### 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:	B3HD
Fac	ility ID: 00740

1. MEDICARE/MEDICAID PROVIDER NO.       3. NAME AND ADD (L3) EDENBROOI         (L1) 245275       (L3) EDENBROOI         2.STATE VENDOR OR MEDICAID NO.       (L4) 6200 XERXES (L5) RICHFIELD,			OK OF EDINA ES AVENUE S		(L6) <b>55423</b>	4. TYPE OF ACTION  1. Initial 3. Termination 5. Validation 7. On-Site Visit	2. Recertification 4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG	ORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey After C	
• •	<b>2/2017</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF	FISCAL YEAR ENDING	G DATE: (L35)
11. LTC PERIOD OF CERTIFICATIO From (a): To (b):  12.Total Facility Beds 13.Total Certified Beds	85 (L18) 85 (L17)	B. Not in Com	nce With equirements	ram	And/Or Approved Waivers Of  2. Technical Personnel  3. 24 Hour RN  4. 7-Day RN (Rural SN  5. Life Safety Code  * Code: A*	6. Scope of Serv 7. Medical Direct	vices Limit
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 85 (L37) (L38)	DWN 19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REM See Attached Remarks	IARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):			
17. SURVEYOR SIGNATURE Date :  Sandra Tatro, HFE NEII 09/22/2017				18. STATE SURVEY AGENCY		Date:	
3411414 14110, 111 2 14211		0	9/22/2017	(L19)	Mark Meath	, Emorcement Specialis	09/22/2017 (L20)
				` /	OFFICE OR SINGLE S		09/22/2017
	RT II - TO BE ( LITY  Participate	COMPLETED F		GIONAL	OFFICE OR SINGLE S  21. 1. Statement of Fina	STATE AGENCY uncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (H	(L20)
PA  19. DETERMINATION OF ELIGIBIT  _X 1. Facility is Eligible to	RT II - TO BE ( LITY  Participate e (L21)  23. LTC AGREEN BEGINNING  (L41)  27. ALTERNATI A. Suspension	20. COMPLETED F  20. COMPLETED F  20. The second of the second of Admissions:	BY HCFA RE	EGIONAL H CIVIL	21. 1. Statement of Fina 2. Ownership/Contr	STATE AGENCY  Incial Solvency (HCFA-2572)  In	(L20) (CFA-1513)
PA  19. DETERMINATION OF ELIGIBIT  X 1. Facility is Eligible to 2.  2. Facility is not Eligible  22. ORIGINAL DATE  OF PARTICIPATION  05/01/1985  (L24)  25. LTC EXTENSION DATE:	RT II - TO BE ( LITY  Participate e (L21)  23. LTC AGREEN BEGINNING  (L41)  27. ALTERNATI A. Suspension	20. COMPLETED E  20. CO	BY HCFA RE IPLIANCE WITH HTS ACT:  4. LTC AGREEM ENDING DAT (L25)	EGIONAL H CIVIL	21. 1. Statement of Fina 2. Ownership/Contr 3. Both of the Abov 26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Termination	STATE AGENCY  Incial Solvency (HCFA-2572)  In	ICFA-1513)  30)  CARY eet Health/Safety eet Agreement
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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

Facility ID: 00740

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART L. TO BE COMPLETED BY THE STATE SUBVEY AGENCY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

**C&T REMARKS - CMS 1539 FORM** 

STATE AGENCY REMARKS

CCN: 24 5275

On June 5, 2017, a Health Post Certification Revisit (PCR) was completed and verified the facility achieved and maintained compliance with Federal certification requirements. Based on our PCR we have determined the facility has corrected all deficiencies issued pursuant to the standard survey completed April 13, 2017, effective May 25, 2017. As a result of this visit, the Department discontinued the Category 1 remedy of state monitoring, as if May 25, 2017.

In addition, we recommended to the CMS Region V Office the following enforcement action as it relates to the remedy outlined in our letter of May 4, 2017.

- Civil Money Penalty for deficiency cited at F314, be imposed.

Effective May 25, 2017 the facility is certified for 85 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245275

September 22, 2017

Mr. John Doughty, Administrator Edenbrook of Edina 6200 Xerxes Avenue South Richfield, MN 55423

Dear Mr. Doughty:

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 May 25, 2017 the above facility is certified for:

Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 85 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: <u>mark.meath@state.mn.us</u>

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

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 22, 2017

Mr. John Doughty, Administrator Edenbrook of Edina 6200 Xerxes Avenue South Richfield, MN 55423

RE: Project Number S5275027

Dear Mr. Doughty:

On May 4, 2017, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective May 9, 2017. (42 CFR 488.422)

In addition, on May 4, 2017, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

• Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on April 13, 2017. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On June 5, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 13, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 25, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 13, 2017, as of May 25, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective May 25, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of May 4, 2017:

• Civil money penalty for the deficiency cited at F314, be imposed. (42 CFR 488.430 through 488.444)

Edenbrook of Edina September 22, 2017 Page 2

The CMS Region V Office will notify you of their determination regarding the imposed remedies, and appeal rights.

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

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

Sincerely,

### Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: <u>mark.meath@state.mn.us</u>

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

Enclosure(s)

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 22, 2017

Mr. John Doughty, Administrator Edenbrook of Edina 6200 Xerxes Avenue South Richfield, MN 55423

Re: Reinspection Results - Project Number S5275027

Dear Mr. Doughty:

On June 5, 2017, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 13, 2017. At this time, these correction orders were found corrected.

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 guestions related to this letter.

Sincerely,

### Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

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

cc: Licensing and Certification File



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

Electronically delivered July 20, 2017

Mr. John Doughty, Administrator Edenbrook of Edina 6200 Xerxes Avenue South Richfield, Minnesota 55423

Subject: Edenbrook of Edina - Independent Dispute Resolution (IDR)

CMS Certification Number (CCN): 24 5275

Project Number: S5275027

Dear Mr. Doughty:

This is in response to your letter of May 11, 2017, in regard to your request of an informal dispute resolution (IDR) for the Federal deficiencies at tag F314 and F353 issued pursuant to the survey event B3HD11, completed on April 13, 2017.

