understanding on		
	R76:				12/16/2015 related to the standard		
		0 p.m. LPN-D was observed			practice when assisting R61 with p		

CENTER	49 FOR MEDICARE	& MEDICAID SERVICES			UI	<u>VIB IVO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		245417	B. WING			12/1	17/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DODDING	SDVI E DERIVE & CVI	DE CENTED		3	130 GRIMES AVENUE NORTH		
KUDDIN	SDALE REHAB & CAI	NE GÉNTEK		R	ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	re-applied another using hand sanitize glucometer on the I barrier punctured the drop of blood set the again obtained a resto wait for insulin. Leaned the glucom SANI- PDI Cloth will Super SANI-PDI Cloth will Super SANI-PDI Cloth will super SANI-PDI Cloth will super sanitime to disposed the syndocument still wear R76's MDS dated 1 diabetic and had not set to the super sanitime to the super san	com removed the gloves pair without washing hands or a went into R76's room set the bedside pull table without a ne second finger obtained a ne glucometer on the table rading of 146. LPN-D ask R76 never briefly with a Super pe then wrapped with the oth and set it on the top cart me gloves drew the insuling to room shut the door, came wringe with same gloves ing the same gloves.	F	141	needs. All residents who receive assist with hygeine needs have the potential to affected. Nursing staff will be in - serviced by 1/26/2016 and will include a review policies and procedures related to persons protective equipment (PP Hand hygeine including the use of sanitizer, and infection control stan of practice. A dits will be completed by the DC design a that will monitor infection antroipractices three times per we too weeks, then weekly. Audits will eviewed during the quality assurant (QA) meeting to determine if any trare identified, and recommendation made for continued audits/ monitor needs.	o be of the use of E). hand dards oN or eek for II be noce ends ns	
	was going to next to blood sugar check. gloves got to R1's rether room surveyor is she was supposed gloves changes stated hand sanitizer then hands came out ap p.m. LPN-D went in glucometer on R1's finger obtained a diagnosing the lance container took the gair of gloves without the gloves got to R1's rether the gloves without the gloves got to R1's rether the gloves got	7 a.m. LPN-Is here tated she of R1's room to de another LPN-Is still hearing the same room as she was going into interve of and asked nurse if to wash or hands between ited she us ally would use the went into R1's room washed plied a pair of gloves. At 6:18 into room and set the rop of blood got a reading of om removed the gloves after it and stripe into the sharps gloves off, donned another out washing hands, recorded lew seven units of Novolog			Wound Care: On 12/16/2015 the pharmacy was and sent a new tube of Santyl to re the soiled one. The wound care su were removed from the room and verplaced with new ones to ensure a were exposed to dirty linen. RN-B verbalized on 12/16/2015 understarelated to hand hygeine meeds and and procedure as it related to wour care. All residents who receive wound care have the potential to be affected. Nursing staff will be in -serviced by 1/26/2016 and will include a review policies and procedures related to of personal protective equipment (Hand hygiene including the use of	place upplies were none nding dipolicy nd are of the the use PPE).	

CENTER	RS FOR MEDICARE	: & MEDICAID SERVICES			U	MR MO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		SURVEY PLETED
		245417	B. WING			12/	17/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PORRING	SDALE REHAB & CA	DE CENTED		3	130 GRIMES AVENUE NORTH		
KODDIN	SDALL KLIIAD & CA	KE CENTER		R	ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	into R1's room adm removed gloves out into the room and we when asked if she we hands between rest supposed to wash LPN-D stated "Yest supper was coming "when I was trained glucometer and wratewas using them. I for cart. It's ideal to was anitizer." When as acknowledged she R76's bedside table over the glucometer have been ideal to as she would not readdressed in the tra- sufficient to clean it if she was supposed with used gloves LI should have remove	o control blood sugar) went hinistered it on the left arm tside the room and came back washed hands. At 6:22 p.m. was supposed to wash her idents and if she was her hands after glove change. I was just rushing through as gup." LPN-D further stated dive were trained to wipe the ap it and that's what I did as I orgot the sanitizer in the other ish with water or hand sked about the barrier on a stated there was no blood all it but acknowledged would use a barrier but was not sure emember if that had be a safter each use. Whereasked at to walk down the fallway PN-D acknowledged it was a safter each use.	F 4	141	sanitizer, wound care and treatment policy and procedure, and infection control standards of practice. Audits will be completed by the DC designee that will monitor infection practices are simes per week for weeks then week. Audits will be reviewed aduring the quality assura (CA) meeting to extermine if any trace identifies and recommendation made for continued audits/ monitor hards.	DN or control two nce ends	
	Registered nurse (I R132's room with a blood sugar supplie RN-G set the tote of table without a barr retrieved a glucome next to the tote on	RN)-G was observed enter a small tote which contained es. Upon entering the room directly on the bedside pull rier and then got a paper towel eter from the tote and set it the paper towel. After applied 32's finger with alcohol then					

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,		CONSTRUCTION		E SURVEY PLETED
		245417	B. WING			12/	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		313	REET ADDRESS, CITY, STATE, ZIP CODE 30 GRIMES AVENUE NORTH DBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 441	obtained a reading tossed in garbage, supplies and LPN-I rime took the gluco towel brought it out then then RN-G too third drawer withou observed wipe the and then proceeded Cloth wipe wrapped then washed her has At 11:52 a.m. when supposed to be platable and put back LPN-C present by the both stated the total cleaned on the bott nurses were all obstote. LPN-C stated be taken into the roce R132's MDS dated a diabetic and had R13's blood sugar 12/16/15, at 7:38 a on and glucometer blood sugar, LPN-E table with no barrie obtained a blood sugloves, picked up swithout washing has with gloves on and	ed a drop of blood and of 159. RN-G took gloves off came back gathered the who was in the room at the meter wrapped in a paper of the room set it on the cart ok the tote returned it into the t cleaning it then was glucometer tossed the wiped to get a Super SANI-PDI daround the glucometer and ands with the hand sanitizer. asked if the tote was ced directly on the bedside into the cart, RN-H and he cart outside R132's room was supposed to have been om before it was stored. The served clean the cart at the she preferred the totes not a come.	F4	141			

CENTE	45 FOR MEDICARE	: & MEDICAID SERVICES			0	MR NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245417	B. WING			12/	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		31	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 441	12/16/15, at 8:11 a into R75's room inco blood sugar came of glucometer with a Striefly then went in LPN-B then obtained the bedside pull take whole bottle of glucand lancet. LPN-B the bottle and appling and obtained a drough LPN-B then still with bottle of stripes (miglucometer with us room tossed the bottle of stripes and clicleaned the glucom after touching the the wrapped it then remained sanitizer. At 8 the bottle of stripes room and had touc should have not take have removed my clicked the supplies and the supplies and had touch should have not take the bottle of stripes room and had touch should have not take the supplies and clicked the suppli	observation was completed on m. LPN-B was observed go dicated was going to check the out applied gloves cleaned the Super SANI-PDI Cloth wipe to the room and shut the door, and a paper towel and set it on ole and set the glucometer, a cometer stripes alcohol wipe then obtained one stripe from ed to glucometer asked er then punctured it squeezed profibility of blood with reading of 134. In the same gloves pick up the cultiple-use) and the ed stripe on came out of the ottle into the top drawer with lean glucometer's. Then never with the same gloves and used it with the same gloves and used it with the glove's and used it with the glove's and used gloves refere touching it." It can be the dom and should glove's refere touching it." It can be spull have changed cleaning the plucometer.	F	141			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING		12	/17/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 441	R31the result of B treatment cart,RN-treatment cart and SANI-PDI wipe for R31's annual MDS had diagnosis of dinsulin. On 12/16/15, at 12 an interview with the asked if she did go RN-I stated she withe nurses during assigned a restoracares." RN-I stated the use of a barriet the resident room with the supplies to recommended by (CDC). When asked training RN-I gave cleaning training is done on check list checked she of the nurse hit task appropriately been trained "No got training had been (NAs) on the use of equipment (PPE) are move gloves, was again if coming in she would expect gloves after remove hands then apply at the dressing changes.	lood sugar. RN-A returned to -A placed a paper towel on the I wrapped glucometer in	F4	41		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION DING	(X3) DAT COM	
		245417	B. WING		12	/17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE	(X5) COMPLETION DATE
F 441	nursing (IDON) sta nurses to not walk have removed glov expected the staff t hand sanitizer. IDC supposed to follow bedside table wher		F 4	141		
	by NA-C on 12/16/dining room. At 8:5 open the bathroom a.m. R61 was over help" and NA-C wa gloves and assisted was heard void the cued resident to stagoing to apply a trathen assisted resid observed use toilet twice which was nowith the same glove pad and pants there the wheelchair. NA gloves was heard in bowel movement." wheelchair armrest she wheeled reside the gloves and whele located in the room set resident to was -At 9:02 a.m. Where	being wheeled into her room 15, at 8:51 a.m. from the 5 a.m. R61 was observed door then came out. At 8:56 heard resident call out "pleast is observed go to room splied d resident into the foilet. Ro in stated "am done" NA-C then and then cuec R61 he was insfer belt ground he wait ent to cand. NA-wa page to wice resident bottom oted to care brown-stool then es adjusted R61's incontinent in guided resident to seat on -C still wearing the same indicate to R61 "you had a NA-C then touched the is with the same gloves and as ent through the door removed eseled resident to the sink in and washed her hands and in hands too. In asked if she was supposed after providing pericare NA-C				

CLIVILI	13 I ON MEDICANE	. A MEDICAID SERVICES			Oil	ID NO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION			SURVEY PLETED
		245417	B. WING			12/1	17/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
ROBBIN	SDALE REHAB & CA	RE CENTER		3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD	BE	(X5) COMPLETION DATE
F 441	gloves." NA-C ackr washed her hands -At 9:11 a.m. when supposed to wash and if staff were su during cares the ID surveyor asked RN armrest. Glucose Monitoring Disinfect/Decontar directed staff "Place overhead table on a towel, wax paper." the policy directed "1. Use the disi external parts of the gloves on. 2. Remove glo 3. Perform har 4. Don clean g 5. Obtain a sectowel. 6. Use the wip the glucometer for 7. Place the gl towel. 8. Remove glo 9. Perform har 10. Place glucuntil next blood glucuntil next blood glucuntil next blood glucuntil next soap and we	was supposed to remove the nowledged she should have also. asked if the staff were hands after providing pericare pposed to change gloves ON stated "Yes." At 9:12 a.m. Be to clean the wheelchair gequipment: ninate effective July 2015, at the glucometer on the aclean surface, e.g paper For cleaning the glucometer infectant wipe to clean all a glucometer with et a clean all external parts of the selection of t	F				
	 If hands are vis 	sibly soiled					

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245417	B. WING		12	/17/2015
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIF 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 441	If exposure to e.g, C. difficile A plain soap and hand rub may als If hands are to Before havin Before insert peripheral vascul devices that do not a resident) After contact when taking a pura resident) After contact mucous membra dressings if the houring reside contaminated-book After contact.	g and after using the restroom of spores is suspect or proven a spore with residents and welling catheters, ar catheters, other invasive of require a surgical procedure with a resident's intact skin (e.g., lse or blood pressure and lifting with body fluids or excretions ands are not visibly soiled and are not visibly soiled and site to a clean-lody site with inanimate of jects all equipment) in the inchediate ident	F4	41		
	a.m. R13 was the and rolled (transp bathroom. R13 w NA-C then perfor removed the glov R13 was admitte admission diagno (loss of use of or (difficulty swallow	e observed in 12/16/15, at 7:38 en lifted to the stand platform ported) from the bed to the ras then lowered to the toilet. Immed pericare for R13, she then res, but did not wash her hands. In the facility 5/31/14, with poses of stroke with hemiplegia re side of the body) dysphagia ring food and liquids) and in (difficulty with expressing				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	(X3) DATE SUR' COMPLETE	
	245417	B. WING _		12/	17/2015
NAME OF PROVIDER OR SUPPLIER ROBBINSDALE REHAB & CAR	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	,	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
was cognitively inta required extensive and toilet use. The annual Care And 3/6/15, indicated Recares due to body he R13 required assist assist lift to toilet, who noncompliant with the two staff with EZ states on 12/17/15, at 7:3 confirmed nor denich hands when remove R14's pericare was 9:37 a.m. NA-B was to back and then was changed gloves but prior to putting on find R14's MDS dated 1 required two person personal hygiene at refusing care. Wound care: R14's MDS dated 1 high risk for pressuum obility and impaire noted R14 had an under. R14 required	dated 11/13/15, indicated R13 act, moderately depressed and assist of two staff for transfer rea Assessment (CAA) dated 13 was unable to participate in nabitus and refusals of care. To five staff and a stand ras usually incontinent and oileting schedule. d 3/9/15, indicated assist of and for bed/chair/toilet. 3 a.m. NA-C neither red that she did not wash her ing gloves. observed on 12/6/15, at shed R14's per area from front ashed R14's a ttory NA-B t did not did not wish har as	C			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		TE SURVEY MPLETED
		245417	B. WING _		12	/17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 441	of refusing care. R14 wound care w 9:28 a.m. It was not included a package 4x4 avino dressing cleanser. There was the bucket of clean RN-B applied gloved dressing. The dreshad a dark stain or did not wash their is soiled dressing nor opened a new drestand placed the dreshad placed the dreshad a dark stain or did not wash their is soiled dressing nor opened a new drestand placed the dreshad placed the grand placed the grand placed the Santyl to the dressing package of Santyl ointribag of Santyl ointribag of Santyl ointribag of soiled dressing interview or verified the Santyl pocket. RN-B state on the bed. In a peput down on a steriacknowlwdged the barrier such as a p	as observed on 12/16/15, at steed that dressing supplies e of non sterile guaze, several s, and a bottle of spray wound as a bag of dirty linen on top of				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		E SURVEY PLETED
		245417	B. WING		12/	17/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	soiled pocket. RN-	age 85 eatment cart from the now B also acknowledged the lack ter the removal of the soiled	F 4	41		
F 456 SS=E	IDON stated, "It is bed or bedside take pocket and take to then place in the transhould have their chame on the tube contained. I expect after a soiled dress or use sanitizer."	n 12/17/15, at 2:07 p.m. the not ok to place Santyl on a ble without a barrier, or in your the soiled utility room and reatment cart. Residents own tube of santle with their or container in which it is the nurses to remove gloves sing change and wash hands	F 4			1/26/16
	mechanical, electrequipment in safe This REQUIREME by: Based on observareview, the facility	NT is not me as en located ation, in arciew and document failed to a sure ice machines		F 456 Microwaves have been repla		
	condition. This had	the potential to affect 71 of 72 cility who ate out of the kitchen.		ice machines were cleaned 12/15/2015. Microwaves are utilized in the rooms. Ice machines are on	ne three dining	
	On 12/15/15, at 10 dining room ice ma slowly dripping nea a small area of wh	0:27 a.m. the second floor achine was observed to be ar the spout and the grate had ite stain. In addition, the small amount of food spilled on		cleaning schedule. Staff will be in-serviced by 1 relates to the policies and presentary conditions related to machines and the microway	/26/2016 as it rocedures of the ice	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		E SURVEY IPLETED
		245417	B. WING		12/	17/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 456	manager (NSM) st manufacturer regar confirmed the ice in cleaned and was distated the microward which was done do to 12/15/15, at apstated where ice for did not make a seather ice melted insist through, and confirmed the third floor dining spouts. On 12/15/15, at 10 room microwave we enamel plastic cast the inside door and confirmed it should from service. In admachine had a drip As the ice began to the would check with would check with the would check with the world check with the world check with the world check with the cleaned yesterday. On 12/16/15, at 3:30 observed to still be facility nutrition sedated July 2015 in the cleaned yesterday.	te. 2:25 a.m. nutrition services rated he would check with the rrding the ice machine. He also machine was due to be cleaned on Tuesdays. He ave needed to be cleaned aily. 2:28 a.m. NSM proximately 10:28 a.m. NSM primed inside the ice machine, it all and dripped. He stated as de the machine it dripped rimed it dripped on the front of agroom machine near the area observed to have the sing chipped and worn off on dinside front of any and the late of any worn off on dinside front of any and the late of any worn off on dinside front of any any a gasket. 25 a.m. NSM stated they have ice machines which were	F 4	Audits will be completed by the and/or designee that will monicleaning schedule three times two weeks, then weekly. Audit reviewed tank the quality as meeting to detendine if any treidentifical and recommendation for continuous audits/monitoring	or the a week for s will be surance nds are ns made	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION (X3	X3) DATE SURVEY COMPLETED	
		245417	B. WING _		12/17/2015	
NAME OF PROVIDER OR SUPPLIER ROBBINSDALE REHAB & CARE CENTER						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
F 456 F 465 SS=E	Facility nutrition sed dated July 2015 in scoop, and storag in a clean and san machine will be clooften as needed." MDT5N25 & MDT November 2008 in spouts, sink, grill a periodic cleaning a grill may be remove Undated dining seindicated third and to be cleaned weekly 483.70(h) SAFE/FUNCTION E ENVIRON The facility must p sanitary, and commercial standard commercial standard standard commercial standard st	d thoroughly cleaned twice per n as needed." ervices ice machine procedure dicated "the ice machine, e container will be maintained ditary condition. The ice eaned once per month or more solved to the dispense area: and splash panel will need and maintenance. 2. The sink wed for washing and sanitizing." ervices cleaning schedule of fourth floor microwaves were y and the ice machines are to washing and sanitizing. The sink were good to the ice machines are to washing and sanitizing and the ice machines are to washing and sanitizing.	F 45		1/26/16	
	by: Based on observareview, the facility environment that vof 13 residents (Rothe potential to aff were 13 of 26 residents)	ation, interview, and document failed to provide an was clean and in good repair 3 87, R43, R82). This also had ect 1 of 3 floors in which there dents who potentially could be buth shower on third floor.		F 465 Areas identified on the environmental on 12/16/2015 which included the shoroom, the grab bar, the wheelchair, ar the privacy currtain were all corrected immediately upon identification. The shower door will be corrected by	wer	

245417 B. WING					
NAME OF PROMISE OF CURRILER		/17/2015			
NAME OF PROVIDER OR SUPPLIER ROBBINSDALE REHAB & CARE CENTER STREET ADDRESS, CITY, STATE, ZIP COE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORR PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AFT DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE			
F 465 Continued From page 88 Findings include: On 12/16/15, at 10:37 a.m. to 11:53 a.m. the environmental tour was conducted with the maintenance supervisor (MS), executive director (ED), housekeeping supervisor (HKS), executive director in training and housekeeping and laundry manager (HKLM). During the tour the following concerns that had been identified during stage I of the survey were verified: R87's grab bars secured to bed on 12/14/15, at 4:11 p.m. during room observation were observed to be padded with porous black uncleanable foam which was secured with black tape. The black tape was noted to be wrinkled and not creating a seal which exposed the adhesive part and rendered the foam portion to be an uncleanable surface. During the to-the executive director verified it and stated the grasbars would be replaced with lamb wool skin which can be washed and would voy a padding to resident. R87's quarterly Minimus. Data let (MDS) dated 10/27/15, indicated R87'n revised extensive assist with bed mobility and transh is. R43's right wheelchair armrest was observed to be in ill-repair on 12/15/15, at 8:15 a.m. The vinyl was chipped which exposed the mesh underneath, making it an uncleanable surface, was observed with a thin coating of dust on the entire frame of the wheelchair and the seat was observed ripped/torn on the sitting part both the MS and ED verified stated would replace the seat	orrected by viced by policies and needs. The Director of the bars, ain and doors once monthly lewed during g to entified, and	,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING		12	2/17/2015	
NAME OF PROVIDER OR SUPPLIER ROBBINSDALE REHAB & CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRESPONDED TO THE APPLICATION OF THE APPLICATION	OULD BE	(X5) COMPLETION DATE	
F 465	asked how often the MS and HKS state monthly and at the identified would be and as needed. R43's quarterly ME R43 had severely independent with the awheelchair and was a large yellow and housekeeping the yellow substant When asked how contained the house stated was done diduring the daily rocas needed. R82's quarterly ME R82 had severely occasionally incontrols.	age 89 ne wheelchairs were cleaned ad deep cleaning was done at time if any concerns was reported to MS to address. OS dated 9/11/15, indicated impaired cognition, was ransfers after set up and used walker for locomotion. An on 12/14/15, at 2:04 p.m. at an on it. During the tour ED and laundry manager verified ace on the privacy curtains well be the privacy cu	F 4	65			
	12/16/15, at 10:37 shower rooms wer concerns: -The bottom of left observed to have	ms mental tour conducted on a.m. to 11:53 a.m. the both the re observed with the following shower room door was extreme water damage which edge length to crack all along					

<u> </u>	to i oit iniebio/ iite	S III DIO, IID OLIVIOLO			····	0000 0001
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245417	B. WING		12/	17/2015
NAME OF PROVIDER OR SUPPLIER ROBBINSDALE REHAB & CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 465	Continued From page 90 -The shower room on the right was observed to have white yellow gooey substance on the soap holder on the wall, had a missing towel holder with some parts still screwed on the wall, the privacy curtain behind the door was observed to have multiple stains of brown matter. During the tour the housekeeping supervisor verified the findings. When asked how often the privacy curtains were changed the housekeeping and laundry supervisor stated was checked daily as the shower room was cleaned daily and never indicated if the shower was cleaned between residents. She also indicated the curtains were changed as needed. The executive director verified the missing towel holder. Wheelchair Safety Checks policy effective July 2015, indicated "The center strives to check wheelchairs regularly foot proper operate and safety. When clinical or non-clinical saff notice loose hardware or other possible afety issues with the operation of a wheelchair the esident should be removed from the extent of the safety with the operation of a wheelchair taken out the wheelchair, the wheelchair taken out the wheelchair, the wheelchair taken out the safety taken the safety taken the safety taken the safety taken the		F4	65		
	operation, and repa contacted. The app notified. Regular pr checks on wheelch by the maintenance 483.70(h)(3) CORF SECURED HANDE	air pusonne should be propria pur pair person will be eventath, maintenance airs will be expressed monthly a Department" RIDORS HAVE FIRMLY RAILS	F 4	68		1/26/16
		NT is not met as evidenced				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY PLETED
		245417	B. WING		12/	17/2015
NAME OF PROVIDER OR SUPPLIER ROBBINSDALE REHAB & CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 468	Based on observar failed to ensure all to walls. This had the floors in which there either were ambulated who used the hand. Findings include: 3 North Hallway On 12/16/15, at 8:1 leave the dining rook him and went out ohallway and was of as he grabbed the across from the DR-At 8:12 a.m. survey handrail located rig room to be loose. Vand touched the halloose and not adhered to the facility attent supervisor (MS) ve and immediately tig	tions and interview, the facility handrails were firmly secured he potential to affect 1 of 3 e were 20 of 26 residents who story or were in a wheelchair rails to propel themselves. 1 a.m. R76 was observed om never took his walker with f the dining room to the oserved ambulate to his room handrails along the hallway and went into his room. Yor observed the screw of the hall way and went into his room. You observed the screw of the hall way and went into his room. You observed the screw of the hall way and went into his room. You observed the screw of the hall way and went into his room. You observed to be sered to the walker stability.	F4	F 468 The handrail identified as tightened on 12/16/2015 denvironmental tour. A facility that adit was dother a eas identified wer immediately. Staff will be the erviced on needs related to handrails soured. Addits will be completed to handrails soured.	completed and re corrected on environmental so being firmly on the Director of gnee that will three weeks, and so will be ty assurance on the ty trends are dations made	

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: B1TG Facility ID: 00122

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MEDICARE/MEDICAID PROVII	3. NAME AND ADDRESS OF FACILITY (L3) ROBBINSDALE REHAB & CARE CENTER			4. TYPE OF ACTION: <u>2</u> (L8)			
(L1) 245417				CENTER	1. Initial	2. Recertification	
2.STATE VENDOR OR MEDICAID (L2) 516842200	(L4) 3130 GRIMES AVENUE NORTH (L5) ROBBINSDALE, MN		(L6) 55422	3. Termination 5. Validation	4. CHOW 6. Complaint		
5. EFFECTIVE DATE CHANGE OF	OWNEDCHID	7. PROVIDER/SU		ODV		7. On-Site Visit	9. Other
(L9) 07/01/2015	OWNERSHIP	7. PROVIDER/SU	05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey A	fter Complaint
	17/2015 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR EN	DING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31	
11. LTC PERIOD OF CERTIFICATION	ON	10.THE FACILITY	' IS CERTIFIED	AS:			
From (a):	,,,	A. In Complia			And/Or Approved Waivers Of	The Following Requir	ements:
To (b):		_	equirements e Based On:		2. Technical Personnel	6. Scope of 7. Medical	f Services Limit
		1. A	cceptable POC		4. 7-Day RN (Rural SN		
12. Total Facility Beds	75 (L18)	V D V · · · · · ·	F 34.8		X 5. Life Safety Code	9. Beds/Ro	om
13.Total Certified Beds	75 (L17)	X B. Not in Con Requirements	and/or Applied V	-	* Code: B,5	(L12)	
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF 75	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):			
See Attached Remarks							
17. SURVEYOR SIGNATURE	Date :		18. STATE SURVEY AGENCY APPROVAL Date:				
Rebecca Wong, HFI	E NE II		01/14/2016	(L19)	Kamala Fiske-Downing, Enforcement Specialist 02/03/2016 (L20)		
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY	
19. DETERMINATION OF ELIGIB	ILITY		IPLIANCE WITH	H CIVIL	21. 1. Statement of Fina	• •	
1. Facility is Eligible to	Participate	RIGHTS ACT:		 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligib							
	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DA	ГЕ	VOLUNTARY 00	<u>INVOI</u>	<u>UNTARY</u>
03/01/1987					01-Merger, Closure		to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Termination		to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI				04-Other Reason for Withdrawal	OTHE	
	A. Suspension	n of Admissions:	(L44)			07-Pro 00-Act	vider Status Change ive
(L27)	B. Rescind St	uspension Date:	(ETT)				
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		06301					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	
	•		-	-			•

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00122

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN 24 5417

Documentation supporting the facility's request for a continuing waiver involving LSC K67 is being recommended and forwarded to CMS for approval.



Electronically delivered January 4, 2016

Ms. Kathleen Pankratz, Administrator Robbinsdale Rehab & Care Center 3130 Grimes Avenue North Robbinsdale, MN 55422

RE: Project Number \$5417025

Dear Ms. Pankratz:

On December 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>Electronic 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:

Gloria Derfus, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900 gloria.derfus@state.mn.us Telephone: (651) 201-3792

Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 26, 2016, 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 January 26, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 17, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 17, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division

> P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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

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

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

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

Email: tom.linhoff@state.mn.us Phone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 01/14/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245417	B. WING _		12/17/2015	
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION	
F 000	INITIAL COMMENT	rs	F 00	00		
	as your allegation of Department's acception enrolled in ePOC, year the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are rour signature is not required of first page of the CMS-2567 nic submission of the POC will cion of compliance.				
F 176 SS=D	on-site revisit of you validate that substate regulations has been your verification.	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with NT SELF-ADMINISTER D SAFE	F 17	76	1/26/16	
	the interdisciplinary	ent may self-administer drugs if team, as defined by as determined that this				
	by: Based on observatoreview, facility failed (R82, R87) who we self-administer med Findings include: R82 was observed have a clear plastic in front of R82 with were two blue and word Renvela (prevented)	on 12/14/15, at 7:03 p.m. to medication cup on the table four medications in it. There white capsules, one dark d a white oval that had the rent hypocalcemia-low levels		The submission of this plan of co is not an admission by the provide fact or conclusion set forth in the Statement of Deficiency. This Pla Correction is being submitted bed is required by law. However, evid Robbinsdale Rehabilitation and C Center good faith, the facility offe following plan of correction and h achieved substantial compliance of the areas addressed by Janua 2016.	er of any an of cause it encing care rs the as in each ry 26,	
ABORATOR	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE	

01/12/2016

Electronically Signed

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 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245417	B. WING			12/ ⁻	17/2015
NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
ROBBINS	SDALE REHAB & CA	RE CENTER			30 GRIMES AVENUE NORTH		
				RO	BBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 176	of calcium in the body) printed on it. There were three other residents seated at the table. The medication cup remained at the table throughout		F 1		A Self Medication and Data Collecti assessment was completed for R8	2 on	
	medications at 7:25 (LPN)-D was noted at the time of the ol location where able				1/5/2016 in order to evaluate R82's to safely self-administer her medica. The results were reviewed by the interdisciplinary team (IDT) prior to implementation to determine if the practice is safe.		
	assessment dated was marked not ap requested staff to a Quarterly Nursing D	d Data Collection and 8/31/12, and reviewed 5/11/13, plicable and indicated resident dminister medication. Data Collection and 10/5/15, indicated no for			Licenced Practical Nurse (LPN) D v provided education on 12/15/2015 to self-sdminister drug managemer procedure to ensure LPN -D follows correct procedure when administer medications.	related nt s	
	"self-medicates/des R82's quarterly Min 10/6/15, indicated F cognitively impaired dementia, diabetes stage 4 on dialysis. Nursing Comprehe	imum Data Set (MDS) dated R82 was moderately and had diagnoses of and chronic kidney disease ansive Admission Data dated no for R82 had no desire to			A Self Medication and Data Collecti assessment was completed for R8 1/5/2016 in order to evaluate R87's to self-administer her medications. results were reviewed by the IDT to determine if the practice is safe. LPN-D was provided education on 12/15/2015 related to self-administr management procedure when administering medications. All resignave the potential to be affected by	ability The ration	
ORM CMS-25	orders printed 12/6, one Nephrocap (a cused to treat or prepor diet, certain illucapsule by mouth in capsules (used to tin patients with chrotthree times a day wing by mouth three	nty Medical Center Discharge (15, indicated R82 was to take combination of B vitamins vent vitamin deficiency due to nesses) 1 milligram (mg) in the afternoon, two Phoslo reat high levels of phosphate onic renal failure) 667 mg each with meals and Renvela 800 times daily with meals. There order or care plan for R82 to	1		same deficient practice. A facility wide audit was completed 12/17/2015 and 19 residents were identified with current self- administ of medications and will be re evaluat/26/2016. Measures and systematic changes to ensure that the deficient practice not re occure include reviewing new	on tration ated by made will v	Page 2 of 99

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245417	B. WING			12 /1	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		31	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 176	have a clear plastic in front of R87 with were three other re. The medication cup throughout the ever self-administered the LPN-D was noted that the time of the old location where ables on 12/16/15, at 2:00 powder (used to tree observed on an end applicable and indication and Assessment dated applicable and indication staff adminimately adminimately according to the Physicians of diagnoses of deme of the Physicians of the	on 12/14/15, at 7:03 p.m. to medication cup on the table two white tablets in it. There sidents seated at the table. The remained at the table ning meal until R82 ne medications at 7:20 p.m. to leave the dining room area deservation and was not in a set to visualize R87. To p.m. a bottle of Nystatin the fungal skin infections) was detable in R87's room. To Data Collection and 5/10/14, was marked not cated resident will allow ister medication.	F 1	76	admissions prior to the plan of care meeting, held within 21 days of admissioni. Current in house resid will be reviewed during the facility of comprehensive care plan review mere the assigned schedule. All Reg Nurses (RN) and LPN's will be in some policy and procedure by 1/26/20 Audits will be completed weekly x 4 by the DON and/or designee that of monitor identified residents for the to self-administer drugs. The DON or her designee will complete audit RN's and LPN's related to self-medication. Audits will be reviewed the quality Assurance (QA) meeting determine if any trends are identified recommendations made for continuations made for continuations monitoring needs.	ents veekily eetings gistered erviced 16. weeks vill ability and/ s with during to ed, and	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING _		12	/17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 176	During interview or LPN-D stated, "Yes night for them. The with meals. If you gare in their room, the room. I do not know self-administration verified the medical Phoslo capsules, on Nephrocap. LPN-D R87 were two Tyles. On 12/17/15, at 12 (RN)-B verified R83 self-administration plans. The nurse signedications with the During an interview when asked would cup of medications resident who does of medication order (IDON) said, "No, the assessment, an order IDON verified R82 self-administer medication and Assertion and	in 12/15/15, at 11:55 a.m. is, I left the pills on the table last by both like to take their pills give them their pills when they hey will bring it to the dining w if they have of medication orders." LPN-D ations left for R82 were two on Renvela tablet and one of verified the medication left for nol 500 mg tablets. :28 p.m. registered nurse 2 and R87 do not have orders, assessments or care hould not have left the nem. If on 12/17/15, at 2:07 p.m. you expect nurses to leave a so on the dining room table for a not have a self-administration r, the interim director of nurses hey have to have all three: an der and a care plan." The and R87 could not safely	F 17	6		

	F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245417	B. WING		12/	/17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CAI	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 176 F 225	medications at this Document th re-evaluation as ap	oinister able to self-administer time. e reason and plan for propriate."	F 1			1/26/16
F 225 SS=D	been found guilty of mistreating resident had a finding entereregistry concerning of residents or misa and report any know court of law against indicate unfitness for other facility staff to or licensing authority. The facility must entinvolving mistreatm including injuries of misappropriation of immediately to the atto other officials in a through established State survey and control of the facility must have a violations are thoroup revent further pote investigation is in proceedings.	or the State nurse aide registry ties. Sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law if procedures (including to the ertification agency). In the State nurse aide registry ties. The State nurse aide registry ties.	F 2	25		1/26/16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245417	B. WING		12/17/2015
	PROVIDER OR SUPPLIER	RE CENTER	3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTION
F 225	certification agency incident, and if the appropriate correct This REQUIREMENT by: Based on interview facility failed to imm	uding to the State survey and by within 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced by and document review, the nediately report an allegation of the verbal abuse for 1 of 3	F 225	The initial self report was complete R4 on 12/17/2015 when the facility made aware of the alleged resident resident alligation and a through	was
	indicated R4 was m without signs or syn hallucinations, delu required assistance living. Diagnoses in cerebral palsy, ane	sions or behaviors and with all activities of daily acluded on the MDS included: mia, seizures, anxiety, ohrenia, sleep apnea and		investigation was immedicately initi. The results of the investigation in accordance with state law were rep on 12/22/2015 which was within 5 v days of the report. On 12/23/2015 facility received confirmation from the state survey and certification agency which reads, "On 12/17/2015 the of heaLth facility complaints, (OHFC) recieved a report of possible maltreatment. The track ID for this is 90981. As you are aware the vulnadult act MN statute 626.557; requi	orted vorking the ne y fice of
	p.m., R4 was asked anyone else here a verbal, physical or s "Yes." When asked abuse, R4 stated, " is swearing at me a you tell staff R4 sai R4 was unable to id When asked if had	erview on 12/14/15 at 1:58 d, "Has staff, a resident or bused you - this includes sexual abuse?" R4 answered, to explain R4 said verbal There is another resident who all the time." When asked did d, "Yes, the nurse." However, dentify which nurse he'd told. seen other residents being other resident swears at other		to notify you regarding the initial disposition of the report. The inform has been reviewed and it has been determined that no further action is necessary at this time." All residents have the potential to b affected. Measures put into place include sta education will be completed by 1/26. Three residents will be selected ran	e ff 5/2016.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245417	B. WING			12/	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		31	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH COBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE
F 225	During follow up int a.m. R4 said, "The don't know if he is a safe here. When as swearing occurs R4 asked to explain who elaborate. When member he stated, name the staff menaide. R4 was unable he'd told. When R4 swearing had occur When asked if it ha "Yes." When asked fall, R4 said, "This follow, "This follow, "When asked fall, R4 said, "This follow, "A-C stated, "I have him." On 12/17/15, at 12: (RN)-B stated R4 horesident had sworn not heard any one sthe resident made for replied, "Not that I compared happened, try to find determine a plan to remarked he would it continued he would it	resident swore at me but I still here." R4 stated he felt sked if the staff intervene when a said, "Yes and no." When hat he meant, R4 was unable asked if R4 had told a staff "Yes." When asked if he could hber, R4 said it was a nurse's e to name or describe the aide was asked when the red, R4 did not answer. ppened in the fall, R4 said if it happened last fall or this fall." 38 a.m. nursing assistant swed and stated R4 had not sident's swearing at him. e not seen any one swear at 47 p.m. registered nurse ad never told him that another at him. RN-B added, "I have swear at him." When asked if alse accusations RN-B can think of I have never heard sation against anyone. If this to me, I would find out what d the root of it and would protect him." RN-B also let the facility staff know and if ld bring it to the	F 2	25	for audits that will be completed by Administrator and/or designee on a weekly basis for two weeks and the results will be reviewed at the monmeeting to determine if any rends a identified, and recommendations meantinued audits/monitoring needs.	a e thly QA are nade for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING		- 12	/17/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STAT 3130 GRIMES AVENUE NOF ROBBINSDALE, MN 554	TE, ZIP CODE RTH	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE I TO THE APPROPRIATE EIENCY)	(X5) COMPLETION DATE
F 225	R4's allegation of versident swearing a stated, "No one told that a resident was then informed the stogether with [R4] a and then do a self-ralso stated, "I'll do a an investigation and On 12/21/15, at 1:5 information to the swhich indicated the into the alleged verindicated the facility allegation of abuse Facility Complaints investigation. On 12/22/15, at 11: Health Facility Comparised they had not facility regarding R4 resident Verbal abut The facility's policy, Resident Mistreatm Injuries of Unknown of Resident Propert "All allegations that and substantiated vertage and Adult Protective Identification 1. Identify events, saltercations, bruising states agencies and the local law enforcements and substantiated vertage and Adult Protective Identification 1. Identify events, saltercations, bruising states agencies and the local substantiated vertage and substantiated vertage and Adult Protective Identification 1. Identify events, saltercations, bruising states agencies and the local substantiated vertage and the local substantiated vertage and Adult Protective Identification 1. Identify events, saltercations, bruising states agencies and the local substantiated vertage and the local substantiated v	erbal abuse, due to another at him all the time, the IDON of me about [R4's]an allegation swearing at him." The IDON surveyor, "I'm going to get and see what he can tell me, report to the State." The IDON of incident report and then do do write a five day report." 3 p.m. the facility faxed tate survey team post survey y'd conducted an investigation bal abuse however, the report of had not reported the to the SA's Office of Health prior to initiating an 00 a.m. the state's Office of aplaints was contacted and not received a report from the the total sallegation of resident to see. Prevention and Reporting: International Reporting: Inter	F 2	225		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING _		12/	17/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	report immediately, knowledge of abuse injuries of unknown misappropriation of Reporting 1. Notify the Shift S immediately if alleg mistreatment or mis property occurs. 2. Report the incide Executive Director a nursing]/designee, any allegations of mincluding injuries of misappropriation of applicable state and a. 'Immediately' mot to exceed 24 ho in absence of a shor requirement. 3. Create the eAI [ereport upon identification neglect, mistreatments ource, and/or missed all other agencies an ecessary corrective mistreatment of the substantiated incide all other agencies an ecessary corrective mistreatment.	ident, family, visitor, etc., to without fear of reprisals, any e, neglect, mistreatment, source, and/or property upervisor/Charge Nurse ations of abuse, neglect, sappropriation of resident ent immediately to the and DON [director of Who will immediately report nistreatment, neglect abuse, unknown source, and resident property to dother agencies. neans as soon as possible, but ours after discovery of incident, orter state time frame electronic accident/incident] cation of alleged abuse, ent, injuries of unknown appropriation of property diviolations and all ents to the state agency and to its required, and take all reference.	F 2:	25		
F 226 SS=D	results of the invest 483.13(c) DEVELO ABUSE/NEGLECT	P/IMPLMENT	F 22	26		1/26/16
	policies and proced mistreatment, negle	velop and implement written lures that prohibit ect, and abuse of residents on of resident property.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245417	B. WING		12/	17/2015
NAME OF I	PROVIDER OR SUPPLIEF	R		STREET ADDRESS, CITY, STATE, ZIP C	•	
PORRING	SDALE REHAB & CA	ARE CENTER		3130 GRIMES AVENUE NORTH		
NUDDIN	SUALE REHAD & CA	ANE CENTER		ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 226	Continued From p	age 9	F 2	26		
	by: Based on intervie facility failed to opinmediately repor State agency (SA) reviewed for abuse. Findings include: The facility's policy Resident Mistreatr Injuries of Unknow of Resident Prope "All allegations that and substantiated state agencies and the local law enfor and Adult Protective Identification 1. Identify events, altercations, bruisi patterns, and trend neglect, and/or mid 2. Instruct staff, rereport immediately knowledge of abusinjuries of unknow misappropriation of Reporting	y, Prevention and Reporting: ment, Neglect, Abuse, Including yn Source and Misappropriation rty dated July 2015, included: at meet the definition of abuse violations will be reported to d to all other agencies including rement, elder abuse agencies ye Services, as required such as resident-to resident ng of residents, occurrences, ds that may constitute abuse, streatment. sident, family, visitor, etc., to y, without fear of reprisals, any se, neglect, mistreatment, n source, and/or of property		The initial self report was c R4 on 12/17/2015 when the made aware of the alleged resident allegation and a the investigation was immediate. The results of the investigat accordance with State law won 12/22/2015 which was wdays of the report. On 12/23 facility received confirmation State survey and cerification which reads, "On 12/17/201 health facility complaints, (Oreceived a report of possible maltreatment. The track ID is 90981. As you are aware ault act MN statute 626.557 to notify you regarding the indisposition of hte report. The ahs been reviewed and it had determined that no further a necessary at this time." All residents have the porte affected. Measures put into place inceducation will be completed.	e facility was resident to brough ely initiated. Ely initiated. Ely initiated. Ely initiated. Ely initiated. Ely information the ely information ely information ely initial ely information ely initial to be ely initial to ely initial ely in	
	immediately if allemistreatment or moreoperty occurs.	Supervisor/Charge Nurse gations of abuse, neglect, isappropriation of resident lent immediately to the		Staff will be selected randor that will be completed on a for 2 weeks by the Administ designee and the results will at the monthly QA meeting.	weekly basis rator and/or Il be reviewed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING _		12	/17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIF 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 226	Executive Director nursing]/designee, any allegations of rincluding injuries of misappropriation of applicable state ana. 'Immediately' not to exceed 24 he in absence of a shorequirement. 3. Create the eAI [areport upon identification of a source, and/or missed. Report all alleges substantiated incide all other agencies a necessary corrective results of the investignation of the investignation. Ballocity of the investignation of the investignation of the investignation of the investignation of the investignation. Diagnoses in cerebral palsy, and depression, schizof functional quadriple depression, schizof functional quadriple of the investignation of the investigation	and DON [director of Who will immediately report mistreatment, neglect abuse, funknown source, and fresident property to dother agencies. means as soon as possible, but ours after discovery of incident, orter state time frame electronic accident/incident] cation of alleged abuse, ent, injuries of unknown appropriation of property do violations and all ents to the state agency and to as required, and take all we actions depending on the tigation." mum Data Set dated 11/12/15, noderately cognitively impaired mptoms of delirium, usions or behaviors and ewith all activities of daily included on the MDS included: emia, seizures, anxiety, phrenia, sleep apnea and	F 22	any trends are identified, a recommendations made f audits/monitoring needs.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245417	B. WING		 	12/	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS 3130 GRIMES AV ROBBINSDALE		•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH C	TIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOU EFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 226	When asked if had abused he said the residents. During follow up int a.m. R4 said, "The don't know if he is a safe here. When as swearing occurs R4 asked to explain who elaborate. When member he stated, name the staff men aide. R4 was unable he'd told. When R4 swearing had occur When asked if it ha "Yes." When asked fall, R4 said, "This for the same than the staff men aide. R4 was unable he'd told. When R4 swearing had occur when asked if it ha "Yes." When asked fall, R4 said, "This for the said, "This for the said, "I have him." On 12/17/15, at 10: (RN)-B stated R4 heresident had sworn not heard any one start the resident made for the said that the him make an accus had been reported happened, try to find determine a plan to the said the said the said that th	seen other residents being other resident swears at other erview on 12/17/15, at 9:52 resident swore at me but I still here." R4 stated he felt sked if the staff intervene when 4 said, "Yes and no." When nat he meant, R4 was unable asked if R4 had told a staff "Yes." When asked if he could nber, R4 said it was a nurse's e to name or describe the aide was asked when the red, R4 did not answer. ppened in the fall, R4 said if it happened last fall or this fall." 38 a.m. nursing assistant ewed and stated R4 had not sident's swearing at him. e not seen any one swear at 47 p.m. registered nurse ad never told him that another at him. RN-B added, "I have swear at him." When asked if false accusations RN-B can think of I have never heard sation against anyone. If this to me, I would find out what d the root of it and would protect him." RN-B also let the facility staff know and if	F2	26			