The information presented with your letter, the CMS 2567 dated April 13, 2017 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:

F314-G 42 CFR §483.25 (b)(1)-Pressure Ulcers: Based on the comprehensive assessment of a resident, the facility must ensure that-

- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they are unavoidable; and
- (ii) A resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

Summary of the facility's reason for IDR of this tag: In the written documentation submitted by the facility, dated 5/14/17, the facility requested the tag be removed or lowered in severity, indicated they felt R35's skin injuries were unavoidable due to multiple co-morbidities, a long standing history of rubbing and scratching herself raw, especially her lower extremities, incontinent of urine and bowel and frequently refused to accept cares and assessments. The facility also indicated as proof of good care provided by the facility, they alleged R35 did not have any skin breakdown on her buttocks or peri-area.

Summary of findings: R35 had diagnoses, which included Lichen Simplex Chronicus (neurodermatis, as result of chronic skin irritation), unspecified dementia with behavioral disturbance and pruritus. R35's annual Minimum Data Set (MDS) dated 2/7/17 indicated R35 had moderate cognitive impairment, required extensive assistance for activities of daily living and did not ambulate. The MDS indicated R35

Edenbrook Of Edina July 20, 2017 Page 2

had daily behaviors, which did not put R35 at significant risk for physical illness or injury, did not significantly interfere with residents care and did not reject care. Further, R35's MDS listed R35 was at risk for the development of pressure ulcers and did not have a current pressure ulcer. On 3/2/17, R35 developed an unstageable pressure ulcer on the right inner ankle. R35 did not have a comprehensive skin assessment completed after the development of the unstageable pressure ulcer, evaluating the causal factors, risk factors, and the development of interventions such as a repositioning schedule, alternatives for pressure relief while in bed and chair to attempt to prevent the development of further pressure ulcers and heal the present pressure ulcer. R35's right inner ankle pressure ulcer deteriorated, had exposed tendon on 3/31/17 and R35 had developed a second unstageable pressure ulcer on right inner heel at that time. In addition, approximately one week prior to survey, R35 developed a deep tissue injury of the left heel.

R35 was observed on several occasions during survey to remain in the same position, with feet dependent or resting directly on a firm surface, for prolonged periods, (i.e. 3 hours and 16 minutes, 2 hours and 50 minutes) without staff assisting or offering to assist R35 to reposition. Staff required prompting to complete repositioning for R35 during the observations. In addition, R35 developed a stage 2 pressure ulcer on 4/12/17 (during survey) on the left ischial tuberosity. Further, the facility failed to implement R35's current wound treatment orders, which included the use of calcium arginade.

R35 developed multiple pressure ulcers in the facility, and the facility failed to comprehensively assess R35 after the development of the multiple pressure ulcers and failed to develop interventions in an attempt to heal the current pressure ulcer (s) and prevent the development of further pressure ulcers. In addition, the facility failed to implement current orders for treatment of the pressure ulcers.

This is a valid deficiency at this tag and at the correct scope and severity of G.

F353-F 42 CFR §483.35 (a)(1) Sufficient Staff: The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

- (i) Except when waived, licensed nurses; and
- (ii) other nursing personnel, including but not limited to nurse aides

Summary of facility's reason for IDR dispute: The facility indicated they had consistent nursing patterns based on the individual needs of the floors, and had staffed appropriately. They indicated the facility had not lost any nurses since 3/6/17 and continue to hire certified nursing assistants. The facility indicated the deficiencies at F241, F279, F282, F309, F312, F313, F314, were not staffing issues, but possible poor performance by staff. Since 3/6/17, the facility has hired 23 new staff member, made changes to room occupancy and do not feel the new management company has had

negative impact on the nurse staffing within the building. In addition, the facility felt comments made by both staff and family members were reflections of frustration with transition when new management took over ownership of the facility.

Edenbrook Of Edina July 20, 2017 Page 3

Summary of findings: During the course of the survey, thru both resident and family interviews, there were many complaints regarding not enough nursing staff to meet the needs of the residents. The interviews revealed residents not receiving appropriate assistance with cares such as toileting, personal hygiene, and dressing. Family members reported when they were visiting their family in the facility, having to wait for long periods for call light response(>30 minutes), and their family member had not received assistance with such things toileting and transferring. Several staff indicated frequently the facility was short staffed, inadequate training for new staff and at times there had been one nurse to pass medications and provide cares for 17 residents. Staff indicated they had informed the director of nursing of their concerns in the past. In addition, the nurse practitioner stated she had discussed her concerns regarding staffing and cares with the director of nursing in the past.

In addition to mandating overtime for staff to cover shifts, the facility had modified the occupancy on each floor, and was hiring new staff. The director of nursing indicated the facility attempted to staff at a resident to staff ratio of 10:1 ratio, however, she indicated specific floors were more impacted than others by the staffing challenges. The executive director indicated the facility manager on duty had stopped monitoring call lights, dining service in March, however; indicated a not longer than seven minute response time for call lights was acceptable.

Although the facility was hiring new staff, mandating overtime and modifying occupancy on each floor, the facility did not provide sufficient nursing staff to meet the needs of the residents.

This is a valid deficiency at this tag and at the correct scope and severity of F.

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 Minnesota Department of Health

Licensing and Certification Program
1505 Pebble Lake Road, Suite 300

Fergus Falls, MN 56537

Telephone: 218-332-5140 Fax: 218-332-5196

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

Licensing and Certification File

Susie Haben, Metro D District Supervisor

Sail anderson

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

ID: B3HD

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00740 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 2 (L8) (L3) EDINA CARE & REHAB CENTER (L1) 1. Initial 2. Recertification (L4) 6200 XERXES AVENUE SOUTH 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) 55423 (L2)964043600 (L5) RICHFIELD, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 8. Full Survey After Complaint (1.9)05 HHA 13 PTIP 01 Hospital 09 ESRD 22 CLIA 6. DATE OF SURVEY 04/13/2017 (L34) 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: \_\_ (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 12 RHC 06/30 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 16 HOSPICE 2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: And/Or Approved Waivers Of The Following Requirements: From (a): A. In Compliance With \_\_\_\_ 2. Technical Personnel То (b): Program Requirements Scope of Services Limit Compliance Based On: \_\_\_ 3. 24 Hour RN Medical Director 4. 7-Day RN (Rural SNF) 1. Acceptable POC 8. Patient Room Size 12. Total Facility Beds 85 (L18) \_\_\_ 5. Life Safety Code \_\_\_ 9. Beds/Room 85 (L17) 13. Total Certified Beds **X** B. Not in Compliance with Program Requirements and/or Applied Waivers: (L12)14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 19 SNF ICF IID (L15)18 SNF 18/19 SNF 1861 (e) (1) or 1861 (j) (1): 85 (L37)(1.38)(L39) (L42)(L43) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): See Attached Remarks 17. SURVEYOR SIGNATURE 18. STATE SURVEY AGENCY APPROVAL Date: Date: Mark Meath, Enforcement Specialist Jane Teipel, HFE NEII 05/18/2017 06/19/2017 (L19) (L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 21. 1. Statement of Financial Solvency (HCFA-2572) RIGHTS ACT: 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) X 1. Facility is Eligible to Participate 3. Both of the Above: Facility is not Eligible (L21)22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE VOLUNTARY INVOLUNTARY 05/01/1985 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L24)(L41) (L25)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS OTHER 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: 00-Active (L44)(L27)B. Rescind Suspension Date: (1.45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 03001 (L28) (L31) 31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE (L32) (L33) **DETERMINATION APPROVAL** 

#### 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

Facility ID: 00740

**C&T REMARKS - CMS 1539 FORM** 

STATE AGENCY REMARKS

CCN: 24 5275

On April 13, 2017 a standard survey was completed by the Departments of Health and Public Safety to verify compliance with Federal participation regulations. The most serious deficiency was cited at a scope and severity level of G (isolated deficiencies that constituted actual harm that was not immediate jeopardy), whereby significant corrections were required.

As a result of this survey, the Department imposed the Category 1 remedy of state monitoring, effective May 9, 2017.

In addition, we recommended to the CMS Region V Office the following enforcement remedy for imposition:

- Civil Money Penalty for deficiency cited at F314.

Refer to the CMS 2567 along with the facility's plan of correction. Post Certification Revisit to follow.



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

Electronically delivered

May 4, 2017

Mr. John Doughty, Administrator Edina Care & Rehabilitation Center 6200 Xerxes Avenue South Richfield, MN 55423

RE: Project Number S5275027

Dear Mr. Doughty:

On April 14, 2017, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS 2567, whereby significant corrections are required.

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

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

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

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

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

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

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

### **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:

Maria King, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Mankato Plaza
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001-7789
Email: maria.king@state.mn.us

Phone: (507) 344-2716 Fax: (507) 344-2723

### NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; **OR**
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey **OR** deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; **OR**
- A facility is classified as a Special Focus Facility (SFF) <u>AND</u> has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

• State Monitoring effective May 9, 2017. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

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

### ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the 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 their respective deficiencies (if any) is acceptable.

### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by July 14, 2017 (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 October 14, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

### INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the

specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

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

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

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

Telephone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

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

PRINTED: 05/18/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 04/13/2017		
		245275	B. WING			04/	14/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		62	TREET ADDRESS, CITY, STATE, ZIP CODE 200 XERXES AVENUE SOUTH CICHFIELD, MN 55423		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	тѕ	F0	00			
	signature is not req page of the CMS-2	lled in ePOC and therefore a pured at the bottom of the first 567 form. Electronic POC will be used as oliance.					
	revisit of your facilit validate that substa regulations has bee your verification.	acceptable POC an on-site by may be conducted to antial compliance with the en attained in accordance with					
F 157 SS=D	483.10(g)(14) NOT (INJURY/DECLINE		F 1	57			5/25/17
	(g)(14) Notification	of Changes.					
	consult with the res	nmediately inform the resident; sident's physician; and notify, or her authority, the resident then there is-					
		olving the resident which I has the potential for requiring on;					
	mental, or psychos deterioration in hea	ange in the resident's physical, ocial status (that is, a llth, mental, or psychosocial threatening conditions or ns);					
	a need to discontin treatment due to ac	treatment significantly (that is, ue an existing form of dverse consequences, or to form of treatment); or					
	(D) A decision to tra	ansfer or discharge the					
I ABORATOR'	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE		TITLE		(X6) DATE

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

**Electronically Signed** 

05/11/2017

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		245275	B. WING_		04/1	4/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		
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F 157	resident from the fa §483.15(c)(1)(ii).  (ii) When making n (14)(i) of this section all pertinent information is available and prophysician.  (iii) The facility must resident and the result when there is-  (A) A change in rocas specified in §483  (B) A change in result (e)(10) of this section (iv) The facility must update the address phone number of the This REQUIREMED (by:	otification under paragraph (g) on, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the st also promptly notify the sident representative, if any, om or roommate assignment 3.10(e)(6); or sident rights under Federal or tions as specified in paragraph on.  St record and periodically (mailing and email) and the resident representative(s).	F 1:			
	review, the facility f physician when a p	tion, interview, and document ailed to promptly notify the ressure ulcer developed and residents (R35) reviewed.		Potentially could affect any res facilityR35 passed away prior to the SODPolicies and procedures revieupdated and are currently up to	receipt of	
	R35's progress not identified on 3/6/17 was painful to toucl notation regarding 4/1/17, a skin chec documentation of:	es from 3/6/17, to 4/11/17, , R35's right inner malleolus h and tender and there was no an update to physician. On k was completed with 'Other right heel-pressure ight ankle (inner) pressure-		-Training provided to staff. Re: MD of change of condition2-3 Audits of skin assessment completed. Refusal of skin ass to be charted in EMR. Audits to completed weekly x 3. Then, m-Audit results to be reviewed at determination of compliance at	Updating t being essments b be nonthly. t QAPI for	

		IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 157	stage II" and identification following day on 4/2 that the dressing of completed and had drainage from the value lacked evidence the notified. On 4/6/17, the right ankle dress and the wound look substance in the whowever, the record the physician had be with the providence of the physician had be with t	fied no new skin areas. The 2/17, documentation identified nange to right ankle was I a large amount of yellowish wound site. Documentation at the provider had been the progress note identified sing change was completed ked bigger, had a white ound site and was odorous, d lacked documentation that been updated.  The specialist evaluation is specialist evaluation is seen aware of R35's right ure ulcer on 3/2/17 and right	F 157	to continueDON or designee will be responsauditsDate of compliance May 25, 201			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER  ARE & REHAB CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		•			
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F 157	dressing change.  On 4/12/17, at 10:1 assessment of the DON stated the left superficial skin loss Stage I on 4/11/17. noted the Stage I p notify the physician paperwork at that ther jaw and had futurn to her left side left heel, which she tissue injury measureported the area v  On 4/12/17, at 1:44 stated she was new with R35. NP-A sta staff would contact alterations, but had problems with R35 the resident on 4/3 observed, NP-A wo pressure and imple interventions. If a reshe would potentia  On 4/12/17, at 6:15 was conducted with He reported he saw 4/7/17 and was foll and right heel presunaware of the left and skin break dow expected to be not wounds. It was also	age 3 "That hurts!" during the  19 a.m. the DON completed an resident's skin condition. The t ischial tuberosity had so over the previously identified. The DON stated although she pressure ulcer, she did not a or complete any related ime. R35 moaned, tightened rowed brows when assisted to a the DON then observed the estated was a suspected deep uring 1 cm x 1 cm x 1 cm. R35 was painful to touch.  It p.m. nurse practitioner (NP)-A who to the facility and unfamiliar ted it was an expectation the the NP with new skin and to been informed of any is skin since she began seeing who wound had developed, and institute orders to off load ement pressure relieving new wound had developed, and wound physician (MD)-A. W R35 for the first time on owing the right medial ankle sure ulcers. MD-A was suspected deep tissue injury on R35's buttocks. MD-A ified of significant decline in a expected daily dressing performed on R35's right	F 15	7				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245275	B. WING		04/14/2	017
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(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)	D BE COM	(X5) MPLETION DATE
F 176 2 SS=D [	ulcer, and would hawithout appropriate MD-A's impression neels, and at a minithe heels to be off to would be reposition to east every two hou would implement profer R35's heels, and consider the NP when observed, as the NP when observed, as the NP R35. The DON stated dressing changes.  The facility's 4/21/1 Wound Care Programment upon ider on the NP when observed in a timely treatment upon ider on the NP R33.10(c)(7) RESID DRUGS IF DEEME (c)(7) The right to set the interdisciplinary S483.21(b)(2)(ii), he coractice is clinically This REQUIREMENT op:  Based on observative self-administered metals in the receivent of the self-administered metals with the self-administered metals w	ded R35 had a Stage IV ankle ove increased in size/severity dressing changes. It was the staff were elevating R35's imum would have expected he bed, and the resident ed out of her wheelchair at rs. It was also expected staff ressure relieving interventions (le, and buttocks.)  O p.m. the DON stated her enurse should immediately the skin alteration was Pultimately oversaw care for ed R35 experienced pain with 4, Chalet Living and Rehab am policy and procedure would "initiate wound care of the wound with the dot or efer to the wound with the dot or efer to the wound care of fashion."  DENT SELF-ADMINISTER the elf-administer medications if team, as defined by as determined that this	F 157		er	5/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G	` '	(X3) DATE SURVEY COMPLETED	
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F 176	Findings include:  R53 was interviewed when licensed pract R53's evening medincluded an Ipratrop treatment. LPN-A land reported there mask. Without resensuring R53 receileft the room. LPN-Ipratropium-Albuter R53's medication at On 4/10/17, at 7:21 should have set up R53 but did not been medication left in her R53's physician or Ipratropium-Albuter milligrams/3 millilite times a day for chrodisease. R53's recresident had been self-administration current care pland capable and chose nebulizer treatment. The director of nursat 2:30 p.m. R53 with medications. Howeverified the staff has assessment that shelf-administering the self-administering to the self-administering the self-admini	ed on 4/10/17, at 5:08 p.m. etical nurse (LPN)- A brought in lications. The medications pium-Albuterol nebulizer booked at the nebulizer mask was still medication left in the starting the treatment and ved all of the medicine, LPN-A A then documented that the rol nebulizer was given on administration record (MAR).  I p.m. LPN-A stated that he the nebulizer treatment for cause the resident still had is nebulizer mask.  I ders included rol Solution 0.5-2.5(3) ers, 1 vial inhale orally four onic obstructive pulmonary ord also lacked evidence the assessed for of medications, and R53's id not reflect the resident was to self-administer the	F 176	-Staff have been educated on of self administration assessme allowing self administration2-3resident audits will be done per week/audits to be complete month on residents self admininebulizersDON or designee is responsib audits. Audits to be reviewed nequarterly at QAPI for determina compliance and need to contine. Date of compliance 5/25/2017	ent prior to e 1-2 times ed x 1 stering le for o less than ation of ue.		

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 176		ige 6 ed the nebulizer treatment was mented R53 did not receive	F 1	76			
F 225 SS=D	Medication Policy a resident who reque medications will be resident is able to s	ed Self-Administration and Procedure directed "A sts to self-administer assessed to determine if afely self-medicate."  1)-(4) INVESTIGATE/REPORT DIVIDUALS	F 2	25		5/25/17	
	483.12(a) The facil (3) Not employ or o who-	ity must- therwise engage individuals					
		d guilty of abuse, neglect, propriation of property, or court of law;					
	nurse aide registry	ing entered into the State concerning abuse, neglect, atment of residents or their property; or					
	or her professional body as a result of	hary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or resident property.					
	licensing authorities actions by a court of	ate nurse aide registry or s any knowledge it has of of law against an employee, te unfitness for service as a facility staff.					