-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245417	B. WING _		12/·	17/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	nursing (IDON) and interviewed. When R4's allegation of veresident swearing a stated, "No one told that a resident was then informed the stogether with [R4] a and then do a self-ralso stated, "I'll do a an investigation and On 12/21/15, at 1:5 information to the swhich indicated the into the alleged vertindicated the facility allegation of abuse Facility Complaints investigation.	7 p.m. the interim director of I DON in training were informed by the surveyor of erbal abuse, due to another at him all the time, the IDON I me about [R4's]an allegation swearing at him." The IDON urveyor, "I'm going to get and see what he can tell me, report to the State." The IDON an incident report and then do di write a five day report." 3 p.m. the facility faxed tate survey team post survey y'd conducted an investigation on al abuse however, the report of had not reported the to the SA's Office of Health	F 22	26		
F 257 SS=E	Health Facility Comverified they had no	plaints was contacted and of received a report from the l's allegation of resident to se. FORTABLE & SAFE	F 25	57		1/26/16
	This REQUIREMEN	NT is not met as evidenced				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245417	B. WING		12/1	7/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER	;	STREET ADDRESS, CITY, STATE, ZIP CODE B130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 257	review, the facility of temperature was marcoms (Three Sout affect 25 of 26 resist the unit. Findings include: 3rd floor North dinity On 12/14/15, at 6:3 dining room observation 11 resist (DR) waiting for the served. As resident R61 were seated at and were overhear hot. On 12/15/15, at 8:2 meal R165 was oven DR was hot which DR. R13 nodded he forehead with her marchot. R13's Minimum Daindicated had impass however, R13 had needs and underst R61's Minimum Daindicated had impass however, R61 had needs and usually R165's Minimum Daindicated had impass however, R61 had needs and usually R165's Minimum Daindicated had impass however, R61 had needs and usually R165's Minimum Daindicated had impass however, R61 had needs and usually R165's Minimum Daindicated had impass however, R61 had needs and usually R165's Minimum Daindicated had impass however, R61 had needs and usually R165's Minimum Daindicated had impass however, R61 had needs and usually R165's Minimum Daindicated had impass however, R61 had needs and usually R165's Minimum Daindicated had impass however, R61 had needs and usually R165's Minimum Daindicated had impass however, R61 had needs and usually R165's Minimum Daindicated had impass however, R61 had needs and usually R165's Minimum Daindicated had impass however, R61 had needs and usually R165's Minimum Daindicated had impass however, R61 had needs and usually R165's Minimum Daindicated had impass however, R61 had needs and usually R165's Minimum Daindicated had impass however, R61 had needs and usually R165's Minimum Daindicated had impass however, R61 had needs and usually R165's Minimum Daindicated had impass however, R61 had needs and usually R165's Minimum Daindicated had impass however, R61 had needs and usually R165's Minimum Daindicated had impass however, R61 had needs and usually R165's Minimum Daindicated had impass however, R61 had needs and usually R165's Minimum Daindicated had impass however, R61 had needs and usually R165's Minimum Daindicated had impass however, R61 had needs and u	tion, interview and document ailed to ensure comfortable naintained in 1 of 3 dining h). This had the potential to dents who used the dining in a room to p.m. to 7:10 p.m. during a ration the dining room was arm. At the time of the dents were in the dining room to food and then they got as waited for food, R46 and the far table, close to door do state the room was very as the other side of the split er head as she wiped her tapkin. The set (MDS) dated 10/22/15, irred cognition impairment the ability to express their and others.	F 257	Staff offered to remove the sweater R61, which was declined. The fan mounted on the wall in the dining rowas cleaned immediately during the environmental tour on 12/16/2015. All residents have the potential to be affected. Staff will be in-serviced on actions can take when residents verbalize concerns related to temperatures, statements such as, "It's hot in here 1/26/2016. The pnuematic thermost are being re-calibrated to create a comfortable environment for the residents. Audits will be completed by the Dira Maintenance and/or designee 3 times week times 2 weeks, then weekly the weeks to monitor air temperatures various locations. The dining room will be audited by the housekeeping supervisor or designee to ensure the cleaned per the cleaning schedules results will be reviewed at the monimeeting to determine if any trends identified, and recommendations meeting to audits/monitoring needs.	ethey e.g. e" by stats more ector of nes a imes 2 in fans g ney are The lthly QA are nade for	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245417	B. WING _		12	/17/2015		
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	•	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 257	R13's MDS dated having intact cognitheir needs. On 12/16/15, at 7:4 have removed her brought into the DF exercises R61 kep a.m. restorative stalook tired do you wtake a nap" R61 st here." Restorative table offered to renbut R61 stated "Juston Month of the desired for the properties of the desired for	d the ability to express their and others. 11/13/15, identified R13 as tion and was able to express 40 a.m. R61 was observed to sweater shortly after being R for exercises. During the t dozing on and off and at 7:59 aff approached asked R61 "You ant to stay for breakfast or go ated "What time is it. It's hot in staff then wheeled R61 to the nove her sweater completely	F 25	57				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING _		12/	17/2015	
	PROVIDER OR SUPPLIER SDALE REHAB & CAI	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 278 SS=D	the dining room dire residents sat during often the fan was contained asked when the far last housekeeping ashe was not sure as responsible for overdone. Housekeeping she had not been a and thought would 2015, last. On 12/16/15, at 11: policy was requested 483.20(g) - (j) ASSI ACCURACY/COOF The assessment material assessment with participation of heat assessment is common Each individual who assessment must state that portion of the auxiliary and knowing false statement in a subject to a civil more assessment in a subject to a civil more assessment in a subject to a civil more and a civil more discovered as the contained and a civil more and a civil more discovered as the c	be running and blew air into ectly onto the tables where a meals. When asked how eaned the housekeeping and ated every other month. When in the DR had been cleaned and laundry manager stated as the previous manager was reseing the cleaning was g and laundry manager stated to the facility for three months have been cleaned in August accurately reflect the must conduct or coordinate with the appropriate of the professionals. must sign and certify that the pleted. completes a portion of the ign and certify the accuracy of	F 25			1/26/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	` ,	(X3) DATE SURVEY COMPLETED	
		245417	B. WING _		12	/17/2015	
	PROVIDER OR SUPPLIER SDALE REHAB & CAI	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 278	to certify a material resident assessment penalty of not more assessment. Clinical disagreemed material and false so this REQUIREMENT by: Based on interview facility failed to ensum Minimum Data Set reviewed for urinary. Findings include: R98's admission M resident had been dincontinent and on a dated 10/23/15, had frequently incontine bladder continence. The Urinary incontine bladder continence. The Urinary incontine continence of the undersion, had seven such as being new major surgery and the chance of incontinence of incontinence of bower continence of contin	gly causes another individual and false statement in a ant is subject to a civil money than \$5,000 for each ent does not constitute a statement. NT is not met as evidenced and document review, the ure 1 of 3 residents (R98) (MDS) was coded accurately incontinence. DS dated 7/25/15, indicated coded as occasionally the subsequent quarterly MDS dependent entire to facility, had recently had a mook a diuretic which increased attinence. The CAA had also alert and oriented and was stance and had the potential with toileting as well as	F 27	R98 Quarterly MDS ARD dat was reviewed on 12/17/2015 modification was completed of Resident was discharged on All residents have the potential affected by this practice. The IDT will receive the re-exaccuracy standards per the F by 1/26/2016. Re-education was conducted by the Regional Disconducted by the Regional Disconducted by the Regional Disconducted by 1/26/16 on redocumentation. The Regional Director of Revintegrity and/or designee will MDS's per month for a period months to validate accuracy. The facility's IDT weekly compound to validate accuracy of coding after the MDS has be completed. Results of audits reviewed at the facility's QA monthly until resolved.	and a on 1/6/16. 11/1/2015. ial to be ducation MDS RAI manual will be birector of signee. The lucate the esident venue audit three d of three eting will be of MDS en will be		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION			E SURVEY PLETED
		245417	B. WING			12/	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CAI	RE CENTER		STREET ADDRESS, CITY, STATE, ZIF 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	ODE CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 278	plan directed staff to three-day elimination voiding pattern, contained assessment and assessment and assessment, and mobtained from quart R98's undated Blad Assessment indicate and on the undated Assessment was in and used a diuretic. On 12/17/15, at 12: the MDS coordinate used to code the Madmission MDS with through 7/25/15, RS incontinence during why he was coded a The quarterly MDS assessments dates R98 to have had six which put him to be incontinent. The MD a surgery on 10/9/1 facility on 10/12/15, done within two we about the undated a R98 was continent she was not sure an co-signed them and with the licensed probeen put on a toileticense and assessment and the undated a R98 was continent she was not sure an co-signed them and with the licensed probeen put on a toileticense and assessment and the licensed probeen put on a toileticense and assessment and the licensed probeen put on a toileticense and assessment and the license and the lic	urinary continence the care of complete care tracker in tracking to determine a implete bladder data collection mong others. Cluded arthritis, cident, abnormal gait, hip joint muscular wasting and was derly MDS dated 10/23/15. Ider Data Collection And ded resident was continent. Bowel Data Collection and dicated resident was continent of the data despective of the time frame and that was as occasionally incontinent. Idea of the time frame and that was as occasionally incontinent. Incomplete of the time frame and that was as occasionally incontinent. Incomplete of the time frame and that was as occasionally incontinent. Incomplete of the time frame and that was as occasionally incontinent. Incomplete of the time frame and that was as occasionally incontinent. Incomplete of the time frame and that was as occasionally incontinent. Incomplete of the time frame and that was as occasionally of the time frame and that was as occasionally incontinent. Incomplete of the time frame and that was as occasionally of the time frame and that was as occasionally of the time frame and that was as occasionally of the time frame and that was as occasionally of the time frame and that was as occasionally of the data of the time frame and that was as occasionally of the data	F 2	278			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		245417	B. WING _		12/	17/2015	
	PROVIDER OR SUPPLIER SDALE REHAB & CAI	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 278 F 282 SS=E	data that nursing as care tracker and did data at the time and supposed to have be incontinent as the a acknowledged the coded inaccurately with the consultant modified. -At 3:03 p.m. interir stated the nurses we data and follow up with the consultant change and then for information was account was going to be modup with the nurse.	had been coded based the sistants had documented in d not realize it was mistaken d acknowledged resident was been coded as occasionally dmission MDS. RN-E quarterly MDS had been and stated would follow up to see if MDS could be an director of nursing (IDON) were supposed to analyze the with data and ask questions to was accurate if there was a allow up with a notation the curate. IDON stated the MDS diffied and was going to follow RVICES BY QUALIFIED	F 25			1/26/16	
	must be provided be accordance with eacare. This REQUIREMENT by: Based on observative review, the facility for care was implement reviewed for ADL's; reviewed for reposition (R72) for standard of the care was implement reviewed for reposition (R72) for standard of the care was implement reviewed for reposition (R72) for standard of the care with the	led or arranged by the facility y qualified persons in ch resident's written plan of one of the facility with the plan of the facility and document failed to ensure the plan of the for 1 of 3 residents (R91) for 1 of 3 residents (R14) the facility for 1 of 3 residents of the facility for 1 of 3 residents of the feeding and feedi		Shaving: R91 was given extensive assist w shaving needs on 12/18/2015. A facility wide audit was complete 12/18/2015 and seventeen male r are noted to require extensive ass shaving needs. In-servicing will be provided to all	d on esidents sist with		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245417	B. WING _		12/-	17/2015
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		DE 0511750		3130 GRIMES AVENUE NORTH		
KORRIN	SDALE REHAB & CA	RE CENTER		ROBBINSDALE, MN 55422		
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F 282	Continued From pa	age 19	F 28	32		
	Findings include:			12/26/2016 that address the	e need to	
	Shaving: R91 was not shaved according to the plan of care.			provide services by qualifie accordance with each residence (POC). Staff in-service address direct observation be taken if residents are observed.	d persons in lents plan of ing will also and actions to	
	(w/c) in his room of the resident face with t	ted 10/25/15, indicated R14 assist of two with personal uded combing of hair, shaving, essing. :43 p.m. registered nurse ewed and indicated R91 did not aved. R91 did not receive the		Audits will be completed by or designee that will monitoresidents requiring assist withree times a week for two weekly. The weekly audits completed during facility carounds. Audits will be reviet QA meeting to determine if identified, and recommends continued audits/ monitorin Repositioning: R14 elected hospice servict POC and phsician orders wand updated on 1/5/2016. A facility wide audit was con 12/18/2015 with eight resid that require assist with repositions.	or the DON and / or identified with shaving weeks, then will be uring partners ewed during the any trends are ations made for g needs. es and the were reviewed impleted on ents identified	
	care and services according to the plan of care for personal hygiene as he remained unshaved from 12/14 15 through 12/17/15. Repositioning: Physician's Order signed 11/30/15, indicated staff were to "Reposition every 2 hours in bed and every 1 hour in chair." R14's Skin Integrity Assessment:Prevention and Treatment Care Plan undated, instruct staff to implement an individualized turning schedule in applicable "q [every] 2 hrs [hours]", to lay R14 on			based on physician recommod ln - servicing will be provided staff by 1/26/2016 that additional provided services by qualified accordance with each resided staff in - serviceing will also review of the skin integrity apprevention program and tree. Audits will be completed by and/or designee that will metals.	mendations. ed to all nursing resses need to d persons in dents POC. The include a persons in dessessment eatment POC. The DON	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIEF	3		STR	REET ADDRESS, CITY, STATE, ZIP CODE	/ .	1,2010
				313	0 GRIMES AVENUE NORTH		
KORRIN	SDALE REHAB & CA	ARE CENTER		RO	BBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	the left side while to turn R14 with tw W/c positioning per R14 was not repositioning to the per Con 12/16/15, R14 and the following was therapy in DR. - At 9:45 a.m. was therapy in DR. - At 10:30 a.m. the in the w/c. - At 10:45 a.m. the dice. - At 12:17 p.m. R1 - At 12:25 p.m. R1 in the DR. - At 1:32 p.m. R14 went for three and repositioned. On 12/16/15, at 12 and was asked if so "I have not been to have preferred to dice game. They so at 12:30 p.m. nu interviewed and st down yet. - At 12:31 p.m. a so NA-H, remarked, she was playing down yet. - At 1:32 p.m. RN-bed between brea only keep her up a have not seen her Con 12/17/15, at 10 and 12/17/17/15, at 10 and 12/17/17/17/17/17/17/17/17/17/17/17/17/17/	in bed but not at all times, and we pillows slightly high on side. For medical doctor (MD) order. Sitioned every two hours lan of care. was observed for repositioning	F 2		residents requiring assist with repositioning three times a week for weeks, then weekly. Audits will be reviewed during the quality assurar (QA) meeting to determine if any trare identified, and recommendation made for continued audits/monitorineeds. G-Tube placement: R72's Orders and POC was review 12/17/2015 as it relates to G-tube placement, medication administratinutritional formula tube feeding administration. Resident recieves be feedings, which he tolerates without or symptoms of adverse affects, to him increased independence rathe have a continuous tube feeding for administered. RN-D was provided re-education a relates to bolus tube feedings, g-tuplacement verification and G-tube medication administration on 12/28. A facility wide audit was completed 12/17/2015 and four residents were identified that have the potential to affected by this practice. In-servicing will be provided to staff 1/26/2016 that addresses standard practice as it relates to G-tubes and feedings. Audits will be completed by the DO and/or designee that will monitor id residents requiring G-tube placements requiring G-tube placements.	ence ends as ang red on on and solus allow rethan mula sit be s/2015. on end be solus of tube Nentified	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER		3	STREET ADDRESS, CITY, STATE, ZIP CODE B130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
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F 282	the bathroom facil repositioned every she did not refuse - At 10:52 a.m. Narepositioned every when R14 was in her down after me - At 12:33 p.m. RN here and the doctor RN-B remarked, "reposition her eve with turning and reme we were having the wound had be months. During interview of interim director of resident who has a tendon, joint capsit tracts also may be pressure ulcers] to physician recomm MDS and care plasshould not have stip.m. without being staff to follow the of G-tube placement R72's gastrostomy checked for place care. R72's medication enteral feeding via from 8:34 a.m. unobserved to flush	ities. R14 was to be two hours from left to right and to bed. A-H stated R14 was to be two hours and sometimes the chair the aide(s) would lay als. I-B stated the wound doctor or noted the wound was better. Staff normally turn and ry two hours. She is compliant eposition. No one came and told g problems." RN-B indicated en present for over three In 12/17/15, at 2:07 p.m. the nursing (IDON) stated, "A a stage 4 pressure ulcer [e.g., ale. Undermining and sinus associated with Stage 4 be repositioned based on endations, what is on their n." The IDON stated, "R14 tayed up from 9:45 a.m. to 1:30 repositioned. I would expect care plan and physician orders."	F 282	checks, medication and tube feed administrations, three times a we two weeks, then weekly. Audits were reviewed during the quality assur (QA) meeting to determine if any are identified, and recommendation made for continued audits/monitorneeds. Skin alteration: An assessment was completed a monitoring was put into place on 12/16/2015 for R61 related to ide non-pressure skin issues. All residents have the potential to affected by the same practice. Education will be provided to staffected by the same practice. Education will be provided to staffected to provide the necessary services by 1/26/2016. Audits will be completed by the Dand/or designee weekly for reside identified to have non-pressure stissues to ensure monitoring is in Audits will be reviewed during the assurance (QA) meeting to deter any trends are identified, and recommendations made for continudits/monitoring needs.	ek for vill be ance trends ons oring and ntified be f as it gray. ON ents kin place. e qulity mine if	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY PLETED
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F 282	placement. RN-D medications via drand pushing them administering med G-tube with 50 cc Jevity (a calorically tube feeding) 1.5 via the G-tube. RN-D cc of Jevity had be G-tube with 50 cc medication ome preflux disease-GE with 50 cc of wate. The Nutrition Risk as nutritional risk frisk of dehydration typically consumed of meals, swallowing cell cancer of the feedings. The interest.	then continued to administer awing them up into a syringe into the G-tube. After lications RN-D flushed the of water and drew up 50 cc of a dense nutritional formula for with a syringe and pushed it into repeated that action until 225 een given. RN-D flushed the of water than gave the azole (for gastroesophageal RD) and flushed the G-tube r. Care Plan dated 10/8/14, listed actors were cardiac disease, a, low sodium levels, R72 d approximately 10 percent (%) ng difficulty due to squamous throat, and requires tube reventions directed staff to check t prior to feeding and	F 2	82			
	Physician Orders ineoplasm of the maddition, the order	sted on the December 2015 included dysphagia, malignant nouth, GERD, and stroke. In s directed staff to check for prior to feeding and medication					
	gastrostomy tube checked before gir feeding. RN-D stat gastrostomy tube gravity through a s	27 a.m. RN-D verified the placement should have been ving the medication or tube ted they had never given medications or feedings via syringe, "that is old practice." n 12/17/15, at 2:07 p.m. the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	IDON stated, "I wo prepare the medica explain what they a Check placement a separate the plung tube and then pour into the syringe flus done flush the tube hands. You can mit doctor's order." R7 followed for the cheg-tube. Skin alteration: R61's skin alteration to the plan of care. R61 was interviewed and during the intersweater sleeve and observed. When as her R61 denied but through cares/assiston 12/16/15, at 7:10 dressed had a swe wheeling herself in how she had slept was hurting at the farthritis. At 7:30 a.m. to 7: asleep on her w/c and R61 had remobruises noted on the fading bruise noted. At 7:45 a.m. restored.	auld expect the nurses to ations, go into the room and are doing to the resident, and check residuals, if ok, er from the syringe, flush the reach individual medication shing between meds. When expressed and wash at all the meds if you have a 2's plan of care was not ecking of the placement of the expressed if someone had abused to added the staff rushed string her. If o a.m. R61 was observed all eater on seated on the w/c to the day room. When asked R61 stated good but her arm time and thought was from the far corner of the table wed her sweater. There were the left arm fading and another if on the right arm. Orative assistant (RA) ffered to join the exercise and	F 28				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		DATE SURVEY COMPLETED
		245417	B. WING			12/17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CAI	RE CENTER		STREET ADDRESS, CITY, STATE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 5542	E, ZIP CODE TH	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 282	- At 7:59 a.m. RA a look tired do you wa take a nap?" The realt's hot in here." The table offered to rembut resident stated visibleAt 8:08 a.m. reside -At 8:15 a.m. to 8:5 eating breakfast. R61's skin integrity treatment care plan resident was at risk impaired/decreased bowel and bladder adue to the use of As moderate pain and inflammation). The inspect the skin for breakdown. An Occurrence Repconcern had been be facility staff by the several bruises/skin The note indicated bruises/skin conditionally resembled a bruises/skin conditionally resembled a bruises/skin posterior for many scaly lesion; - Right posterior late brown scaly lesion; - Right forearm production of the purple in color and resembled and incomplete and incompl	proached asked R61 "You ant to stay for breakfast or go esident stated "What time is it? RA then wheeled R61 to the love her sweater completely "just leave it." Bruises were ent at the table eyes closed. O a.m. observed resident assessment: preventation and dated 8/14/14, indicated related to a mobility, was incontinent of and was at risk for bruising spirin (used to treat mild to to reduce fever or care plan directed staff to signs and symptoms of cort dated 12/16/15, (after brought to the attention of surveyor), indicated R61 had a conditions to both arms. The measurements of the cons were as follows: earm 2 centimeter (cm) x 1.6 uise; eral forearm 0.6 cm x 0.8 cm attal upper arm 1.4 cm x 1.4 cm scaly; ximal posterior lateral 0.6 cm x	F 2	282		