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 225	exploitation, or mise (1) Ensure that all a abuse, neglect, explicted including injuries or misappropriation or reported immediate after the allegation cause the allegation serious bodily injure the events that cause and do not reported immediate after the allegation serious bodily injure the events that cause and do not reported including adult protective serior jurisdiction in lost accordance with Seprocedures.  (2) Have evidence thoroughly investigation, or mise investigation is in procedures.  (4) Report the result administrator or his representative and with State law, included Agency, within 5 wife the alleged violate corrective action many the serior many that is represented in the serior many that is the serior	allegations of abuse, neglect, treatment, the facility must:  alleged violations involving poloitation or mistreatment, if unknown source and if resident property, are ally, but not later than 2 hours is made, if the events that in involve abuse or result in y, or not later than 24 hours if use the allegation do not involve result in serious bodily injury, to if the facility and to other to the State Survey Agency and revices where state law provides ing-term care facilities) in tate law through established that all alleged violations are ated.  potential abuse, neglect, treatment while the progress.  alts of all investigations to the sor her designated to other officials in accordance uding to the State Survey orking days of the incident, and ion is verified appropriate	F 2	Alleged tag could potential residents.	ly affect all	
		allegations of neglect or abuse		-OHFC reports were filed o	n R75 and	

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(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 225	to the facility admin agency (SA) for 1 cabuse prohibition.  Findings include:  R42 sustained a brknee measuring 4.3 cm wide according 3/29/17. The report nursing assistant (Noreported it to regists she was not sure however, R42 also "grabbed out" of hew Witness/Observer NA-B noted while a cares, she reported the way she was transparent to RN RN-A had done any also reported it to hinterviewed R42.  The facility was askevidence the admin notified of the alleg been notified three submitted at report NA-B was interviewed R42.  NA-B was interviewed and stated that on the morning of 3/19 bruise on her left king cares the night before	istrator and designated State of 1 resident (R42) reviewed for use on 3/19/17, on her left centimeters (cm) long by 2.3 to an incident report dated indicated that on 3/19/17, NA)-B noted the bruise and ered nurse (RN)-A. R42 stated ow she sustained the bruise now it had happened.	F 2	225	R42.  -Dispositions of "no further action to have been received from OHFCPolicy has been reviewed and is undate.  -Staff were reeducated on importary immediately reporting resident injuried including list of types of injuries that be reported.  -On call process revised to include immediate call to DON and ED of a suspected abuse.  -OHFC report log updated and now includes section of when administrated by was updated on the issue.  -Staff background checks have been completed. HR is using a spreadshaudit that background checks are completed on new hire employees.  -Multiple staff have the ability to file reports and have been trained in sall in the event one is unable to make report, the background reporter call will make report for them.  -2-3 Audit of OHFC timeliness will done weekly x 4, monthly x 2 and reviewed quarterly at QAPI for determination of compliance and not continue.  -Social services and ED or designed be responsible for audits.  -Date of compliance 5/25/2017.	p to nce of ries t must all dator or en neet to e VA ame. e n and be eed to	

to NA-D.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
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F 225	a.m. RN-A stated hinformed of a bruis  During an interview a.m. the DON state the night the incide to me on 3/19/17, to the MDH until 3/our process regard MDH. We should him the DON, Executiv was not done. The documentation as notified.  During an interview stated she was attacted she was attacted she was attacted. It was you on me and hit my lepeople. I felt panicle attacked before. The people. I reported in the process of the occurred on 3/19/1 incident. He further the facility is to call should contact the	age 9  If conducted on 4/12/17, at 9:19 the did not remember being the on R42 at any time.  If conducted on 4/13/17, at 8:16 the did she was the nurse on call that occurred and was reported by NA-D and was not reported 22/17. We have since changed ling reporting incidents to the thave reported it right away to the Director and the MDH which facility could not provide to the nurse on call being  If on 4/11/17, at 1:14 p.m. R42 the acked sometime last winter the nurse on call been there may have been three the right away to RN-A.  If on 4/13/17, at 12:02 p.m. The stated he did not recall if he the incident to R42 which The did remember the The stated in this type of incident the nurse on call and they DON, LSW and myself. We determine if it needs to	F 22	5		
	Executive Director deny if he had bee	H.  on 4/13/17, at 1:04 p.m. stated he could not confirm or notified of the incident /19/17, but the policy is to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` '		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245275	B. WING		04	/14/2017	
NAME OF PROVIDER OR SUPPLIER  EDINA CARE & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP ( 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 225	was not done.  During an interview LSW-B stated it was reported a bruise to and I was notified of indicates that if a b notify LSW or the E and that did not hall based on interview facility failed to immunknown origin or a to the facility admin of 1 resident (R54)  Findings include:  R54 reported she has when interviewed of alleged her roomm being physically ab reported it to a nurs room for the weeked to a different room  R54's medical diagriculated anxiety disorder, borderlined disorder, B54's min 3/7/17, identified he care plan printed 4/5 facility as current and vulnerable adult indinterventions: Rem situations, observe interventions to min re-occurrence, rem	e this within 24 hours and that  of on 4/12/17, at 9:25 a.m. as my understanding that a NA of R42's left knee on 3/19/19, on 3/22/17. The facility policy ruise is noted the staff would of oN to start an investigation open in this instance. and document review, the nediately report injuries of allegations of neglect or abuse sistrator and state agency for 1 incident reports reviewed.  and been abused at the facility on 4/11/17, at 8:36 a.m. R54 ate, R74 began hitting her and usive. R54 immediately se. R54 moved to a different and and then R74 was moved the following Monday.  noses on the admission record forder, major depressive a personality disorder, bipolar animum data set (MDS) from are to be cognitively intact. The alternative of the following ove from potentially abusive for and implement	F 22	5			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245275	B. WING		04	/14/2017	
NAME OF PROVIDER OR SUPPLIER  EDINA CARE & REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STATE, ZIP 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423	· · · · · · · · · · · · · · · · · · ·	04/14/2017	
(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 ACTIVE CROSS-REFERENCED TO THE CORRECTION OF	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 225	behaviors.  The incident documerare center dated 3 had moved to room the weekend for he was verbal/physical for the concerns of agreed to place her dentified resident to occurred on 3/31/1 state agency on 4/3 (LSW)-A. R54 state corner, hit her and of the room to alert staff members as we R54 moved to anote Monday when private moved to a private noted.  On 4/13/17, at 10:4 (DON) stated regisk now immediately a LSW-A was called the report filed due she was called immincident. The abuse state agency the net the facility recently Nurses should the on-call nurse calls administrator, social and LSW-A will coll report abuse incident.	nented in progress note from 8/31/17, identified "Resident 223 and will be staying over resafety. Resident's roommate aggression toward her, and her safety, the RN on call resident abuse. The incident 7, and was reported to the 1/17, by licensed social worker ed R74 backed her into a tried to punch her. R54 ran out the nurses. R74 tried to hit well. No injuries noted to R54, her room for the weekend, on ate room available R74 was room. No further incidences  8 a.m. the director of nursing tered nurse (RN)-E let the her about this abuse incident and LSW-A was not able to get to internet issues, however nediately regarding this abuse incident was reported to the ext morning. The DON stated changed abuse reporting. Call on-call nurse and the everyone else like the DON, alworker, MD, etc. The DON laborate on if they should ant to the state agency. LSW-A one to submit abuse report.		225			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
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F 225	Resident/client/part procedure for the fat 12/12, stated emploa abuse immediately building supervisor. per protocol and wi making and will be agency in accordant also identified if the altercation was a w was to cause harm individual, a willful it altercation should the is no injury. The fact monitor to prevent alleged abus Supervisor or the Best Executive Director/must be contacted reporter regarding a abuse/neglect. Immediately in the state of the State accordance with state substantiated, it will licensing board. Based on interview failed to complete of the state of t	dicipant protection policy and acility dated as last revised in byees must always report to the supervisor or the The DON will be contacted Il involve LSW in decision reported to the state reporting ace to the state law. The policy resident to resident illful act, the resident's intent or wanted to hurt the other infliction of injury this hen be reported, even if there cility must minimize and reoccurrence.  Intified employees must always e/neglect immediately to the uilding Supervisor. The or designated representative immediately by Supervisor or	F 23	25		

NAME OF PROVIDER OR SUPPLIER  EDINA CARE & REHAB CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423  D PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
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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	
DEFICIENCY)	
During a review of employee records and interview with human resource (HR) director on 4/12/17, at 8:36 a.m. one employee/dietary aide (DA)-A, whose date of hire was 3/9/17, idi not have a completed background check in the employee file. DA-A was on the schedule and had worked in the facility, DA-A had not been supervised or with another staff person at all times. HR explained the "expectation is to have the background completed for all staff. I can see that I will need to do an audit to make sure this was done". At 4/12/17 11:01 a.m. HR reported this employee was removed from the schedule pending her completed background Screening", revised 7/1/12, identified potential employees would receive job offers contingent upon the satisfactory completion of a background screening.  F 226  483. 12 (b) The facility must develop and implement written policies and procedures that:  (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,  (2) Establish policies and procedures to investigate any such allegations, and  (3) Include training as required at paragraph \$483.95,	5/25/17

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NAME OF PROVIDER OR SUPPLIER  EDINA CARE & REHAB CENTER				0-11 1-11 20 11	
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F 226	483.95 (c) Abuse, neglect, the freedom from a requirements in § 4 provide training to educates staff on- (c)(1) Activities that exploitation, and m property as set fort (c)(2) Procedures for neglect, exploitation resident property (c)(3) Dementia maprevention. This REQUIREMED by: Based on interview facility failed to implimmediately report allegations of neglect administrator and so (R42).  Findings Include:  The facility's Policy Resident/client/par Reporting and Resemployees must all abuse/neglect (i.e. abuse, neglect, injumisappropriation of property) immediated Building Supervisor designated representations.	and exploitation. In addition to abuse, neglect, and exploitation 183.12, facilities must also their staff that at a minimum t constitute abuse, neglect, isappropriation of resident	F 220	Alleged tag could potentially affect residents.  -OHFC reports were filed on R75 at R42.  -Dispositions of "no further action thave been received from OHFC.  -Policy has been reviewed and is undate.  -Staff were reeducated on importar immediately reporting resident injurincluding list of types of injuries that be reported.  -On call process revised to include immediate call to DON and ED of a suspected abuse.  -OHFC report log updated and now includes section of when administrated to be successed to the issue.  -Staff background checks have becompleted. HR is using a spreadship.	aken" p to nce of ries t must all v ator or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245275	B. WING			04/	14/2017
NAME OF PROVIDER OR SUPPLIER  EDINA CARE & REHAB CENTER				62	TREET ADDRESS, CITY, STATE, ZIP CODE 200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	all allegations of abreporting may be reanswering machine time of notification. contacted per protes services or designed abuse occurred, it is Reporting Agency in the abuse is substated the registry or licented Include who was notification occurred designee in the not.  An incident report of 3/19/17, nursing as a bruise on her left registered nurse (Recentimeters (cm) lowas asked by nurses she stated she was R42 also stated she out of her wheelched Statement dated 3/morning cares on Fupset with previous supper. A bruise was which was reported unsure whether RN then reported incide consulted with R42.  The facility could not director of nursing Executive Director 3/22/17. The incide	use/neglect. Immediate eported via voice mail, e, or fax. Document date and Director of Nursing will be cool and will involve Social se. If there is suspicion that will be reported to the State in accordance with state law. If antiated, it will be reported to sing board. Documentation: otified and the time the d. Include social services or ification.  Isted 3/29/17, indicated on sistant (NA)-B noted R42 had knee and reported it to N)-A. Bruise measured 4.3 ang by 2.3 cm wide. When R42 is how it could have happened in the sure how it happened in the hours in the sure happened in the s	Fź	2226	audit that background checks are completed on new hire employees.  -Multiple staff have the ability to file reports and have been trained in sall in the event one is unable to make report, the background reporter carwill make report for them.  -2-3 Audit of OHFC timeliness will be done weekly x 4, monthly x 2 and reviewed quarterly at QAPI for determination of compliance and necontinue.  -Social services and ED or designed be responsible for audits.  -Date of compliance 5/25/2017.	e VA ame. e n and oe	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 226	During an interview 10:00 a.m. NA-B si 3/19/17, R42 told hence and was upselbefore and the NA' immediately to RN-During an interview 9:19 a.m. RN-A stabeing told about a During an interview a.m. DON stated so night the incident of me on 3/19/17, by the MDH until 3/22 our process regard MDH. We should he DON, Executive was not done. The documentation as a notified.  During an interview stated she was attacted she was attacted she was attacted before. The people. I felt paniculated attacked before. The reported it right as During an interview executive Director was apprised of the occurred on 3/19/1 incident. He further the facility is to call should contact the	conducted on 4/12/20, at tated on the morning of tated on the morning of the tated on 04/12/17, at tated he did not remember the tated the did not remember the tated the tated on 4/13/17, at 8:16 the was the nurse on call the courred and was reported to NA-D and was not reported to NA-D and was not reported to 1/17. We have since changed thing reporting incidents to the tated reported it right away to be Director and the MDH which facility could not provide to the nurse on call being to on 4/11/17, at 1:14 p.m. R42 tacked sometime last winter the tated the	F 22	26			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  B	(X3) DATE SU COMPLE		