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	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282	scabbed lesion; - Left lateral upper purple discoloration - Left posterior providesion. On 12/16/15, at 2:3 expect the staff to recondition to the nurasked if it included surveyor and RN-B R61 who was seateroom. When RN-B R61 stated "the kid they grab me." RN-arms stated the brunot able to describe On 12/17/15, at 7:5 investigation had be 12/16/15, after the facility attention prone to bruising reuse, the way reside in the common area When asked even possible causes if sto be investigated so Pressure Ulcer CA due to wheeling set as indicated by the On 12/17/15, at 3:0 expect the NAs to rethe nurse as soon and the nurse need The care plan for R	arm 0.6 cm x 0.4 cm irregular arm 0.6 cm x 0.4 cm irregular arm of the control of	F 28			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	.E CONSTRUCTION (X	(3) DATE SURVEY COMPLETED
		245417	B. WING		12/17/2015
	PROVIDER OR SUPPLIER	RE CENTER	3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 282	Program Manual ef "Monitor area(s) of abrasion, bruise, bu	ge 26 n and Management Clinical fective July 2015, directed skin impairments e.g. urn, excoriation, or rash daily t Administration Record until	F 282		
F 309 SS=D	Each resident must provide the necessary or maintain the high mental, and psycho	CARE/SERVICES FOR EING receive and the facility must ary care and services to attain nest practicable physical, esocial well-being, in e comprehensive assessment	F 309		1/26/16
	by: Based on observate review, the facility for review, the facility for root cause and provent bruising for reviewed for non-preserviewed for non-preservie	0 a.m. R61 was observed all ater on seated on the neeling herself into the day how she had slept R61 stated		F 309 An assessment was completed and monitoring was put into place on 12/16/2015 for R61 related to identife non-pressure skin issues. All residents have the potential to be affected by the same practice. Education will be provided to staff as relates to monitoring and reporting observations related to skin alteration to the team member qualified to provide the necessary services by 1/26/2016 Audits will be completed by the DON	it n(s) ide
	good but her arm w thought was from a	as hurting at the time and rthritis.		and/or designee weekly for residents identifed to have non-pressure skin is	

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	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
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F 309	- At 7:30 a.m. to 7:4 asleep on her w/c of and R61 had remove bruises noted on the fading bruise noted and R61 had remove bruises noted on the fading bruise noted approached R61 of wheeled her into the state of the fading bruise noted approached R61 of wheeled her into the state of the fading bruise and fading bruise noted to the fading breakfast. On 12/16/15, at 8:5 assistant (NA) where the fading breakfast. On 12/16/15, at 8:5 assistant (NA) where the fading breakfast. On 12/16/15, at 8:5 assistant (NA) where the fading breakfast. On 12/16/15, at 8:5 assistant (NA) where the fading breakfast. On 12/16/15, at 8:5 assistant (NA) where the fading breakfast. On 12/16/15, at 8:5 assistant (NA) where the fading breakfast. On 12/16/15, at 8:5 assistant (NA) where the fading breakfast. On 12/16/15, at 8:5 assistant (NA) where the fading breakfast. On 12/16/15, at 8:5 assistant (NA) where the fading breakfast. On 12/16/15, at 8:5 assistant (NA) where the fading breakfast. On 12/16/15, at 8:5 assistant (NA) where the fading breakfast. On 12/16/15, at 8:5 assistant (NA) where the fading breakfast. On 12/16/15, at 8:5 assistant (NA) where the fading breakfast. On 12/16/15, at 8:5 assistant (NA) where the fading breakfast. On 12/16/15, at 8:5 assistant (NA) where the fading breakfast. On 12/16/15, at 8:5 assistant (NA) where the fading breakfast. On 12/16/15, at 8:5 assistant (NA) where the fading breakfast.	In a.m. R61 was observed on the far corner of the table oved her sweater. There were eleft arm fading and another on the right arm. In rative assistant (RA) fered to join the exercise and e group. In proached asked R61 "You and to stay for breakfast or go esident stated "What time is it? In the rove her sweater completely "just leave it." Bruises were ent at the table eyes closed. Of a.m. observed resident I a.m. observed nursing el resident out of the dining in NA-C stated "I will see you do "thank you" as resident er room." I rived resident open the door to	F3	809	to ensure monitoring is in place. As will be reviewed during the quality assurance (QA)meeting to determ any trends are identified, and recommendations made for contin audits/monitoring needs.	ine if	

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	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER	STREET ADDRESS, CITY, STATE, ZIP CO 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422			
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F 309	bowel and bladder due to the use of A moderate pain and inflammation). The inspect the skin for breakdown. R61's Pressure ulc dated 3/19/15, indic pressure related is: in mobility and active R61's diagnoses in non-Alzheimer's dis disorder/epilepsy, a osteoporosis, deprete quarterly Minim 11/25/15. In additions severely impaired of the concern had been facility staff by the several bruises/skin conditions and purple in color and resembled a bruises/skin conditions are resembled as a br	d related to d mobility, was incontinent of and was at risk for bruising spirin (used to treat mild to to reduce fever or care plan directed staff to signs and symptoms of er Care Area Assessment cated R61 was at risk for sues due to being dependent vities of daily living. Cluded dementia sease, seizure anxiety, osteoarthritis, essive disorder obtained from um Data Set (MDS) dated in, the MDS indicated R61 had cognition. Doort dated 12/16/15, (after brought to the attention of surveyor), indicated R61 had in conditions to both arms. The measurements of the ons were as follows: Tearm 2 centimeter (cm) x 1.6 uise; Tearl forearm 0.6 cm x 0.8 cm Stal upper arm 1.4 cm x 1.4 cm scaly; ximal posterior lateral 0.6 cm x	F 30	09		

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F 309	purple discoloration - Left posterior provilesion. On 12/16/15, at 2:3 for interview to detenoted during morni On 12/16/15, at 2:3 (RN)-B stated he wany changes in skin identified with carest bruising. At 2:35 p. room approached for wheelchair in her rollook at R61's arms get them because the bruises on both old bruises and wathe changes. On 12/17/15, at 7:5 nursing (IDON) stated prone to bruising reuse, the way reside in the common are IDON indicated the R61's risk for bruisiaround and position IDON. On 12/17/15, at 3:0 expect the NAs to a the nurse as soon and the nurse need.	arm 0.6 cm x 0.4 cm irregular n; ximal forearm 0.8 cm x 0.4 cm 80 p.m. NA-C was unavailable ermine if the bruises were	F 30	9		

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F 309	"Monitor area(s) of abrasion, bruise, bu using the Treatmen healed"	fective July 2015, directed skin impairments e.g. ırn, excoriation, or rash daily t Administration Record until	F 309			
F 312 SS=D	DEPENDENT RES A resident who is usedaily living receives	ARE PROVIDED FOR IDENTS nable to carry out activities of the necessary services to tion, grooming, and personal	F 312			1/26/16
	by: Based on observate review, the facility for facial hair was prowed for activitic dependent on staff. Findings include: R91 was observed in his room on 12/1 resident face was on R91 was asked about shave every morning seen by a young law 8:49 a.m. R91 was breakfast and still won 12/17/15, at 7:4 seated in the area I unshaven.	ion, interview and document ailed to ensure removal of ided for 1 of 3 residents (R91) es of daily living and who was for shaving. to be sitting in the wheelchair 4/15, at 3:52 p.m. and the overed with facial hair. When but be shaved, he stated "I g" and "it disturbed him to be dy unshaven." On 12/16/15, at in the dining room eating was observed to be unshaven. 5 a.m. and 1:07 p.m. R91 was ounge and remained		F 312 R91 was given extensive assist with shaving needs on 12/18/2015. A facility wide audit was completed 12/18/2015 and 17 male residents noted to require extensive assist with shaving needs. In-servicing will be provided to all start 1/26/2016 that addresses need to provided to all staff by 1/26/2016. It addresses need to provide services qualified persons in accordance with residetn's POC. Staff in-servicing waddress direct observation and active taken if residents are observed unshaven. Audits will be completed by the DO and/or designee that will monitor id residents requiring assit with shave three times a week for two weeks, weekly. The weekly audits will be	on are ith taff by hat s by th each vill also ions to to be N entified ring	

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			E SURVEY IPLETED
	245417	B. WING _		12/	17/2015
PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	•	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETION DATE
going forward, and of any refusals of car R91's care plan dat required extensive which included comand undressing. The Minimum Data indicated R91 recei assist for personal R91 had no behavior cognition level was On 12/17/15, at 10: stated, "told the mashaved]' and the mashaved]' and the mashaved]' and the mashaved and services for peremained unshaved 12/17/15. During interview on interiem director of asked about being requests to be shaw attempt to do it the changes their mind document if the res 483.25(c) TREATM PREVENT/HEAL P	the Nursing Notes were void are. ed 10/25/15, indicated R14 assist with personal hyigene abing of hair, shaving, dressing Set (MDS) dated 10/30/15, ved extensive two person hygiene. The MDS also noted ors of refusal of care and the severely impaired. 52 a.m. nursing assistant-D nager 'yes [R91 needed to be anager was going to go back 43 p.m. registered nurse-B d indicated R91 did not look R91 did not receive the care resonal hygiene as he d from 12/14 15 through 12/17/15, at 2:07 p.m. the nursing stated, "If a resident is shaved and says yes or red, I expect the staff to same day unless the resident. I would expect them to ident refused when asked." ENT/SVCS TO RESSURE SORES		completed during facility Caring I rounds. Audits will be reviewed of quality assurance (QA) meeting determine if any trends are ident recommendations made for contaudits/monitoring needs.	uring the o fied, and	1/26/16
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa going forward, and of any refusals of care plan dat required extensive a which included com and undressing. The Minimum Data indicated R91 recei assist for personal IR91 had no behavior cognition level was On 12/17/15, at 10: stated, "told the mashaved]' and the mashaved]' and the mashaved]' and the mashaved and services for peremained unshaved and services for peremained unshaved 12/17/15. During interview on interiem director of asked about being a requests to be shaw attempt to do it the changes their mind document if the results 483.25(c) TREATM PREVENT/HEAL P	PROVIDER OR SUPPLIER SDALE REHAB & CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 going forward, and the Nursing Notes were void of any refusals of care. R91's care plan dated 10/25/15, indicated R14 required extensive assist with personal hyigene which included combing of hair, shaving, dressing and undressing. The Minimum Data Set (MDS) dated 10/30/15, indicated R91 received extensive two person assist for personal hygiene. The MDS also noted R91 had no behaviors of refusal of care and the cognition level was severely impaired. On 12/17/15, at 10:52 a.m. nursing assistant-D stated, "told the manager 'yes [R91 needed to be shaved]' and the manager was going to go back and do it." On 12/17/15, at 12:43 p.m. registered nurse-B was interviewed and indicated R91 did not look like he got shaved. R91 did not receive the care and services for personal hygiene as he remained unshaved from 12/14 15 through	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 going forward, and the Nursing Notes were void of any refusals of care. 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During interview on 12/17/15, at 2:07 p.m. the interiem director of nursing stated, "If a resident is asked about being shaved and says yes or requests to be shaved, I expect the staff to attempt to do it the same day unless the resident changes their mind. I would expect them to document if the resident refused when asked." 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	PROVIDER OR SUPPLIER SDALE REHAB & CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 going forward, and the Nursing Notes were void of any refusals of care. R91's care plan dated 10/25/15, indicated R14 required extensive assist with personal hygiene which included combing of hair, shaving, dressing and undressing. The Minimum Data Set (MDS) dated 10/30/15, indicated R91 received extensive two person assist for personal hygiene. 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CITY, STATE, ZIP CODE 3130 GRIMBS AVENUE NORTH ROBBINDALE, MN 55422 STREET ADDRESS. CITY, STATE, ZIP CODE 3130 GRIMBS AVENUE NORTH ROBBINDALE, MN 55422 STATE ADDRESS. CITY, STATE, ZIP CODE 3130 GRIMBS AVENUE NORTH ROBBINDALE, MN 55422 SCHAP CHOCHES CHAPTION F 312 SUMMES AVENUE NORTH ROBBINDALE, MN 55422 STATE ADDRESS. CITY, STATE, ZIP CODE 3130 GRIMBS AVENUE NORTH ROBBINDALE, MN 55422 SCHAP CHOCHES CHAPTION GROS-REFIX DEAT NORTH ORTH ADDRESS CITY STATE, ZIP CODE GROS-REFIX DEAT NORTH ORTH ADDRESS CITY STATE Completed during facility Ca	## PROVIDER OR SUPPLIER STAREET ADDRESS, CITY, STATE, ZIP CODE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		E SURVEY PLETED	
		245417	B. WING		12/	17/2015	
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 314	who enters the fact does not develop produced individual's clinical they were unavoidable pressure sores recessives to promot prevent new sores This REQUIREME by: Based on observative, facility faile residents who had pressure ulcers recrepositioning. Findings include: R14's Minimum Daindicated R14 was	lity without pressure sores ressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and e healing, prevent infection and	F 3	,	npleted on ts identified sitioning nendations		
	transfer. The MDS unstageable Stage thickness skin loss tissue necrosis, or supporting structur Undermining and sassociated with Starequired two persombility and had not According to the wnoted: On 11/25/15, unsthickness loss in w covered by slough the true depth of the structure of the struct	further noted R14 had an 4 pressure ulcer (full with extensive destruction, damage to muscle, bone, or es (e.g., tendon, joint capsule. inus tracts also may be age 4 pressure ulcers) R14 in assist for transfers and bed to behaviors of refusing care. Dound sheets the following was ageable ulcer (full-tissue hich the base of the ulcer was or an eschar and, therefore, e damage cannot be se are removed) measured 2.8		In-servicing will be provided staff by 1/26/2016 that addrof the skin integrity assessing prevention program and treat for residents identified with and pressure ulcer treatment. Audits will be completed by and/or designee that will more residents requiring assist with repositioning and pressure attreatments three times a weakened to the weekly. Audits reviewed during the quality (QA) meeting to determine are identified, and recomminate for continued audits/massessimples.	esses a review nent atment POC repositioning nt needs. the DON onitor identified th ulcer eek for two will be assurance if any trends nendations		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	` '	SURVEY PLETED
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	PROVIDER OR SUPPLIER	RE CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	well with no slough - On 12/2/15, unsta X 1.4 cm X 0.4 cm week On 12/9/15, unsta X 0.6 cm X 0.4 cm slough noted On 12/15/15, unscm x 0.6 cm x 0.4c no drainage. Pink i R14's Skin Integrity Treatment Care Plimplement an indivapplicable "q [eventhe left side while if to turn R14 with tw Wheelchair (w/c) p (MD) order. Physician's Order swere to "Reposition every 1 hour in characteristics of the property of the left side while in the following wear of the	A 1.4 cm X 0.4 cm and healing noted. ageable ulcer measured 2.8 cm and no change from last ageable ulcer measured 2.4 cm and healing well with no tageable ulcer measured 2.4 cm and granulation noted with noclor. Assessment:Prevention and an undated, instruct staff to idualized turning schedule in yl 2 hrs [hours]", to lay R14 on hed but not at all times, and o pillows slightly high on side. ositioning per medical doctor signed 11/30/15, indicated staff hevery 2 hours in bed and tir." was observed for repositioning was noted: was up in the w/c with speech	F3	314	needs.		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	` ´com		E SURVEY PLETED
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	PROVIDER OR SUPPLIER SDALE REHAB & CAI	RE CENTER		STREET ADDRESS, CI 3130 GRIMES AVENI ROBBINSDALE, M	UE NORTH	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORF	R'S PLAN OF CORRECTIO RECTIVE ACTION SHOULI RENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	and was asked if shell have not been to have preferred to shell dice game. They sate and the trivile wed and state down yet. At 12:30 p.m. nursinterviewed and state down yet. At 12:31 p.m. a set NA-D, remarked, "Nahe was playing dident and the down." On 12/17/15, at 10: would ask for assist the bathroom facilit repositioned every shed down after means at 12:33 p.m. RNhere and the doctor RN-B remarked, "S reposition her every with turning and remarked we were having the wound had bee months and the fact weekly.	25 p.m. R14 was interviewed ne had laid down. R14 replied, bed. I did not refuse. I would leep in my bed. I did enjoy the aid I need to eat." sing assistant (NA)-B was ted, "I have not laid her [R14] econd NA was interviewed and No, I have not laid her down ee and it is lunch now." tered nurse (RN)-B stated, bed between breakfast and y only keep her up a couple of ave not seen her refuse to lay 38 a.m. NA-C stated R14 tance when she needs to use ies. R14 was to be two hours from left to right and o bed. D stated R14 was to be two hours and sometimes he chair the aide(s) would lay		14			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	(X3) DATE COMP	
		245417	B. WING _	·····	12/	17/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 314 F 322 SS=D	asked about being requests to be shave attempt to do it the changes their mind document if the rest 483.25(g)(2) NG TRESTORE EATING. Based on the compresident, the facility (1) A resident who halone or with assist tube unless the rest demonstrates that unavoidable; and (2) A resident who is gastrostomy tube retreatment and service pneumonia, diarrhemetabolic abnormalistics.	shaved and says yes or yed, I expect the staff to same day unless the resident. I would expect them to ident refused when asked." REATMENT/SERVICES -	F 31			1/26/16
	by: Based on observative review, the facility for checked placement (G-tube) prior to inf	NT is not met as evidenced ion, interview, and document ailed to ensure nursing staff of a gastrostomy tube using medication and formula R72) observed to have a tube survey.		F 322 R72's Order and POC was review 12/17/2015 as it relates to G-tube placement, medication administr nutritional formula tube feeding administration. Resident recieves	e ation and	