		245275	B. WING		04/14/	2017	
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F 226	the MDH.  During an interview Executive Director deny if he had bee involving R42 on 3 report incidents like was not done.  During an interview stated it was my ur reported a bruise to and I was notified of indicates that if a bruifly SS or DON to did not happen in the Based on interview interview, the facility policy to immediate origin or allegations facility administrator resident (R54) incidentally and procedure 12/12, stated empleabuse immediately building supervisor per protocol and with making and will be agency in accordance also identified if the altercation was a was to cause harmindividual, a willful	or on 4/13/17, at 1:04 p.m. stated he could not confirm or n notified of the incident /19/17, but the policy is to e this within 24 hours and that or on 4/12/17, at 9:25 a.m. SS-B inderstanding that a NA or R42's left knee on 3/19/19, on 3/22/17. The facility policy bruise is noted the staff would or start an investigation and that	F 226				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		E SURVEY MPLETED	
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NAME OF PROVIDER OR SUPPLIER  EDINA CARE & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423	1 0.0.1.0.2011		
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F 226	possible for a willfusomeone with dem minimize and moni The policy also idereport alleged abus Supervisor or the Executive Director/must be contacted reporter regarding abuse/neglect. Impreported via voice of fax. Document date there is suspicion to reported to the Star accordance with star substantiated, it will licensing board.  R54 reported she has when interviewed alleged her roomm being physically ab reported it to a nurs room for the weeked to a different room  R54's medical diag included anxiety disdisorder, borderlined disorder. R54's min 3/7/17, identified he current care plan p R54 being a vulner following interventice.	act to be committed by tentia. The facility must altor to prevent reoccurrence.  Intified employees must always be neglect immediately to the Building Supervisor. The or designated representative immediately by Supervisor or all allegations of nediate reporting may be mail, answering machine, or exand time of notification. If hat abuse occurred, it will be the Reporting Agency in ate law. If the abuse is all be reported to the registry or and been abused at the facility on 4/11/17, at 8:36 a.m. R54 ate, R74 began hitting her and ausive. R54 immediately see. R54 moved to a different and and then R74 was moved the following Monday.  Incoses on the admission record sorder, major depressive a personality disorder, bipolar nimum data set (MDS) from are to be cognitively intact. The provided as current addressed able adult including the ons: Remove from potentially observe for and implement	F 22	6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED	
<b>245275</b> B. WING	04/14/2017	
NAME OF PROVIDER OR SUPPLIER  EDINA CARE & REHAB CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423	0.41.4.2011	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPROPROPROPROPED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	D BE COMPLÉTION	
F 226  Continued From page 19 behaviors.  The incident documented in progress note from care center dated 3/31/17, identified "Resident had moved to room 223 and will be staying over the weekend for her safety. Resident's roommate was verbal/physical aggression toward her, and for the concerns of her safety, the RN on call agreed to place her to 223 temporary."  An investigative report provided by the facility identified resident to resident abuse. The incident occurred on 3/31/17, and was reported to the state agency on 4/1/17, by licensed social worker (LSW)-A. R54 stated R74 backed her into a corner, hit her and tried to punch her. R54 ran out of the room to alert the nurses. R74 tried to hit staff members as well. No injuries noted to R54. R54 moved to another room for the weekend, on Monday when private room of wailable R74 was moved to a private room. No further incidences noted.  On 4/13/17, at 10:48 a.m. the director of nursing (DON) stated registered nurse (RN)-E let the her know immediately about this abuse incident and LSW-A was called. LSW-A was not able to get the report filed due to internet issues, however she was called immediately regarding this abuse incident. The abuse incident was reported to the state agency the next morning. The DON stated the facility recently changed abuse reporting. Nurses should the call on-call nurse and the on-call nurse calls everyone else like the DON, administrator, social worker, MD, etc. The DON and LSW-A wail collaborate on if they should report abuse incident to the state agency. LSW-A		