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NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	,2010
ROBBIN	SDALE REHAB & CA	RE CENTER			30 GRIMES AVENUE NORTH OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETION DATE
F 322	enteral feeding via until 9:27 a.m. regiobserved to flush to centimeters (cc) of placement. RN-D to medications via drand pushing them administering medications with 50 cc. Jevity (a calorically tube feeding) 1.5 with the G-tube. RN-D cc of Jevity had be G-tube with 50 cc. medication omeprate flux disease-GE 50 cc of water. The Nutrition Risk as nutritional risk for dehydration, low so consumed approximeals, swallowing cancer of the throat The interventions of placement prior to administration. Nutritional Status of 8/18/15, indicated nutrition via feedinunsafe weight cha aspiration or choking the consumed approximation or choking the consumed approximation.	administration observation and R72's G-tube from 8:34 a.m. stered nurse (RN)-D was he G-tube with 100 cubic water without first checking then continued to administer awing them up into a syringe into the G-tube. After ications RN-D flushed the of water and drew up 50 cc of dense nutritional formula for with a syringe and pushed it into repeated that action until 225 are given. RN-D flushed the of water than gave the azole (for gastroesophageal RD) and flushed the g-tube with Care Plan dated 10/8/14, listed actors: cardiac disease, risk of odium levels, (R72) typically mately 10 percent (%) of difficulty due to squamous cell at, and requires tube feedings. directed staff to check for tube feeding and medication care area assessment dated R72 received the majority of g tube and was at risk for nges, dehydration and	F3	322	feedings, which is tolerated without sympotms of adverse affects, to all increased independence rather that a continuous tube feeding formula administered. RN-D was provided re-education as it relates to bolus to feedings, g-tube placement verification and G-tube medication administration 12/28/2015. A facility wide audit was completed 12/17/2015 and four residetns were identified that have the potential to affected by this practice. In-servicing will be provided to nurse staff by 1/26/2016 that addresses standards of practice as it relates to G-tubes utilizing facility policies and procedures as well as the CMS tube feeding status critical element path tool. Audits will be completed by the DO and/or designee that will monitor id residents requireing G-tube placement checks, medicaiton and tube feeding administrations, three times a weel two weeks, then weekly. Audits will reviewed during the quality assurar (QA) meeting to determine if any trare identified, and recommendation made for continued audits/monitorineeds.	low un have ube ation ion on e be sing o d be way o N lentified nent ng k for I be nce rends ns	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245417	B. WING _		12	/17/2015	
	PROVIDER OR SUPPLIER SDALE REHAB & CA			STREET ADDRESS, CITY, STATE, ZIP CO 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422			
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F 322	11/12/15, indicated received "51 % or through the feeding. R72's diagnoses liphysician Orders in neoplasm of the mobstructive pulmor addition, the orders G-tube placement administration. On 12/17/15, at 9:3 gastrostomy tube proceeding. RN-D stated gastrostomy tube in gravity through a subject of the nurse stand residuals before RN-A verified when medication by a Gravible with water medications, take medications, take medications, rinse the feeding tube." During interview or interim director of the nurses to preparoom and explain water grown and expla	R72 was cognitively intact and more" of his total calories	F 32	22			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245417	B. WING		12/17/2015	
	PROVIDER OR SUPPLIER	RE CENTER	;	STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTION	
F 322	into the syringe flus done flush the tube hands. You can mix doctor's order."	ge 38 hing between meds. When , remove gloves and wash a all the meds if you have a	F 322			
F 323 SS=E	instructed staff to: "10. Verify tube placa. install 10-20 tube while simultan left upper quadrant stethoscope to valid stomach and b. Aspirate 2-10 reinstall." "13. Remove plung	cement. mL [milliliters] of air into the eously auscultating over the of the abdomen with a date air movement in the 0 mL of gastric contents and er from syringe, attach syringe ation(s) into syringe, and allow	F 323		1/26/16	
	environment remain as is possible; and	sure that the resident ns as free of accident hazards each resident receives on and assistance devices to				
	by: Based on observat review, the facility for smoking materials of residents (R167, R4 R168, R135). In add	NT is not met as evidenced ion, interview and document ailed to ensure supervision for was provided for 9 of 16 43, R31, R41, R72, R68, R8, dition, the facility failed to was properly used for 1 of 1		F 323 Smoking: On 12/22/2015 the smoking safety collection and assessment was confor R167 and resident's status has improved and R167 is now assessed.	npleted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245417	B. WING		12/1	7/2015
NAME OF F	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1	.,
ROBBIN	SDALE REHAB & CA	ARE CENTER		3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	Continued From page	age 39	F 323	3		
	residents (R13) wh	an independent smoker. R167's family				
	Findings include:			and the POC were updated. On 12/22/2015 the smoking policy and procedure was reviewed with R167		
	12/15, 12/16, and observations were (three sided tent) in Ave entrance. The three wooden bend cigarette butts stree front door to the smoking receppolicy directed smoking receppolicy directed smoking a locked drawer assessed as depermaterials secured R167 was identified and was admitted diagnosis of right in (spread) to brain with tumor is pressing to the smoking receppolicy directed smoking receptor directed smoking rec	g of 12/14, and the days of 12/17/15, of the survey, made of the smoking structure in the parking lot on the Grimes are were burn marks in three of ches in the smoking area, and the swing of the structure. Cigarette and in the garbage can, next to stacle. The facility smoking obkers assessed as a keep their smoking materials in their room. Smokers in the medication rooms. If you have smoking in the medication rooms. If you have smoking in the facility on 12/10/15, with the same and the side, causing the basis.		On 12/29/2015 the smoking policy procedure was reviewed with R43 guardian and the POC was update On 12/24/2015 the smoking policy procedure was reviewed with R31, R72, and R68. On 12/24/2015 the smoking policy procedure was reviewed with R118 the resident is identified as R8 on statement of deficiencies, but upor this is a typo and should read "R11 there is no R8 on the listing provide the survey team member. R168 was discharged; however, a smoking safety data collection and assessment was completed as we review of the smoking policy and procedure prior to discharge. R135 was discharged.	and ed. and R41, and B. Note the review 8" as ed by	
	would provide smoking secondar. The Smoking Safe Assessment dated could not light his windy, due to use able to let go of cig to weakness. R16	ed 12/10/15, indicated family oking materials and assist with		A facility wide audit was completed 12/17/2015 and fifteen residents he potential to be affected by this practical becking drawers were provided for identified resdients on 12/31/2015. staff will be in-serviced by 1/26/2015 smoking policy and procedure as winterventions in place for identified residents. Audits will be completed by the Dir Social Services and/or designee the monitor random identified residents.	ave the ctice. with all All 16 on vell as	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
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	PROVIDER OR SUPPLIEF			3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH COBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	On 12/15/15, at 1: his cigarettes and easy retrieval. R16 his family outside, cigarettes and ligh he knew they show station. On 12/15/15, the fand also identified area, and directed residents for safe On 12/16/15, at 9: (LPN)-C stated R1 the 4th floor medic were observed in the 4th floor medic were observed in the cigarettes and With permission the cigarettes and pocket. R43's quarterly Mi 9/11/15, indicated cognition. Elopemindicated resident smoking program floor/unit/room after R43's diagnoses in depressive disorder encephalopathy of record dated 10/13. The Smoking Safe	255 p.m. R167 stated he kept lighter in his coat pocket for 27 stated he only smoked with he just liked to keep the ter in his pocket, even though ald be kept at the nursing rice marshal surveyed the facility the issues with the smoking the facility to reassess all smoking. 255 a.m. licensed practical nurse 67's cigarettes were secured in eation room. The cigarettes the medication room. 200 a.m. R167 stated the social took his cigarettes last night. The jacket pocket was checked, lighter were no longer in the simum Data Set (MDS) dated R43 had severely impaired ent plan of care dated 9/11/15, had dementia and was on a and always returned to the er going out to smoke.	F3	323	times a week for one week, then the times a week for one week, and we thereafter. Audits will aslo include the cigarettes are being properly disposed. Audits will be reviewed during the quassurance (QA) meeting to determine any trends are identified, and recommendations made for continuaudits/monitoring needs. Safe transfers: On 12/28/2015 Director of Rehability (DOR) completed a clincial review the assist in modifications to R13's POO relates to transfers and toilet use. POC was updated. A facility wide audit was completed 12/17/2015 and twenty residents has potential to be affected by this practive which staff use the mechanical lift. Inservicing will be provided to nurse staff by 1/26/2016 that addresses standards of practice as it relates to transfer techniques. Audits will be completed by the DOI and/or designee that will monitor idea residents requiring transfer assist, including those residents who requires of a mechanical lift, three times week for two weeks, then weekly. A will be reviewed during the quality assurance(QA) meeting to determinany trends are identified, and recommendations made for continuaudits/monitoring needs.	ekly nat sed of. uality ne if led ration o C as it R13's on ave the tice for ling o safe N entified re the s a udits ne if	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON A. BUILDING	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED				
		245417	B. WING _		12	/17/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	independent smok did not indicated stilighters had been runderstood where policy. On 12/15/15, at 9: smoking area loca entrance door survigarbage with the instationed outside to a clear plastic baging cigarette butts wer can. Right next to cigarette receptaciand cigarette butts hole. Also noticed the area on the floopast the yellow line inside the smoking marks along the sinobservation two rewhich included R4: observed dispose receptacle by the general after putting went into the buildiculation clothing checked in the smoke receptacle observed to be full observed inside the smoke receptacle observed inside the observed inside the smoke receptacle observed to be full observed inside the smoke receptacle observed to be full observed inside the smoke receptacle observed to be full observed inside the smoke receptacle observed to be full observed to be full observed to be full observed to served two	er, however the assessment torage of the cigarettes, and reviewed to ensure R43 to store them per the facility 11 a.m. during a tour to the ted to the left side of the reyors observed a concert iside made of hard plastic the tent. The can was lined with and trash with multiple e observed disposed in the garbage can was a black that was observed to be filled were seated on the receptacle were several cigarettes butts in or all the way to the entrance and the benches located tent were observed with burn ting part. At the time of sidents in the area smoking and the lighter in her jacket and ing. During observation R43's to burns holes noted. 45 p.m. observed several tent smoking at the time. The stationed by the garbage can and some cigarette butts the garbage can at the time.	F 32	23		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	` '	E SURVEY PLETED
		245417	B. WING			12/ ⁻	17/2015
	PROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	director and several were present. On 12/15/15, at 1: (HKA)-A stated "I at the smokers go out and has not seen to she could do if she around the room. If find cigarettes for a around the room some nurse to make surthave the cigarettes around the room and the room are room and the room are room are room and the room are room are room and the room are room ar	oring the tour the executive all other management staff on p.m. housekeeping aide actually do not see that many it as they go when they want them stored when asked what it is saw the cigarettes stored all the HKA further stated if she would a resident who left them lying the would bring them to the ite the resident was supposed to	F3	23	DEFICIENCY)		
	them knew the fac they were not sure back to surveyor. V smoking supplies to	oom. When asked if either of ility smoking policy both stated at this time and would get When asked specifically about being locked both stated they and would be getting back to					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING			12/ ⁻	17/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS 3130 GRIMES AV ROBBINSDALE		•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH C	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD FERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	not supposed to sm have the tank at the would not get it after would not get it after on the facility for five yout smoking with oxygen the facility for five yout smoking with oxygen the facility for five yout smoking policy ED orientation. ED stat flag as not being sat the assessment and would help and in the had to swap cigare the past they have had been very relia expect all the staff is stated she would notice the safety but the answers exactly about storage of cig stated if residents he safe like in their assessed to be safe supplies. ED also se cigarettes and othe bed it would flag for re-assessed. When were done to make through with the po audits and would chany concerns would further stated she he	oth indicated residents were noke with oxygen and would of front of the building and er they are done smoking. 1 p.m. the executive director do not seen any resident out and ED stated she had worked at ears and had not had anyone exygen. When asked about the stated was done on general ed "We have not had anyone at a some of the unit managers are past some residents have attes with their oxygen tank. In left the tank at the front and able." When asked if she would not know the smoking policy ED on the expect as this was more the staff should be able to be able to know to the policy. When asked garettes and other supplies ED and on their possession would pockets as they had been at the tated if a resident would take are supplies and left them on the asked about checks/audits sure residents followed licy ED stated she did do neck and if she had noticed do address it immediately. ED and not seen any concerns and thought the facility had one	F3	23			

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245417	B. WING _		12	2/17/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	and HKA-A approa would be able to ke also have them sto rooms which they lead to have them storooms which they lead to have them storooms which they lead to have them storooms which they lead to have a sessment/plan or indicated resident first floor. Intervent jacket and remind not wearing a jacker rules and conseque the Care Area Assindicated cognitive 5/15/15, indicated to him of the fall injury assimanagement plan dated 12/15/15, indicated the smoking policy and him of the smoking onto can for resider request assist. R31's smoking saff assessments date an independent sm smoking policy ward goals and interven Smoking assessments dated an independent sm smoking policy war goals and intervents of the plan of cared the plan of	a.m. both the floor care tech ached and stated residents eep the cigarettes on them and ored in the cabinets in their had a key to. The ehavior symptom of care rewritten 5/8/15, smoking in-between door on tions included offer to get of risks and consequences of et. Re-direct and remind of ences. The essment (CAA) dated 5/18/15, impairment. CAA dated poor memory. The essment: prevention and of care dated 5/15, plan entry dicated resident found to have boom, goal was to comply with dintervention was to remind goolicy. Maintenance will hold ent and when he wants to refill ety data collection and dint/6/15, indicated R31 was noker. Non-compliance with schecked along with address tions on the plan of care. ent dated 8/27/15, 5/8/15, and esident was an independent seessment would be addressed	F 32	23			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245417	B. WING _		12	/17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	disease. The comprehensive dated 11/18/15, ind smoking safety dat reviewed and updated. On 12/15/15, at 11: cigarettes observed observed R31 in his hall toward his roor and had a pack of R31 indicated he rothad done that for twice shoppers get mater received some toda which was used as table was a rolling approximately four lighter fluid bottle owhich stated flamm stated the Zippo sh 10 rolled cigarettes stated other resident they ask permission. On 12/15/15, at 12: (RN)-A stated he wilghter fluid. R31 stated it would RN-A stated it was p.m. RN-A stated he	e care plan review summary icated R31 was a smoker, ed collection and assessment ted and care plan reviewed 49 a.m. R31 not in room, no d in room. At 11:57 a.m. swheelchair going down the n. R31 stated he did smoke cigarettes in his wheelchair. olled his own cigarettes and vo years now. He stated rials for him and that he ay. In the room next to his, a library, observed on the machine, tobacco, lighters in a drawer, and a BiC with him. He also had a Zippo in the shelf above the table, rable on the outside. R31 ould be tossed. R31 also had in a box on the table. R31 nts do not wander in the room, in to come into his library. 109 p.m. registered nurse as not aware of the Zippo ated it should be tossed and d be tossed. At 12:17 p.m. disposed of properly. At 12:57 e gave it to the maintenance hey had a locked place in their	F 32	3		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245417	B. WING		12	/17/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	management plan R41 rolled her own R41's smoking sat assessments date indicated R41 was address goals and care were checked it was written in "rechanges-signed by The quarterly MDS was cognitively intanemia and hyper The Comprehensidated 10/9/15, indismoking safety dareviewed and updated. On 12/15/15, at 11 in her room and st today. R41 opened drawer and showe R41 had two pack drawer and half (1/2)	sessment: prevention and of care dated 5/14 indicated of care dated 5/14 indicated of cigarettes occasionally. Sety data collection and double of the date of the	F3	23		
	care plan dated re	ehavior symptom assessment written 10/3/14, entry dated 2 started to roll his own				
	R72's smoking sa	fety data collection and				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY PLETED
		245417	B. WING		·····	12 /	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		31	REET ADDRESS, CITY, STATE, ZIP CODE 30 GRIMES AVENUE NORTH DBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	and 11/12/15 indical independent smoke interventions on the R72's Fall/injury as management pland indicated R72 was. The CAA dated 8/1 cognitive impairment. The quarterly MDS was cognitively intal anemia, hypertensiand dementia. The comprehensive dated 11/25/15, ind. On 12/15/15, at 11: room to have six er top of the refrigeration top of the dresse cigarettes were obsiding are to smoke outsino cigarettes in his. R68 On 12/15/15, at 12: smoked and kept a lighter in her camp smoked about two R68's 11/25/15, sm.	I 2/14/15, 5/15/15, 8/12/15, ated resident was an er and address goals and explan of care were checked. Sessment: prevention and of care dated 8/12/15, independent with smoking. 8/15, indicated R72 had ent. dated 11/12/15, indicated R72 ct and diagnoses included on, cerebrovascular accident excare plan review summary icated R72 was a smoker. 44 a.m. observed resident's explant three empty packages er table eight individual erved on the bedside table, in a pack in his hat, along with side table. R72 stated he was ide anytime and stated he had	F 3	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245417	B. WING		 	12/17/2015	
	PROVIDER OR SUPPLIER	RE CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	D BE COMPLÉTIO	
F 323	goals and intervent checked. The quarterly MDS was cognitively into cerebrovascular actions and lighter sitting of the community of the commu	dout at desk" and address tions on the plan of care was dated 11/25/15, indicated R68 act and diagnoses included cident.	F3	323	BEHOLINOTI		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING	COMPLETED
245417 B. WING	12/17/2015
NAME OF PROVIDER OR SUPPLIER ROBBINSDALE REHAB & CARE CENTER STREET ADDRESS, 0 3130 GRIMES AVE ROBBINSDALE,	CITY, STATE, ZIP CODE NUE NORTH
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COI	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 323 Continued From page 49 management care plan dated 12/9/15, indicated fall/injury risk related to smoking. The undated comprehensive care plan review summary for R168 indicated smoker. On 12/15/15, at 12:59 p.m. nursing assistant (NA)-A stated if she saw smoking materials she would report it to the nurse and charge nurse. There was no smoking allowed in the building, residents have to smoke in the area outside. On 12/15/15, at 1:01 p.m. LPN-A stated sometimes she saw materials in certain rooms, usually a lighter, roll paper and bags of tobacco. If they were not harming anything she would let it be. If the resident was at risk she would involve social services. Social services divided cigarettes and handed them out in the morning. Social services supplies cigarettes to residents and they are purchased with resident's money. A resident must go outside past the door, past the line to the smoke shack. Some people have had certain smoking times in the past, they would keep a lighter at the desk, would go downstairs with a resident, light their cigarettes, watched them smoke and brought them back upstairs. On 12/15/15, at 1:11 p.m. NA-B stated if she saw smoking materials in rooms she would take it to the nurse's station. NA-B stated she was not aware of the smoking policy. On 12/15/15, at 1:14 p.m. RN-A stated he did not know what he would do if he saw smoking materials out and about. It is their home if they want to leave smoking materials on their table.	

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	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	concerns with cigar a concern he would locked up. RN-A stramoking policy thorough the policy thorough the policy thorough the policy through the policy to make the policy to reason the policy to rea	rette stealers. If they did have d suggest the cigarettes were ated he had not read the roughly. If a resident was a , the cigarettes and lighter eaning they could not smoke did have one resident who stribute her cigarettes. She had on the medication cart to avoid g spent on cigarettes. RN-A se was an independent ed he would refer to the ead it. RN-A stated he was not in charge of the policy or how it. If to the facility on 7/23/15, and he facility as a smoker on the ensive Admission Data assment dated 7/23/15. Nursing lmission Data Collection an ted, "Complete Smoking tion and Assessment, if yes (or	F 3.	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245417	B. WING _		12	/17/2015
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	Assessment dated assessed as an ind R135's Fall/Injury A Management Care "Assessment Fall/In (independent) Goal smoking daily Intersmoking policy." R135's Fall/Injury A Management Care "Assessment Fall/In (independent) Goal smoking daily Intersmoking policy." R135's Social Serv page 2 dated 7/30/smoking in his roor "Resident's cigarett nurses station. Staf smoke, but family room. On 12/15/15, at 1:0 aware of the smoki yes a resident can room. On 12/15/15, at 1:1 facility enforces the we ensure the resid have to intervene to have a family mem	y Data Collection and 7/30/15, indicated R135 was	F 32	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING _		12	/17/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
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F 323	the interim director about R135 smoki there would have a Requested IDON I as it was not provid Also requested coprogress notes for director of nursing does the smoking resident who is ideadmission have a completed DON st (SW)-A], she will k During interview or said if residents wassessment on the day, otherwise I had They (resident) mas smoked since the talk to the resident smoking protocol a regulations. I was transitional care unworker will talk to the smoke in their roof MN (Minnesota) S 2014, directed: "1. All residents who was transitional care unworker will talk to the smoke in their roof MN (Minnesota) S 2014, directed: "1. All residents who was a moke independed and smoke independent and smoke independed and smoke independed and smoke independed and smoke independed	n 12/17/15, at 2:07 p.m. when of nurses (IDON) was asked in in room in July, IDON stated been an incident report. Ocate it and provide to surveyor ded when requested earlier. Dy of smoking assessment and 7/23 through 7/301/15. The (DON) stated social service assessments. When should a entified to smoke upon smoking assessment and 12/17/15, at 3:45 p.m. SW-A and to smoke I do the eday of admission or the next old off until they want to smoke. By say they smoke but have not by have been in the hospital. It is upon admission about the and let them know there are off on 7/23/15, and 7/24/15. If a nit resident admits the social the resident. Residents can not more moking policy revised January and smoke will be evaluated uarterly, and with a significant in, to determine any special d to assess their ability to	F 32	3		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	smokers may retain material per the case a locked storage case residents must adhorequirements: Combustible itematerials will not between the key in the No smoking migiven to another retailed.	g area are assessed as "Independent in possession of their smoking ire plan. In such circumstances abinet will be provided. Such itere to the following items other than smoking items other than smoking items other than smoking items of the locked cabinet item will be locked at all times possession of the resident aterials will be stored for or sident" follow the policy as the either or both smoking	F3	23			
	R13 was observed morning cares. The R13 indicated she was assisted to the assist. When the N around R13 the be "tight." The belt wa not fit. The Velcro stransfer R13 to the into the correct pos R13 was lowered to toilet use R13 was by having staff tilt t accommodate the legs could not spreed R13 was admitted admission diagnos (loss of use of one	on 12/16/15, at 7:38 a.m. for a cares were completed NA-C. had to use the bathroom. R13 a edge of the bed by two NA IA-C went to put the safety belt it would not fit as it was too is adjusted and again it would safety straps were not used to toilet. NA-C assisted the stand sition over the toilet and then it is on the toilet. After the placed in the wheelchair (w/c) he w/c backwards to legs of the stand as the stand and as wide as the w/c width.					

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F 323	thoughts). The annual CAA dunable to participal and refusals of car staff and a stand a incontinent and no schedule. The care plan date two staff with "EZ sfor bed/chair/toilet. The quarterly MDS was cognitively intarequired extensive mechanical stand R13 also had no factor of the work of the work of the work of the work of the work." On 12/17/15, at 7:3 while since they have to lift the work of the work of the work. On 12/17/15, at 7:3 while since they have back far enough to get of the work. On 12/17/15, at 2:3 and indicated the sand they should have and they should have september 2014, sept	(difficulty with expressing ated 3/6/15, indicated R13 was te in cares due to body habitus te. R13 required assist of two ssist lift to toilet, was usually noompliant with toileting ed 3/9/15, indicated assist of stand" [Stand Up Patient Lift]	F3	323			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245417	B. WING		12/	/17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE
F 329 SS=D	Patient Lift dated 20 attachments are not patient back onto the correct this problem may occur." Staff we damage to all parts any pivot for slings deformation or determined defective parts IMM the lift is not used to 483.25(I) DRUG REUNNECESSARY DECENSARY	manual for the Stand Up 010 directed staff "if any of properly in place, lower the ne stationary surface and n - otherwise, injury or damage were to also detect wear and se.g. "slings, lifting arm and for signs of cracking, fraying, erioration. Replace any MEDIATELY and ensure that until repairs are made." EGIMEN IS FREE FROM ORUGS or gregimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nces which indicate the dose or discontinued; or any	F3			1/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	` ´COMBLET		
		245417	B. WING		12/1	7/2015
_	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER	3	STREET ADDRESS, CITY, STATE, ZIP CODE 1130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	Continued From pa	ige 56	F 329			
	by: Based on interview did not ensure adverse being completed for reviewed for unnect. Findings include: R68's Care Area Assindicated R68 recemedications. The facility's consuct Consultation Report dated 5/12/15, included the second seco	Itant pharmacy report entitled, to Omnicare of Minnesota uded: "receives an sereported to have fallen or be Please consider monitoring sures (BP) at least for orthostatic hypotension per advised by prescriber)." The seed any evidence of this been brought forward to the gain even though no ressures for R68 had been ay of 2015. Ininistration Record (MAR) lated 5/13/15, for orthostatic be completed monthly, if schotic. R68's MAR for May nitoring of orthostatic blood been completed. In addition,		F 329 Medication monitoring including poblood pressures, (e.g. orthostatic by pressures) for R68 was put into plat 12/28/2015. All residents have the potential to be affected by this same practice; how facility wide audit was completed of 12/28/2015 and fourteen residents identified at risk for monitoring nee postural blood pressure needs. Nursing staff will be in-serviced by 1/26/2016 on policy and procedure psychoactive medication symptom assessment/care plan needs. Audits will be completed by the DC and/or designee for identified residensure adequate monitoring is in pweekly. Audits will be reviewed dur quality assurance (QA) meeting to determine if any trends are identified recommendations made for continuadits/monitoring needs.	elood ace on one wever, a on were ds for on one one one one one one one one one	
	antipsychotic, and i at high risk for falls postural blood pres monthly/assessing facility policy (or as medical record lack irregularity having be facility's attention a orthostatic blood precompleted since M. The Medication Addincluded an order of blood pressures to utilizing an antipsych 2015 indicated mor pressures had not be medical record. Treatment Adminis	s reported to have fallen or be Please consider monitoring sures (BP) at least for orthostatic hypotension per advised by prescriber)." The sed any evidence of this been brought forward to the gain even though no ressures for R68 had been ay of 2015. ministration Record (MAR) lated 5/13/15, for orthostatic be completed monthly, if shotic. R68's MAR for May nitoring of orthostatic blood		psychoactive medication symptom assessment/care plan needs. Audits will be completed by the DC and/or designee for identified resid ensure adequate monitoring is in p weekly. Audits will be reviewed dur quality assurance (QA) meeting to determine if any trends are identified recommendations made for continuous.	on ents to lace ing the	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING _		12	2/17/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CC 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		, , <u>-</u>
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F 329	November of 2015 The facility provide dated 5/15/15. The interventions for act for R68's use of Set Zoloft (an antidepression an opportunity to happropriate for succession of the plan remained Repetitive physical sitting, hypotension unsteady gait, fall is 31-180 days, hip from weight loss and ort R68's quarterly Mir 11/27/15, indicated had diagnoses inclus accident, traumatic depression. R68 was activities of daily live and set up help on MDS also indicated facility on 4/16/15. The signed Physical indicated R68 recession (mg) every morning mood disorder. Starisk of psychopharinoted staff were to the medical record The licensed nurse monitoring for the medications however orthostatic blood potential indicated place.	d R68's current care plan care plan lacked any diverse side effect monitoring eroquel (an antipsychotic) or essant). Although there was ave selected interventions the monitoring, an entire section ed unchecked including: movement, balance while n, dizziness/vertigo, syncope, n past 30 days, fall in past acture, swallowing problem,	F 32	29		

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING _		12/	17/2015	
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F 329	(RN)-B stated they blood pressures. On 12/17/15 at 3:23 nursing (IDON) stat documentation indic pressures were being confirmed she experimplemented in accomplemented in acco	use of Seroquel. 9 a.m., registered nurse did not monitor orthostatic 8 p.m., the interim director of red she did not see cating orthostatic blooding monitored. The IDON rected such monitoring to be ordance with the consultant	F 32	29			
F 332 SS=D	dated 7/15, directed side effects as indice Medication Symptom R68's care plan data symptoms to monite 483.25(m)(1) FREE RATES OF 5% OR	OF MEDICATION ERROR MORE	F 33	32		1/26/16	
		sure that it is free of tes of five percent or greater.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	SURVEY PLETED		
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	PROVIDER OR SUPPLIER	RE CENTER	3	TREET ADDRESS, CITY, STATE, ZIP CODE 1130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	- -	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 332	Continued From pa	age 59	F 332			
	by: Based on observareview, facility faile for 2 of 7 Residents medication adminis 7.7% medication e Findings include: Gastrostomy tube R72's G-Tube medication was 9:27 a.m. registere to crush the listed rablue plastic cup. The medications was 1 milligrams (mg) (a muscle relaxer) (an antidepressant Finasteride (treatm hyperplasia (BPH) Norco (an analgesi Keppra (used to treatblet, and Calcium units (promote bon milliliters (ml) of on gastroesophageal as ordered by the I Orders. RN-D put on glove centimeter) syringe pushed it into the Coco of water and	(G-Tube) administration: lication administration and sobserved from 8:34 a.m. until d nurse (RN)-D was observed medications and place them in ere Aspirin (a mild analgesic) chewable one tablet, Baclofen 10 mg one tablet, Wellbutrin) 75 mg two tablets, ent of benign prostatic		F 332 G-Tube placement: R72's Orders and POC was review 12/17/2015 as it relates to G-tube placement, medication administrati nutritional formula tube feeding administration. Resident receives be feedings, which is tolerated without symptoms of adverse affects, to all increased independence rather tha a continuous tube feeding formula administered. RN-D was provided re-education as it relates to bolus to feedings, g-tube placement verificated and G-tube medication administration 12/28/2015. A facility wide audit was completed 12/17/2015 and four residents were identified that have the potential to affected by this practice. In-servicing will be provided to staff 1/26/2016 that addresses standard practice as it relates to G-tubes and feedings. Audits will be completed by the DO and/or designee that will monitor id residents requiring G-tube placement checks, medication and tube feeding administrations, three times a week two weeks, the weekly. Audits will be reviewed durign the qulaity assurar (QA) meeting to determine if any trare identified, and recommendation	on and olus sign or ow for n have ube tion on on e be by s of d tube N entified ent ng c for oe ice ends	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		245417	B. WING _		12/	17/2015	
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	OULD BE	(X5) COMPLETION DATE	
F 332	the 60 cc syringe F and pushed the methen threw the plasmedications in the lumps in bottom of G-tube with 50 cc Jevity (nutritional sand pushed it into Jevity had been giwith 50 cc of water flushed the G-tube layer of omeprazol cup. R72's quarterly Min 11/12/15, indicated was independent with the exception of earn light and "Check for G-tand medication and 250 ml of water at PM, 4 PM and 8 P At 12/17/15, at 9:2 medication powder bottom of the cup of RN-D verified that the crushed medic RN-D also verified omeprazole still had better the company to the company the	taining the medications. Using RN-D drew up the medication eds into the G-Tube. RN-D stic cup that had contained the trash with white liquid and cup. RN-D then flushed the of water and drew up 50 cc of upplement) 1.5 with a syringe the G-Tube until 225 cc of ven. RN-d flushed the G-tube than gave the omeprazole and with 50 cc of water. A visible e remained in the medication nimum Data Set (MDS) dated R72 was cognitively intact and with activities of daily living with ating. Sted on the December 2015 included dysphagia, and m of the mouth. In addition, the corush and give meds 60 ML [milliliters] of H2O leds," "Give all Meds via GT," sube placement prior to feeding ministration. Flush G-tube with 12 midnight, 9 AM, 12 PM, 2	F 3:	made for continued audits/morneeds. Insulin administration On 12/28/2015 R76's blood sureviewed and results were disc the diabetic clinic with no new noted. Resident is without any effects noted related to this pray A facility wide audit was completed 12/28/2015 and sixteen reside the potential to be affected. Nursing staff will be in-serviced 1/26/2016 and will include polic procedures related to insulin in utilization of FlexPens, glucose and infection control. Audits will be completed by the and/or designee that will monit residents requiring insulin injectimes a week for two weeks, the Audits will be reviewed during assurance (QA) meeeting to dany trends are identified, and recommendations made for containing needs.	gars were cussed with orders adverse actice. eted on a have dispection, e monitoring e DON or identified etions three en weekly, the quality etermine if		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245417	B. WING _	·····	12	/17/2015	
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 332	should have been of medication or tube never given gastrosfeedings via gravity practice." During interview or stated a nurse sho residuals before given tube. RN-A verified medication by a G-G-tube with water to medications, take to medication in the standing water to the the medication. You medications, rinse the feeding tube. During interview or interim director of respect the nurses into the room and of the residuals, if ok, sepsyringe, flush the transitional medication between meds. Wheremove gloves and the meds if you have the medication of	checked before giving the feeding. RN-D stated had stomy tube medications or through a syringe, "that is old in 12/17/15, at 9:33 a.m. RN-A and check placement and ving anything by a gastrostomy when a nurse administers tube they would flush the then add water to the crushed the syringe apart, pour the yringe. You might have to keep a cup to make sure you get it all a would then do liquid out cup. Then you would flush in 12/17/15, at 2:07 p.m. the nursing (IDON) stated, "I would to prepare the medications, go explain what they are doing to a placement and check parate the plunger from the sube and then pour each on into the syringe flushing then done flush the tube, I wash hands. You can mix all we a doctor's order." Therefore the dated July 2015 The cement of air into the tube while scultating over the left upper domen with a stethoscope to	F 33				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245417	B. WING			12/	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CAI	RE CENTER		31	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 332	b. Aspirate 2-10 reinstall." "13. Remove plung to tube pour medicate of flow by gravity." It dose of medications Insulin administratic R76s Admission Reindicated R76 had or R76's blood sugars ranged from a low of the Physicians Ord 2015, directed staff Flexpen (used to counit/milliliter sliding with meals For blood 201-250=8 units 25 units, 351-400= 20 than 400 =24 units. During medication at 12/16/15, at 12:18 processed and would need eight attached the needle units for administration the stopper of the Normal prime the pen. LPN alcohol wipe and grid Novolog. Surveyor and had LPN-B con Flexpen. LPN-B did	o mL of gastric contents and er from syringe, attach syringe ation(s) into syringe, and allow R72 did not receive the full s as ordered by the physician.	F3	32			
		S dated 10/15/15, indicated rintact. Diagnosis identified on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER SDALE REHAB & CAI	RE CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	•	
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F 332	the MDS include dia During interview on interview LPN-B sta priming a Flexpen. the top. I thought it cap." During interview on said it would not hu alcohol, so yes. RN to prime flex pens be medication. RN-B son Flexpen since III During interview on IDON verified the perfexpen: wipe off thattach a needle, pri insulin, dial up the croom, explain procest IDON stated not pri the resident not get the end of the pen composition of the pen composition. The preparation of the pen cap. Wipe in alcohol swab. Remneedle and screw it	abetes mellitus. 12/16/15, at 12:37 p.m. ated, I have never heard about No one said we had to wipe was sterile because it had a 12/17/15, at 12:21 p.m. RN-B art to wipe the stopper off with -B verified you are supposed before you dial up the stated I have not had education have been here. 12/17/15, at 2:07 p.m. the rocess to give Insulin via a see end of the pen with alcohol, me the pen with 2 units of sees, administer the insulin. The ming the pen would result in sting the full dose. Not wiping off could result in an infection. and Medication Transfer Record or NovoLog Flexpen provided ert. It instructed residents to on and usage instructions	F3	332			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245417	B. WING		12/17	⁷ /2015
	PROVIDER OR SUPPLIER SDALE REHAB & CAI	RE CENTER	;	STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE C	(X5) COMPLETION DATE
F 333 SS=D	injection: small amore cartridge during nor and ensure proper to select 2 units. He needle pointing up, few times, which metop. Press the push dose selector is bac should appear at the appears, change the not receive the full aby the physician. 483.25(m)(2) RESII SIGNIFICANT MED. The facility must enany significant med. This REQUIREMENT by: Based on observative review, the facility f	ounts of air may collect in the mal use. To avoid injecting air dosing: Turn the dose selector old your Flexpen with the and tap the cartridge gently a coves the air bubbles to the button all the way in until the ck to 0. A drop of insuling tip of the needle. If no drop the needle and repeat." R76 did amount of insulin as ordered DENTS FREE OF DERRORS	F 333		were ed with es rse e. n ave a	/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245417	B. WING _		12/·	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 333	unit/milliliter sliding with meals For blo 201-250=8 units 25 units, 351-400= 20 than 400 =24 units. During medication 12/16/15, at 12:18 (LPN)-B verbalized and would need eig attached the needle units for administra the stopper of the N prime the pen. LPN alcohol wipe and gr Novolog. Surveyor and had LPN-B cor Flexpen. LPN-B did the Flexpen prior to R76's quarterly Min 10/15/15, indicated Diagnosis identified mellitus. During interview on interview LPN-B sta about priming a Flewipe the top. I thou had a cap." During interview on registered nurse (R wipe the stopper of verified you are supbefore you dial up to the stopper of the stopper of verified you are supbefore you dial up to the stopper of the stopper of you dial up to the stopper you dial up to the your young you	scale based three times a day od sugar 150-200=4 units, i1-300= 12 units 301-350=16 units, blood sugar greater	F 33	Audits will be completed by the and/or designee that will mor residents requiring insulin injutimes a week for two weeks, Audits will be reviewed during assurance meeting to determ trends are identified, and recommendations made for audits/monitoring needs.	nitor identified ections three then weekly. g the quality nine if any	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, STATE 3130 GRIMES AVENUE NORT ROBBINSDALE, MN 5542	Н		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD O THE APPROPI	BE	(X5) COMPLETION DATE
F 371 SS=E	interim director of no process to give Instead of the pen with prime the pen with dose required, take process, administer not priming the pen not getting the full open off could result. Discharged Reside printed 12/17/15, for as manufacture instead in Team all preparation from your healthcar package." NovoLog Flexpen in April 2015, instruct "Step 1: Prepare your the pen cap. Wipe alcohol swab. Rem needle and screw if Step 2: Step 2: Doin injection: small amount cartridge during not and ensure proper to select 2 units. However, which may top. Press the push dose selector is back should appear at the appears, change the 483.35(i) FOOD Press the position of the process to the process to the process to the process to the process the push dose selector is back should appear at the appears, change the 483.35(i) FOOD Press the position of the process to	12/17/15, at 2:07 p.m. the pursing (IDON) verified the pursing (IDON) verified the pullin via a Flexpen: wipe off the alcohol, attach a needle, 2 units of insulin, dial up the president to room, explain the insulin. The IDON stated a would result in the resident dose. Not wiping the end of the in an infection. Int Medication Transfer Record or NovoLog Flexpen provided ert. It instructed residents to on and usage instructions are professional and the product manufacture guidelines dated users to our NovoLog Flexpen: Pull of the rubber stopper with an ove the protective tab from the at onto your Flexpen tightly. In the air shot before each punts of air may collect in the rmal use. To avoid injecting air dosing: Turn the dose selector old your Flexpen with the and tap the cartridge gently a oves the air bubbles to the abutton all the way in until the collection of the needle. If no drop the needle and repeat."	F 3				1/26/16
	appears, change th 483.35(i) FOOD PF	e needle and repeat." ROCURE,	F 3	71			1/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE C	(X5) COMPLETION DATE
F 371	considered satisfa authorities; and	om sources approved or ctory by Federal, State or local distribute and serve food	F 371			
	by: Based on observative review, the facility sanitary condition preparation areas. to ensure hair rest	ation, interview and document failed to ensure a safe and in the kitchen storage and food In additional, the facility failed raints were worn. This had the 71 of 72 residents in the facility kitchen.		F 371 No residents were found to be affe this practice; however, this had the potential to affect 71 of 72 resident facilty on that day. All residents have the potential to a by these practices that eat out of the kitchen.	s in the	
	nutrition services r was observed: -a 1/4 quart full confull container of chuse date on them. -3/4 full bag of oper Although the facilit package, the pack without closure to noodles. During the entire to	on p.m. during kitchen tour with manager (NSM), the following tainer of white milk and ¾ quart occolate milk, with no open for a pasta noodles was observed by found a used by date on the age of noodles were left open prevent contamination of the our through the kitchen, walk-ingron 12/16/15, at 2:09 p.m. the		In-servicing will be provided to the staff related to food storage and sa conditions and review policies and procedures related to infection con the Nutrition Services Mangaer (NS and/or designee by 1/26/2016. Audits will be completed by the NS and/or designee that will monitor sa storage in food prep areas, includir wearing of hair nets, the cleaning schedule three times a week for two weeks, then weekly. Audits will be reviewed during the quality assurant meeting to determine if any trends identified and recommendations m	trol by SM) Manitary ng ro nce are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245417	B. WING		12	/17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 371	restraint to cover h was also observed and lift individual be ensure they were compared to the dishwasher dish traside on the floor in dietary aide remove from the floor, place and loaded it with a dishwasher coveray to the outside onto the clean one sanitary to be doned dietary aide. On 12/17/15, at 10 should have dates stated the pasta not tie on the bag and On 12/17/15, at 10 working with food stated if they were was not necessary would wear a net if serving at the steam. The 2013 Food and Food Code under the steam of the steam	d to not be wearing a hair is beard. During the tour, NSM to bend down to lower shelves aking pans to inspect them to lry. 22 a.m. the dirty dish area are were three empty ays standing upright on their front of the dishwasher. The ed an empty dishwasher tray ed it on the dishwasher belt, dirty dishes. She then opened are and pushed the clean dish by pushing the dirty dish tray. The NSM stated it was not a that way and informed the clean dish by a stated it was not a that way and informed the clean. 29 a.m. NSM stated the milk when opened for use. He codles should have had a twist be closed. 32 a.m. NSM stated anyone should wear a beard net. He not mixing/working with food it to wear one. He stated he he was cooking food and m table. d Drug Administration (FDA) he section of Hair Restraints	F 371	,	eds.	
	section, FOOD EM restraints such as I beard restraints, ar hair, that are desig	is provided in (B) of this IPLOYEES shall wear hair hats, hair coverings or nets, and clothing that covers body ned and worn to effectively a contacting exposed FOOD;				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING		12 /	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371 F 428	and unwrapped SIN SINGLE-USE ARTI The facility sanitation July 2015, included times Cover all of Beards must be con	n, UTENSILS, and LINENS; IGLE-SERVICE and CLES." on procedures policy dated "3. Wear a hair restraint at all hair, including facial hair.	F 37			1/26/16
SS=D	The drug regimen of reviewed at least of pharmacist. The pharmacist must the attending physical regimes to the pharmacist must be attending physical regimes at the pharmacist must be attending physical regimes at the pharmacist must be attended to the pharmaci	of each resident must be note a month by a licensed st report any irregularities to cian, and the director of reports must be acted upon.				
	by: Based on interview facility failed to ens recommendations with the commendations of the c	NT is not met as evidenced and document review, the ure consultant pharmacist were acted upon for 1 of 5 iewed for unnecessary		R68's consultant pharmacist recommendations to monitor postublood pressures at least monthly woobtained and put into place on 12/28/2015.		
	indicated R68 recei medications.	ssessment dated 4/24/15, ved antipsychotic		All residents have the potential to be affected by this same practice, how facility wide audit was completed or 12/18/2015 and fourteen residents identified at risk for monitoring need postural blood pressures. Nursing staff will be in-serviced by	vever a n were	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING			12/1	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH BOBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	dated 5/12/15, incluantipsychotic, and at high risk for falls postural blood presmonthly/assessing facility policy (or as medical record lackirregularity having a facility's attention a orthostatic blood presmonthly/assessing facility's attention a orthostatic blood presmonthly and included an order of blood pressures to utilizing an antipsyce 2015 indicated morpressures had not the medical record Treatment Administ evidence of any orthaving been moniton November of 2015 The facility provide dated 5/15/15. The interventions for action of the plan remained an opportunity to heap propriate for successive physical sitting, hypotension unsteady gait, fall in	rt Omnicare of Minnesota uded: "receives an is reported to have fallen or be Please consider monitoring issures (BP) at least for orthostatic hypotension per advised by prescriber)." The ked any evidence of this been brought forward to the gain even though no ressures for R68 had been ay of 2015. ministration Record (MAR) dated 5/13/15, for orthostatic be completed monthly, if chotic. R68's MAR for May nitoring of orthostatic blood been completed. In addition, which included the MAR and tration Record, lacked chostatic blood pressures bred between May and d R68's current care plan care plan lacked any liverse side effect monitoring eroquel (an antipsychotic) or essant). Although there was ave selected interventions h monitoring, an entire section and unchecked including: movement, balance while n, dizziness/vertigo, syncope, n past 30 days, fall in past acture, swallowing problem,	F4	128	1/26/2016 on policy and procedure psychoactive medication symptom assessment/ care plan needs. Audits will be completed by the DO designee for identified residents to adequate monitoring is in place we Audits will be reviewed during the casurance (QA) meeting to determ any trends are identified, and recommendations made for continuaudits/ monitoring needs.	N or ensure ekly. quality ine if	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245417	B. WING _		12	2/17/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP OF STATE, Z			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 428	R68's quarterly Min 11/27/15, indicated had diagnoses included accident, traumatic depression. R68 wactivities of daily like and set up help on MDS also indicated facility on 4/16/15. The signed Physic indicated R68 rece (mg) every mornin mood disorder. Starisk of psychophar noted staff were to the medical record The licensed nurse monitoring for the medications however orthostatic blood pthe pharmacist to his side effects for the On 12/17/15 at 9:3 (RN)-B stated they blood pressures. On 12/17/15 at 3:2 pharmacist stated pressures to be medication ind pressures were be confirmed she exp	nimum Data Set (MDS) dated I R68 was cognitively intact and uding: cerebrovascular brain injury, anxiety, and as independent with most ving and required supervision, ly with locomotion off unit. The d R68 had been admitted to the dian Orders for December 2015, sived Seroquel 25 milligrams g, and 50 mg every evening for aff were also to monitor for the macological medications and if document the information in and notify the medical doctor. As documented "O" for risk of psychopharmacological ver, there were no documented ressures as recommended by help identify potential adverse use of Seroquel. 9 a.m., registered nurse of did not monitor orthostatic 1 p.m., the consultant she expected orthostatic blood onitored at least monthly. 3 p.m., the interim director of sted she did not see icating orthostatic blood ing monitored. The IDON ected such monitoring to be cordance with the consultant	F 42	28			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	` '	(X3) DATE SURVEY COMPLETED	
		245417	B. WING		12/	17/2015	
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	·		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		ILD BE	(X5) COMPLETION DATE	
F 431 SS=E	AstraZeneca Pharm 10/29/13, indicated effects for Seroque The information incadvised of the risk (symptoms include upon standing, white especially during the and also at times or increases in dose." The facility's policy dated 7/15, directed side effects as indiced Medication Symptom R68's care plan data symptoms to monited 483.60(b), (d), (e) ELABEL/STORE DROTTHE facility must enalicensed pharmacof records of receip controlled drugs in accurate reconciliated records are in order controlled drugs is reconciled. Drugs and biological labeled in accordar professional princip appropriate access	t information for Seroquel from maceuticals, last revised one of the adverse side one of the adverse side of was orthostatic hypotension. Sluded; "Patients should be of orthostatic hypotension feeling dizzy or lightheaded on may lead to falls), he period of initial dose titration, for re-initiating treatment or one of staff to "Monitor regularly for cated on the Psychoactive of Assessment/Care Plan." and See See See See See See See See See Se	F 4	328		1/26/16	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245417	B. WING		12/	17/2015
	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
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F 431	facility must store a locked compartme controls, and perm have access to the The facility must p permanently affixe controlled drugs list Comprehensive Di Control Act of 1970 abuse, except whe package drug districted.	a State and Federal laws, the all drugs and biologicals in onts under proper temperature out only authorized personnel to e keys. Trovide separately locked, d compartments for storage of sted in Schedule II of the rug Abuse Prevention and and other drugs subject to en the facility uses single unit ribution systems in which the minimal and a missing dose can	F 431			
	by: Based on observative review, the facility medications/treath medications rooms outgoing (medications and the residents. The facility did not opatches were accupotential diversion Also, the facility fail	ation, interview, and document did not ensure expired nents were discarded in 3 of 3 st; the facility did not ensure ons to be sent back to oyed in 1 of 3 medication ne potential to affect all 73 lity failed to ensure the experigerator was cleaned and medication rooms. In addition, ensure Fentanyl (narcotic) trately destroyed to prevent for 2 of 3 residents (R29, R10). Illed to ensure medication carts of 6 medications carts that were		The expired medications identified 3 medication rooms were discarded medications requiring to be sent by the pharmacy or destroyed was completed on 12/17/2015. The medication storage refrigerator look the second floor medication room cleaned and defrosted on 12/17/20 facility wide audit was completed of 12/18/2015 to ensure medication of were locked and Fentanyl patches accurately destroyed to prevent positiversion, no additional findings we noted. All residents have the potential to affected. Nursing staff will be in - serviced by	ed and ack to cated in was 015. A on carts were otential ere	

OLIVILI	10 I OIT WILDIOALIL	A MEDICAID SETTICES			<u>U</u>	IVID IVO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245417	B. WING			12/1	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CAI	RE CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	storage tour was co (RN)-A who provide room. Upon openin shelves were obser bottles, pill cards of treatments. A tote v observed stored unto have dry water stored to have dry water stored medications were brown drips on the substance was. In a observed: - 15 bottles of lodof packing stripes) stored medication room of and four loosely lyir dried white soap so verified and stated, store them. We do - Three Zinc 50 mill tablets bottles with - Engerix B (hepatit drops and with ace stored together in a one infusion ball of (an antibiotic) stored drawer with a discase on 12/17/15, at 1:5 expired medications supposed to be stored acknowledged and that needs to be do medications were of pharmacy to be distime it had been do	ation room 6 p.m. the medication room ompleted with registered nurse ed access to the medication g, the second cabinet the red overflowing with multiple various medications and with multiple medications was der the sink, which appeared tain and water damage. Some e observed to either have cap or side unsure what the addition, the following were form (antiseptic wound ored inside the sink in the which some were in a box ng inside the sink that had um all over the sink. RN-A "They is a better place to be have a supply room." igram (mg) high potency 100 expiration 10/15. is B medication) vials, eye taminophen suppositories	F	431	1/26/2016 on the policies and procrelated to receipt and disposition of controlled drugs, the storage of druprocess to discard expired drugs, or requiring to be returned to the phate and the monitoring and care relate medication refrigerators including to cleaning and defrosting process. Audits will be completed by the DC designee for all of the medication medication and treatments carts to adequate monitoring is in place that times per week for one week, then weekly. In addition controlled drug will be completed to ensure Fentar patches were accurately destroyed prevent potential diversion three times weekly for one week, then weekly, will be reviewed during the quality assurance (QA) meeting to determ any trends are identified, and recommendations made for continuaudits/monitoring needs.	f all ugs, the drugs macy, d to the he N or ooms, ensure ee audits to nes Audits ine if	

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER SDALE REHAB & CAI	RE CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
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F 431	medication room R responsibility is min medications were s	ations were not stored in the N-A stated "The final le." When asked if upposed to be stored together RN stated they should have	F 4	31			
	On 12/17/15, at 1:5 storage tour with RI to have a two-three Three ice packs we frost. In addition, th have an orange dis nurses on night shift	AIGERATOR FREEZER 4 p.m. during medication N-A the freezer was observed inch thick build up frost. ere observed encased in the e thick frost was observed to coloration. RN-A stated the fit were supposed to be st the refrigerator and freezer					
	the tour inside the ropened box of Fent asked what the faci used patches RN-A witness the destruct supposed to sign of Administration Record R29's MAR and nat 12/16/15, it was reventanyl patch five times two nurses hadestruction.						
	Third Floor On 12/17/15, at 2:3	0 p.m. RN-F provided access					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER SDALE REHAB & CAI	RE CENTER		STREET ADDRESS, CITY, STAT 3130 GRIMES AVENUE NOR ROBBINSDALE, MN 554:	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	NOF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE	
F 431	During the tour, threwere observed stor When asked what the destroying the used nurse were suppost RN-F verified R10 flowers which four times did sign off witnessing no nurse had signed destruction on 12/1.	art and the narcotic box. ee Fentanyl patches for R10 ed inside the narcotic box. he facility policy was for I patches, RN-F stated two ed to witness the destruction. had the patch removed and from 12/1/15, to 12/16/15, of d not have a second nurse the destruction and one time d off on the MAR the 6/15.	F 4	.31			
	medication tour to to to who provided access observed: -Hemoccult (a test skit with expiration 5. Anticoat absorbent expiration 1/2014, a stored in a shelve in addition, the biohaz with two inches built would be cleaned. Veresponsible for makewas free of expired stated was the nursemanagers would he shelves of the refrigulations with insulin flex per asked about medicate policy to separate of 12/17/15, at 2:5	5 p.m. during a subsequent he medication room with RN-F as the following were to look for blood in stool) test /2015, and three boxes of wound dressings with and other two 12/2013, all at the medication room. In ard refrigerator was observed dup frost. RN-F verified stated When asked who was king sure the medication room medications and treatments are manager and the other elp. Also on the second greator was observed Glycerin el stimulant) stored together as, and eye drops. When ation storage RN-F stated was te the medications.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245417	B. WING		1	2/17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP O 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
F 431	room for destruction supposed to be stomedications. IDON supposed to follow when the patches a and the nurses wer for cleaning the reformedications were medication cart and not properly secure. Improperly stored in The medication cart and 19:55 a.m. with RI floor treatment cart nursing (DON). Bot Santyl wound product oral medication. RN Santyl was not place wound tube product contained two empredifferent resident in a risk was of using the residents RN-B repmight take somethic another resident." A bottle of eye drop glaucoma) 1 % was RN-B stated [R87] treatment. RN-B stated treatment is disconfiremove the ointment Unlocked medication On 12/16/15, at 11:	led from cart and medication in and suppositories were red separately from other further stated the nurses were the policy of two nurse sign are removed and destruction in esupposed to follow the policy rigerators. Into properly stored on one of two medication carts were discussed. In the dication: It was observed on 12/16/15, N-B. RN-B checked the 3rd with RN-B and director of the nurses acknowledged the fact was not separated from the N-B Stated, "You are right, the fined in bag " as it was the only to the drawer. The drawer the bags which with two the same tube on two different lied, "If not handled right youing from one resident to the value of the same tube on the cart was not receiving this atted if a medication or tinued the nurses are to not from cart.	F 4	31		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI IER/CLIA

	IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245417	B. WING		12	/17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
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F 431	unlocked At 11:56 a.m. LPN No resident, staff of cart At 12:05 p.m. the unlocked as LPN-B perform a blood sudoor to R76's room of sight At 12:08 p.m. the resident, staff or vis while it remained under to help a resident, staff or vis while it remained under to help a resident, staff or vis while it remained under to help a resident, staff or vis while it remained under to help a resident, staff or vis while it remained under to help a resident, staff or vis while it remained under the cart unload to the seed in the cart of the cart unload to the cart unload t	g the medication cart I-B returned and locked cart. r visitor had approached the medication cart was left walked into resident room to gar test. LPN-B closed the . The medication cart was out LPN-B returned to the cart. No sitor had approached the cart nlocked. ugh 12:13 p.m. LPN-B left ocked on South hall way and lent wheel down the hall. No sitor had approached the cart nlocked. I-B left R76's insulin pen with p of the medication cart while medication cart was not in ew. I-B was interviewed and said, eft it there. I got rattled and the cart when I went down to und. I am not supposed to sked. It is not how I normally dication cart contained various 21 p.m. RN-B stated, "Carts hen the nurse is not with should not be left on top of not at the medication cart."	F 4	31		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
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F 431	Continued From pa	ge 79	F 4	31		
F 441 SS=E	2015, directed: "2. Destroy used tr Fentanyl), following a. Two licensed nur destruction of the u Medication Adminis Storage and Expira Biologicals, Syringe 1/1/13, directed: "3. General Storage 3.2. Facility should medications and bid from internal use m 3.4. The facility sho therapy products ar separately from oth biologicals, under a sterility conditions, a manufacturer's or s 16. Facility should of discontinued, outda medications or biolo pharmacy return/de Applicable Law," 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and of to help prevent the of disease and infection (a) Infection Control	tion of Medications, and Needles policy revised ensure that external use pologicals are stored separately redications and biological, and ensure that infusion and supplies are stored er medications and appropriate temperature and according to the supplier's recommendations. Destroy or return all ated/expired, or deteriorated origical in accordance with estruction guidelines and other atablish and maintain an accommendation accommendations.	F 4	41		1/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 441	in the facility; (2) Decides what p should be applied (3) Maintains a rec actions related to i (b) Preventing Spr. (1) When the Infect determines that a prevent the spread isolate the residen (2) The facility mus communicable disc from direct contact direct contact will t (3) The facility mus hands after each d hand washing is in professional practi (c) Linens Personnel must ha	ich it - ontrols, and prevents infections procedures, such as isolation, to an individual resident; and ord of incidents and corrective infections. Bead of Infection tion Control Program resident needs isolation to it of infection, the facility must it. It prohibit employees with a bease or infected skin lesions is with residents or their food, if ransmit the disease. It require staff to wash their irect resident contact for which dicated by accepted	F 4	411			
	by: Based on observareview, the facility precautions for 8 of	NT is not met as evidenced ation, interview and document failed to follow infection control f 8 residents (R13, R76, R1, R61, R14) reviewed for infection			Diabetic care: R13, R 76, R1, R132, R75, R31, R R14 clinical records were reviewed 1/5/2016 for infection control purpo ensure each resident was without infections at the time this practice v observed. No infections were note LPN-D, RN -G and RN-A verbalized	on ses to vas d.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING			12 /-	17/2015
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	12/	1772010
ROBBIN	SDALE REHAB & CA	RE CENTER			30 GRIMES AVENUE NORTH OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			BE	(X5) COMPLETION DATE	
F 441	(LPN)-D was obserwearing a pair of glander hand. LPN-D digrabbed the tip of the disposed it in the sign of saline part of the s	age 81 24 p.m. licensed practical nurse rved come out of R13's room loves and had a glucometer in isposed the lancet then he used stripe with blood harps container, then took a rmicidal disposable wipes) that reatment cart wiped the wrapped it with wipe set the on the top drawer of cart. Paring the same gloves picked inted in the treatment sheets. The drawer with same gloves vial draw insulin went to R13's vacy curtain was overheard as was going to give her insulin. Out of room with same gloves get then went into R13's out of room to the hallway then sell the cart down the hallway he south hallway to the last hallway still with same gloves mum Data Set (MDS) dated R13 was a diabetic and had	F	141	correct infection control practice after eview(s) completed after observat were made on the specific dates not affected by this practice as it relate infection control, however a facility audit was completed on 12/28/2015 sixteen residents with diagnosis of diabetes and who also have orders monitor their blood sugars have the potential to be affected. Nursing staff will be in -serviced by 1/26/2016 and will include a review policies and procedures related to of personal protective equipment (Fill Hand hygeine including the use of sanitizer, glucose monitoring equiping disinfect/ decontaminate procedure bloodborne pathogens related to in control standards of practice. Audits will be completed by the DO designee that will monitor infection practices three times per week for weeks, then weekly. Audits will be reviewed during the quality assurar (QA) meeting to determine if any trare identified, and recommendation made for continued audits/ monitor needs. Peri Care: NA-C verbalized understanding on 12/16/2015 related to the standards practice when assisting R61 with princeds. All residents who receive assist with hygeine needs have the potential to affected. Nursing staff will be in - serviced by 1/26/2016 and will include a review	of the use PPE). and ment: and fection Nor control two nee ends ing s of ericare h be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING			12 /1	17/2015
NAME OF F	PROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE		
DODDING	CDALE DELIAD & CA	DE CENTED		31	130 GRIMES AVENUE NORTH		
ROBBIN	SDALE REHAB & CA	NE CENTER		R	OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	to wait for insulin. L cleaned the glucom PDI Cloth wipe the SANI-PDI Cloth an still with same glov and went to room s disposed the syring still wearing the said R76's MDS dated diabetic and had not a disposed to make the said to the	eading of 146. LPN-D ask R76 LPN-D went out of room neter briefly with a Super SANI-n wrapped with the Super d set it on the top cart drawer es drew the insulin from vial shut the door, came out ge with same gloves document me gloves.	F 4	141	policies and procedures related to a personal protective equipment (PPI Hand hygiene including the use of a sanitizer, and infection control stand of practice. Audits will be completed by the DO designee that will monitor infection control practices three times per we two weeks, then weekly. Audits will reviewed during the quality assurant (QA) meeting to determine if any trace identified, and recommendation made for continued audits/ monitorineeds. Wound Care: On 12/16/2015 the pharmacy was rand sent a new tube of Santyl to repeated with new ones to ensure rand were exposed to dirty linen. RN-B verbalized on 12/16/2015 understant related to hand hygeine meeds and and procedure as it related to wound All residents who receive wound can have the potential to be affected. Nursing staff will be in -serviced by 1/26/2016 and will include a review policies and procedures related to to of personal protective equipment (Fi Hand hygiene including the use of its sanitizer, wound care and treatment and procedure, and infection control standards of practice. Audits will be completed by the DO designee that will monitor infection practices three times per week for the sanitizer was a serviced by the procedure times per week for the procedure	E). hand dards N or ek for I be ice ends is ing hotified polace pplies were ione hding policy d care. re of the he use PPE). hand t policy ol N or control	
	residents and if she	to wash her hands between e was supposed to wash her hange LPN-D stated "Yes. I			weeks, then weekly. Audits will be reviewed during the quality assuran		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245417	B. WING		12	/17/2015	
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, STATE, Z 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		,=0.10	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 441	up." LPN-D further were trained to wip and that's what I did the sanitizer in the with water or hand the barrier she ack the barrier on R76's was no blood all ov acknowledged wou barrier but was not remember if that ha training and though each use. When as walk down the hall acknowledged she	rough as supper was coming stated "when I was trained we ethe glucometer and wrap it d as I was using them. I forgot other cart. It's ideal to wash sanitizer." When asked about nowledged she had not used a bedside table stated there er the glucometer but Id have been ideal to use a sure as she would not ad been addressed in the t was sufficient to clean it after sked if she was supposed to vay with used gloves LPN-D should have removed them.	F 4	(QA) meeting to determine are identified, and recommade for continued audit needs.	mendations		
	Registered nurse (IR132's room with a blood sugar supplied RN-G set the tote of table without a barrietrieved a glucome next to the tote on the stripe wiped R1 punctured it obtained to btained a reading tossed in garbage, supplies and LPN-Frime took the glucotowel brought it out then then RN-G too third drawer without	d on 12/15/15, at 11:44 a.m. RN)-G was observed enter small tote which contained es. Upon entering the room lirectly on the bedside pullier and then got a paper towel eter from the tote and set it the paper towel. After applied 32's finger with alcohol then ed a drop of blood and of 159. RN-G took gloves off came back gathered the was in the room at the meter wrapped in a paper of the room set it on the cart ok the tote returned it into the t cleaning it then was glucometer tossed the wipe					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG		COMPLETED	
		245417	B. WING _		12	2/17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 441	and then proceede Cloth wipe wrapped then washed her had 11:52 a.m. when as to be placed directly back into the cart, I the cart outside R1 was supposed to hottom before it was observed clean the stated she preferred the rooms. R132's MDS dated a diabetic and had R13's blood sugar 12/16/15, at 7:38 a on and glucometer blood sugar, LPN-Etable with no barried obtained a blood sugary without washing hawith gloves on and	d to get a Super SANI-PDI d around the glucometer and ands with the hand sanitizer. At sked if the tote was supposed y on the bedside table and put RN-H and LPN-C present by 32's room both stated the tote ave been cleaned on the as stored. The nurses were all cart and the tote. LPN-C d the totes not to be taken into	F 44	11		
	12/16/15, at 8:11 a. into R75's room inco blood sugar came of glucometer with a Strictly then went in LPN-B then obtained the bedside pull take whole bottle of gluco	observation was completed on m. LPN-B was observed go dicated was going to check the out applied gloves cleaned the Super SANI-PDI Cloth wipe to the room and shut the door. Led a paper towel and set it on ole and set the glucometer, a cometer stripes alcohol wipe then obtained one stripe from				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245417	B. WING			12/·	17/2015	
NAME OF PROVIDER OF ROBBINSDALE RE		RE CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422			
PREFIX (EAC	H DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE	
the bottle resident and obta LPN-B the bottle of with use the bottle and clear glucomes the tip of removed 8:13 a.m she had with the to the robefore to should he the glucomes that the glucomes and washed R31the interestment open and washed R31the interestment should he treatment to the robefore to should he the glucomes and washed R31the interestment should he treatment to the robefore to should he the glucomes and washed R31the interestment should he treatment to the robefore to should he the glucomes and washed R31the interestment should he the robefore to should he the glucomes and the robefore to should he the glucomes and the glucomes and the robefore to should he the glucomes and the robefore to should he the glucomes and the glucomes and the robefore to should he the glucomes and the glu	which fing ained a dromen still with stripes (mode a tripe on the intermediate with the first the gloves start and had not and had not are and had not are and bluching for and had not are and bluching for and had not are and had not are and bluching for and had not are and bluching for an an are are are are and bluching for an are	ied to glucometer asked er then punctured it squeezed p of blood with reading of 134. In the same gloves pick up the ultiple-use) and the glucometer came out of the room tossed op drawer with all the supplies ster's. Then cleaned the esame gloves after touching with blood wrapped it then s and used hand sanitizer. At ked about the bottle of stripes to the room and had touched it ted "I should have not taken it rould have removed my gloves LPN-B acknowledged she led her gloves before cleaning are infections. 12/10/15, indicated R75 was a confections. 159 a.m. RN-A entered R31's efter in hand. RN-A left the door lucometer on bedside table, er obtained blood. RN-A told lood sugar. RN-A returned to A placed a paper towel on the wrapped glucometer in two minutes. dated 9/9/15, indicated R31 abetes which required daily 1:16 p.m. to 12:41 p.m. during the infection control RN-I when the control RN-I when the infection control RN-I when the control RN-I when t	F	141				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245417	B. WING			12/17/2015	
	NAME OF PROVIDER OR SUPPLIER ROBBINSDALE REHAB & CARE CENTER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	RN-I stated she wo the nurses during in assigned a restorat cares." RN-I stated the use of a barrier the resident room a with the supplies the recommended by (CDC). When aske training RN-I gave cleaning training provided training is done oncheck list checked she of the nurse has task appropriately. Been trained "No gittraining had been of (NAs) on the use of equipment (PPE) a remove gloves, was again if coming in a she would expect to gloves after removing hands then apply a dressing change. It supposed to go with the task as recommon to 12/17/15, at 2:4 nursing (IDON) state nurses to not walk thand sanitizer. IDO supposed to follow	in with staff to observe cares and go in and would go with medication pass, "I have give aide to go in, and watch staff had received training on when using a glucometer in and staff was supposed to go ey needed only for the task as centers for Disease Control d if there was on-going example of the glucometer ovided recently and indicated line and staff had to have a off which the staff signed after ad observed then complete the RN-I also stated staff had loves in the hallway" and lone for nursing assistant of personal protective and NA's had been trained to sh hands, put clean gloves contact with fluids. RN-I stated the nurses to remove soiled and the old dressing and wash nother pair to continue with the adicated the staff was the the supplies they needed for	F	141			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245417	B. WING			12 /	17/2015
	PROVIDER OR SUPPLIER SDALE REHAB & CA	RE CENTER		31	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	by NA-C on 12/16/1 room. At 8:55 a.m. bathroom door ther was overheard resi NA-C was observed and assisted reside heard void then stacued resident to stagoing to apply a trathen assisted reside use toilet paper to which was noted to the same gloves and pants then guice wheelchair. NA-C same was heard indicate movement." NA-C same was heard indicate movement. "NA-C same was heard indicate movement." NA-C same supposed to wash to wash hands tooAt 9:02 a.m. When to wash her hands stated "Am sorry I washed her hands -At 9:11 a.m. when supposed to wash I and if staff were suduring cares the ID surveyor asked RN armrest.	being wheeled into her room 15, at 8:51 a.m. from the dining R61 was observed open the n came out. At 8:56 a.m. R61 dent call out "please help" and d go to room applied gloves ent into the toilet. R61 was ted "am done" NA-C then and then cued R61 she was nsfer belt around the waist ent to stand. NA-was observed wipe resident bottom twice have brown stool then with djusted R61's incontinent padded resident to seat on the still wearing the same gloves to R61 "you had a bowel then touched the wheelchair ame gloves and as she brough the door removed the diresident to the sink located in ed her hands and set resident in asked if she was supposed after providing pericare NA-C was supposed to remove the nowledged she should have also. asked if the staff were hands after providing pericare pposed to change gloves ON stated "Yes." At 9:12 a.mB to clean the wheelchair	F 4	441			

directed staff "Place the glucometer on the

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245417	B. WING		1:	2/17/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CC 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 441		a clean surface, e.g paper	F 4	41		
	the policy directed "1. Use the disi external parts of the gloves on. 2. Remove glo 3. Perform har 4. Don clean g 5. Obtain a sectowel.	ves. nd hygiene.				
	the glucometer for 7. Place the gl towel. 8. Remove glo 9. Perform har	the second cleaning. ucometer on the fresh paper ves. and hygiene. cometer in appropriate storage				
	policy effective July	in Soap and Water Handwash 2015, directed: water handwash will be used:				
		ibly soiled and after using the restroom spores is suspect or proven				
	A plain soap and wand rub may also	ater handwash or an alcohol be used:				
	 Before inserting peripheral vascular devices that do not After contact w 	t visibly soiled direct contact with residents g indwelling catheters, catheters, other invasive require a surgical procedure ith a resident's intact skin (e.g,				

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		245417	B. WING _		12	/17/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 441	mucous membrand dressings if the hater on the hater contact with the conta	vith body fluids or excretions, es, non-intact skin and wound ands are not visibly soiled at care if moving from a dy site to a clean-body site vith inanimate objects equipment) in the immediate lent	F 44	41			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245417	B. WING	·····	12	12/17/2015	
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 441	On 12/17/15, at 7:3 confirmed nor deni hands when remove R14's pericare was a.m. NA-B washed back and then was changed gloves but prior to putting on for R14's MDS dated two person assist for hygiene and R14 hocare.	rand for bed/chair/toilet. 33 a.m. NA-C neither ed that she did not wash her ring gloves. 5 observed on 12/16/15, at 9:37 R14's periarea from front to hed R14's bottom. NA-B t did not did not wash hands resh new gloves. 12/8/15, indicated R14 required or toileting and personal ad no behaviors of refusing	F 4	41			
	high risk for pressumobility and impair noted R14 had an ulcer. R14 required transfers and bed rof refusing care. R14 wound care w 9:28 a.m. It was not included a package 4x4 avino dressing cleanser. There was the bucket of clean RN-B applied gloved dressing. The dreshad a dark stain or not wash their hand soiled dressing nor opened a new dress.	12/8/15, indicated R14 was at the ulcers due to impaired bed ed transfer. The MDS further unstageable Stage 4 pressure if two person assist for mobility and had no behaviors as observed on 12/16/15, at oted that dressing supplies of non sterile guaze, several s, and a bottle of spray wound as a bag of dirty linen on top of a dressing supplies. See and removed the soiled sing was dated 12/15/15, and nout side of dressing. RN-B did did after they removed the did they change gloves. RN-B sing with the soiled gloves and g (still in its package) on the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245417	B. WING			12/·	17/2015
	PROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH COBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	product) on bedsic placed tape pieces dressing package Santyl to the dress placed the Santyl to barrier). RN-B remapplied new gloves RN-B applied dress removed gloves, dube of Santyl ointibag of soiled dress room and washed. During interview of verified the Santyl pocket. RN-B state on the bed. In a peput down on a ster acknowlwdged the barrier such as a placed it there instiplaced Santyl in tresoiled pocket. RN-of handwashing af dressing. During interview of IDON stated, "It is or bedside table with pocket and take to place in the treatment have their own tub the tube or contain	age 91 I-B placed Santyl (wound care le table without a barrier. RN-B son bed, then placed the on mattress. RN-B applied sing the soiled gloves and then tube on mattress (without a loved the soiled gloves and so but did not wash their hands. sing and dated it. RN-B id not wash hands, placed the ment in pocket. RN-B removed sing supplies to the soiled utility their hands at 9:42 a.m. In 12/16/15, at 9:45 a.m. RN-B product was in the uniform ed, "No, I should have not put it effect world you would want to rile sheet." RN-B also apper towel. "I should have ead of my pocket." RN-B eatment cart from the now B also acknowledged the lack ter the removal of the soiled In 12/17/15, at 2:07 p.m. the not ok to place Santyl on a bed ithout a barrier, or in your the soiled utility room and then lent cart. Residents should e of santle with their name on the in which it is contained. I to remove gloves after a soiled	F	141			
F 456	dressing change a sanitizer."	nd wash hands or use ENTIAL EQUIPMENT, SAFE	F 4	156			1/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245417	B. WING		12/17/2015	
	PROVIDER OR SUPPLIER SDALE REHAB & CAI	RE CENTER	3	STREET ADDRESS, CITY, STATE, ZIP CODE 1130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 456 SS=E	OPERATING CONI The facility must ma mechanical, electric equipment in safe of the control of th	DITION aintain all essential cal, and patient care operating condition. NT is not met as evidenced alion, interview and document ailed to ensure ice machines are in good operating the potential to affect 71 of 72 ality who ate out of the kitchen. 27 a.m. the second floor chine was observed to be the spout and the grate had are stain. In addition, the mall amount of food spilled on	F 456	F 456 Microwaves have been replaced, a ice machines were cleaned on 12/15/2015. Microwaves are utilized in the three rooms. Ice machines are on an oncleaning schedule. Staff will be in-serviced by 1/26/20 relates to the policies and procedur sanitary conditions related to the ice machines and the microwaves. Audits will be completed by the NS and/or designee that will monitor the cleaning schedule three times a we two weeks, then weekly. Audits will reviewed during the quality assurar meeting to determine if any trends identified, and recommendations meeting to determine in the continued audits/monitoring needs.	e dining going 16 as it res of e M e eek for be nce are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245417	B. WING		12	12/17/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		711/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 456	On 12/15/15, at 10 room microwave wenamel plastic cast the inside door and confirmed it should from service. In admachine had a dript the ice began to move would check with the ice began to move it is three filters on the cleaned yesterday. On 12/16/15, at 9:3 three filters on the cleaned yesterday. On 12/16/15, at 3:3 observed to still be standard July 2015 in clean and sanitized after each use and week or more ofte. Facility nutrition sedated July 2015 in scoop, and storage in a clean and san machine will be cleoften as needed." MDT5N25 & MDT5 November 2008 in spouts, sink, grill a periodic cleaning a grill may be removed. Undated dining se indicated third and	233 a.m. the fourth floor dining vas observed to have the sing chipped and worn off on diniside front opening. NSM do not be used and removed it lidition, he stated the ice of and did not have a gasket. As selt it dripped and indicated he he manufacturer. 57 a.m. NSM stated they have ice machines which were dripping. 20 p.m. the ice machines were dripping. Ervices microwave procedure dicated "will be maintained in a diccondition will be wiped out it thoroughly cleaned twice per	F 4	56			

NAME OF PROVIDER OR SUPPLIER ROBBINSDALE REHAB & CARE CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	17/2015
NAME OF PROVIDER OR SUPPLIER ROBBINSDALE REHAB & CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	
DETIQIENCT)	(X5) COMPLETION DATE
F 456 be cleaned weekly. F 465 SS=E E RIVIRON 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, interview, and document review, the facility failed to provide an environment that was clean and in good repair 3 of 13 residents (R87, R43, R82). This also had the potential to affect 1 of 3 floors in which there were 13 of 26 residents who potentially could be affected for the South shower on third floor. Findings include: On 12/16/15, at 10:37 a.m. to 11:53 a.m. the environmental tour was conducted with the maintenance supervisor (MS), executive director in training and housekeeping and laundry manager (HKLM). During the tour the following concerns that had been identified during stage I of the survey were verified: R87's grab bars secured to bed on 12/14/15, at 4:11 p.m. during room observation were observed to be padded with porous black uncleanable foam which was secured with black tape. The black tape was noted to be wrinkled and not creating a seal which exposed the adhesive part and rendered the foam portion to be an uncleanable surface. During the tour the executive director referenties in a surface. During the tour the executive director recommendations made for continued	1/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245417	B. WING			12/17/2015	
	PROVIDER OR SUPPLIER	RE CENTER		31	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH OBBINSDALE, MN 55422	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 465	replaced with lamb washed and would R87's quarterly Mir	od the grab bars would be wool skin which can be provide padding to resident. Thimum Data Set (MDS) dated I R87 required extensive assist	F 4	65	audits/monitoring needs.		
	be in ill-repair on 1 was chipped which underneath, makin was observed with entire frame of the observed ripped/to MS and ED verified and MS stated arm asked how often the MS and HKS state monthly and at the	hair armrest was observed to 2/15/15, at 8:15 a.m. The vinyl exposed the mesh g it an uncleanable surface, a thin coating of dust on the wheelchair and the seat was rn on the sitting part both the d stated would replace the seat rest would be changed. When wheelchairs were cleaned d deep cleaning was done time if any concerns was reported to MS to address and					
	R43 had severely i independent with to	OS dated 9/11/15, indicated mpaired cognition, was ransfers after set up and used valker for locomotion.					
	had a large yellow and housekeeping the yellow substan When asked how of changed the house stated was done do	ain on 12/14/15, at 2:04 p.m. stain on it. During the tour ED and laundry manager verified ce on the privacy curtain. often the privacy curtains were ekeping and laundry manager aily by housekeeping staff om cleaning and were changed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245417	B. WING		_	12/17/2015		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 3130 GRIMES AVENUE NO ROBBINSDALE, MN 55	ATE, ZIP CODE DRTH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE		
F 465	R82 had severely i occasionally incon	age 96 OS dated 10/6/15, indicated mpaired cognition and was tinent of urine. R82 required with transfers, bed mobility and	F 4	65				
	12/16/15, at 10:37 shower rooms wer concerns: -The bottom of left observed to have ecaused the entire e-The shower room have white yellow cholder on the wall, with some parts stiprivacy curtain behave multiple stain tour the housekeep findings. When ask curtains were charlaundry supervisor the shower room windicated if the shoresidents. She also changed as needed verified the missing. Wheelchair Safety 2015, indicated "Till wheelchairs regulated safety. When clinical loose hardware or with the operation."	mental tour conducted on a.m. to 11:53 a.m. the both the e observed with the following shower room door was extreme water damage which edge length to crack all along it. on the right was observed to gooey substance on the soap had a missing towel holder all screwed on the wall, the sind the door was observed to s of brown matter. During the bing supervisor verified the ked how often the privacy aged the housekeeping and stated was checked daily as was cleaned daily and never over was cleaned between to indicated the curtains were do. The executive director						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245417	B. WING	B. WING		17/2015
NAME OF PROVIDER OR SUPPLIER ROBBINSDALE REHAB & CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		D BE	(X5) COMPLETION DATE
F 465	and repair personn appropriate repair p preventative mainte will be performed m Department"	eelchair taken out of operation, el should be contacted. The person will be notified. Regular enance checks on wheelchairs nonthly by the maintenance	F 4			
F 468 SS=E	SECURED HANDE	uip corridors with firmly	F 4	68		1/26/16
	by: Based on observate failed to ensure all to walls. This had the floors in which there either were ambulated who used the hand. Findings include: 3 North Hallway On 12/16/15, at 8:1 leave the dining root him and went out of hallway and was obtained as he grabbed the lacross from the DF-At 8:12 a.m. surves handrail located right to be loose. When a touched the handral and not adhered to	itions and interview, the facility handrails were firmly secured he potential to affect 1 of 3 e were 20 of 26 residents who tory or were in a wheelchair rails to propel themselves. 1 a.m. R76 was observed om never took his walker with f the dining room to the oserved ambulate to his room handrails along the hallway and went into his room. Yor observed the screw of the ht across from the dining room surveyor approached and iil, it was observed to be loose the wall for stability.		F 468 The handrail identified as being lotightened on 12/16/2015 during the environmental tour. A faciltiy wide audit was completed other areas identified were correct immediately. Staff will be in-serviced on environ needs related to handrails being fisecured. Audits will be completed by the Dir Maintenance and/or designee that monitor once a week for three week monthly thereafter. Audits will be reduring the quality assurance meet determine if any trends are identifications made for continuadits/monitoring needs.	d and ted amental rmly rector of twill eks, and eviewed ing to led, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING			12/17/2015	
NAME OF PROVIDER OR SUPPLIER ROBBINSDALE REHAB & CARE CENTER				STREET ADDRESS, CITY, STATE, 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	H		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 468	to the facility attent supervisor (MS) ve and immediately tig	tour the concern was brought ion and the maintenance rified the handrail was loose ghtened the handrail. MS sappointed at myself. I walk	F4	468			

PRINTED: 01/13/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245417

B. WING

12/15/2015

(X5) COMPLETION

DATE

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

3130 GRIMES AVENUE NORTH

ROBBINSDALE REHAB & CARE CENTER **ROBBINSDALE, MN 55422** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (FACH CORRECTIVE ACTION SHOULD BE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

> UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on December 15, 2015. At the time of this survey, Robbinsdale Rehab & Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 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.

Please return the plan of correction for the Fire Safety Deficiencies (K-tags) to: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/07/2016

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY 1PLETED	
		245417	B. WING		12/	15/2015
NAME OF PROVIDER OR SUPPLIER ROBBINSDALE REHAB & CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COL 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the deficit 2. The actual, or property of the correct the deficit 3. The name and/or responsible for comprevent a reoccurred responsible for compartment and had a census and space monitored for automotification. The far and had a census survey. The requirement and NFPA 101 LIFE SA Smoking regulation less than the follow (1) Smoking is procompartment when	RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. oposed, completion date. or title of the person rection and monitoring to ence of the deficiency. g was determined to be of a uction. It has no basement and red throughout. The facility has a with smoke detection in the es open to the corridor that is matic fire department cility has a capacity of 75 beds of 72 beds at the time of the example of the senced by: AFETY CODE STANDARD The sare adopted and include no	KO	00		1/26/16
	and in any other had area is posted with or with the internat	azardous location, and such a signs that read NO SMOKING ional symbol for no smoking.				

Event ID: B1TG21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245417	B. WING			12/15/2015	
NAME OF PROVIDER OR SUPPLIER ROBBINSDALE REHAB & CARE CENTER					TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
K 066	responsible is proh direct supervision. (3) Ashtrays of non design are provided permitted. (4) Metal container devices into which	ibited, except when under combustible material and safe d in all areas where smoking is s with self-closing cover ashtrays can be emptied are all areas where smoking is	K	066			V
	Based on observa interview, the facility the designated resi with NFPA LSC (00 the facility's smokin practice could affect visitors if an fire incomoking area. Findings include: On facility tour betw 12/15/2015, it was (Deputy Fire Marsh be re-educated on re-evaluating residuals supervised and items shall be addressed and the carry smoking items.	s not met as evidenced by: tions, policy review and staff y has failed to follow policy for dent smoking in accordance) Edition Section 19.7.4, and ng policy. This deficient ct all residents, staff and cident were to occur in the eveen 1:30 PM and 4:30 PM on observed by MDH and myself nal) that the facility staff need to the smoking policy for ents that are allowed to smoke unsupervised. The following ressed: are supervised are not allowed ems on the person. It was a supervised resident had			The submission of this plan of cor is not an admission by the provide fact or conclusion set forth in the Statement of Deficiency. This Plan Correction is being submitted because is required by law. However, evide Robbinsdale Rehabilitation and Cancenter good faith, the facility offers following plan of correction and has achieved substantial compliance in of the areas addressed by January 2016. K66 A description of what has been, or done to correct the deficiency. Each resident who smokes has be educated on the smoking policy we emphasis of properly storing smokitems when not in use, no smoking oxygen on, and proper disposal of	n of any n of ause it ncing are s the s n each / 26, will be een ith the king g with	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245417	B. WING_		12/1	5/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 066	smoking material on them. 2. It was observed improper disposal of cigarette butts on ground around the smoking area and inside of the trash can. 3. It should be made clear to staff that smoking while oxygen is in use is prohibited while smoking. It was stated by staff that using oxygen while smoking is allowed. This deficient practice was verified by the Administrator.		K 066 cigarette butts. Staff has been edion the smoking policy, proper stors smoking items, and the difference supervised and unsupervised smoking vith oxygen is prohibe. The actual, or proposed completion. The correction date will be 1/26/20. The name and/ or title of the person responsible for correction and more to prevent a reoccurance of the deficiency. The director of Social Service and designee will be responsible to prevent a reoccurance by monitoring the responsible to prevent and complete of smoking policy. Director of Maintenance and/ or designee will responsible to prevent a reoccurance monitoring the smoking area for cleanliness and compliance of cigarea.		age of of of king ducated bited. n date. of on nitoring or event a idents' npliance be nce by	1/26/16
K 067 SS=F	Heating, ventilating with the provisions in accordance with	FETY CODE STANDARD I, and air conditioning comply of section 9.2 and are installed the manufacturer's 9.5.2.1, 9.2, NFPA 90A,	K 06			
	Based on observarevealed that the fair conditioning sys	is not met as evidenced by: tions and staff interview, it was acility's general ventilating and stem (HVAC) is not installed in e LSC, Section 19.5.2.1 and		K67 A waiver has been submitted with of Correction	the Plan	

Facility ID: 00122

PRINTED: 01/13/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01		COMPLETED			
		245417	B. WING			/15/2015		
NAME OF PROVIDER OR SUPPLIER ROBBINSDALE REHAB & CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	CODE	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
K 067	NFPA 90A, Section system could affect Findings include: On facility tour betw 12/15/2015, observe revealed that the coand the resident roair and toilet exhaus supply and return cas a return plenum.	2-3.11. A noncompliant HVAC all 72 residents. ween 1:30 PM and 4:30 PM on ations and staff interview orridors had supply air only oms had no supply or return st that runs continually. The air onfiguration uses the corridors	KO	067				