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F 226		ge 20	F 226	5		
F 241 SS=D	l	TY AND RESPECT OF	F 24	1		5/25/17
	resident in a manner promotes maintenather quality of life reindividuality. The fapromote the rights of This REQUIREMENTS assed on observative, the facility for a manner which for 2 of 4 residents activities of daily lividignified dining experior (R49) served in the Findings include:  R1 was observed refully for a manner which for 2 of 4 residents activities of daily lividignified dining experior (R49) served in the Findings include:  R1 was observed refully for a finding include:  R1 was observed refully for a finding include:  R1 was observed refully for a finding include:  R1 was observed refully finding in the room had two large an adjacent apartment of the finding item and lower private at may have entered to from the outside.  R1's care plan dated dementia, severely	t treat and care for each er and in an environment that nce or enhancement of his or cognizing each resident's cility must protect and of the resident.  NT is not met as evidenced cion, interview and document ailed to provide personal cares promoted privacy and dignity (R1, R49) observed for ing (ADL's), and to provide a erience for 1 of 13 residents 3 north (3N) dining room.  Receiving morning cares on a by nursing assistant (NA)-L. bed closest to the door. The windows, one of which faced ent complex. NA-L provided out shutting the window 1's privacy curtain. NA-L a walked across the room to ms for R1 leaving her upper reas exposed to anyone who he room or potentially view d 3/9/17, revealed she impaired decision making and long term memory loss,		All residents have the potential to be affected by this.  -R1 alleged deficiency was corrected time of surveyFacility policy on privacy during can been reviewed and is correctR49 care plan does have finger for be offered per residents preference -Staff were educated on importance providing privacy with cares, this increview of residents rights related to privacy and dignityCare plans are reviewed and upda address resident preferences and changes to their ability no less than quarterly and PRNFacility staff were educated on folk dietary recommendations as noted meal tray cardsResident meal preferences, assistanceds and abilities will be assessed quarterly at care conferences2-3 Privacy audits including pulling closing doors, pulling privacy curtain be completed 2 x times weekly x 3, weekly thereafter. to be reviewed at	ed at res has ods to e of cludes ted to owing on ance blinds, ns will and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	\ , ,	E SURVEY IPLETED
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F 241	Continued From pa	age 21	F 24 <sup>2</sup>			
	staff was directed to resident's needs an agitation.  NA-L reported on 4 been a NA for seven providing privacy disorry," then pulled to the residue of the r	sive assistance to dress. The o anticipate and meet the od to decrease episodes of 1/12/17, at 7:35 a.m. she had eral years. When asked about uring cares NA-L replied, "Oh the privacy curtain shut. NA-L		to determine compliance and continue.  -Dining dignity audits to be compliance and weekly there reviewed at QAPI to determine compliance and need to consume audits.  -Date of compliance 5/25/20	ompleted 2 x eafter. To be ne tinue. sponsible for	
	explained the facility's policy and procedure was to provide dignity by pulling the shades and privacy curtain, and ensuring the door was closed. NA-L verified she should have provided privacy for R1 to ensure she was not exposed.					
	how she felt about cares. R1 replied, "	d following the observation and not being covered during 'It doesn't bother me. This is yday. What can I do?"				
	executive director ( to provide dignity a	on 4/12/17, at 1:46 p.m. the (ED) stated he expected staff and privacy to all residents by and closing the door.				
	Respect & Dignity   "staff are responsib	Policy on Resident Rights, policy and procedure noted ple to maintain and enhance em and worth, by providing				
	seated at a table in served a plate of for patty and scramble scrambled eggs wir	on 4/11/17, at 8:34 a.m. while the 3N dining room. R49 was nod with a pancake, a sausage of eggs. R49 ate bites of her th a spoon, but ate the uncut to sausage patty with her				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  3		(X3) DATE SURVEY COMPLETED	
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F 241	helped another res was provided by N. to cut R49's food outensils.  The following morn R49 was observed room. NA-K set a pand asked if she wasusage cut, but dibacon. R49 replied cut and added map couple of cuts into walked away. Althoron it, it was not full pieces. R49 picked the patty, and then and pulled off a piebacon and broke it.  At 8:34 a.m. NA-P R49 unsuccessfully sausage patty up wicked up the uncut NA-K asked if she poured apple juice some bites of scrapieces dropped on clothing. R49 picked	sat down at R49's table and ident to eat. No assistance A-P or other staff in the room rencourage her to utilize  ning on 4/12/17, at 8:25 a.m. sitting at the table in the dining plate of food in front of R49, anted her french toast and id not offer to also cut her I "yes." The french toast was ple syrup. NA-K quickly made a R49's sausage patty and then pugh the patty had cut marks yout through or into bite-sized I up her fork and stabbed at picked it up with her fingers ece. She picked up a piece of	F 24	,			
	R49's quarterly Mir indicated R49 requ eating, with R49 be activity. Staff provide	rages served at the meal.  nimum Data Set dated 3/1/17,  nired limited staff assistance for eing highly involved in the ded guidance of maneuvering on-weight bearing assistance.					

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F 279 SS=D	resident with meal spieces, and to prov Staff were to provid required at mealtim On 4/13/17, at 10:3 nursing (ADON) state eating with fingers stated staff should her food cut up and plans because that how to provide care. The facility's 1/12, I responsible for carrithe resident to main residents self-estee of dignified care incompanded when and as needed 483.20(d);483.21(b) COMPREHENSIVE 483.20 (d) Use. A facility massessments compand months in the residents of the assess and revise the residents.  483.21 (b) Comprehensive (1) The facility muscomprehensive per staff was a self-estero for the self-es	olan directed staff to assist the set-up, cutting food into small ide supervision with all meals. It is as much assistance as R49 ite.  3 a.m. the assistant director of ated she did not consider to be dignified. The ADON have asked R49 if she wanted I were expected to follow care was how the staff knew of a for their residents.  Dignity policy "Staff are rying out activities that assist that and enhance each em and self-worth. Examples clude Offering assistance ed."  (1) DEVELOP E CARE PLANS  The provious 15 is the control of the control	F 2			5/25/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	includes measurab to meet a resident's and psychosocial nucomprehensive assocare plan must des  (i) The services that or maintain the resiphysical, mental, and required under §48  (ii) Any services that under §483.24, §48 provided due to the under §483.10, inclute at ment under §4  (iii) Any specialized rehabilitative service provide as a result recommendations. findings of the PAS rationale in the resident's representational in the resident's representation of the provide as a result recommendations. (iv) In consultation we resident's representational in the resident's good the provide as a result recommendations. (iv) In consultation we resident's representational in the resident's good the provide as a result recommendations. (b) The resident's good the provided as a result recommendation we resident's representational in the resident's good the provided as a result recommendation of the provided as a result rec	ol(c)(2) and §483.10(c)(3), that le objectives and timeframes is medical, nursing, and mental eeds that are identified in the sessment. The comprehensive cribe the following -  t are to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 3.25 or §483.40 but are not a resident's exercise of rights uding the right to refuse 83.10(c)(6).  services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record.  with the resident and the tative (s)-  goals for admission and  preference and potential for acilities must document at sessed and any referrals to sessed and any referrals to sessed and/or other appropriate	F 2	279			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION  NG		E SURVEY IPLETED
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F 279	(C) Discharge plan plan, as appropriate requirements set for section. This REQUIREME by: Based on observative review the facility for 1 residents respressure ulcers.  Findings include: R35's care plan day had actual alteration cognitively impaired neurodermatitis, at both lower extreming chest. R35's care plan directs. R35's care plan directed staff bed to avoid laying on open are to ensure that proping the chair and potransferring R35 to plan directed staff bed to avoid laying. The care plan did indeep tissue injury fulcer to right heel, and right great toe direct facility staff if turned/repositioned devices were to be R35's annual Mining 2/7/17, identified R impairment and har heumatoid arthritical residuals.	is in the comprehensive care te, in accordance with the orth in paragraph (c) of this in the interview, and document ation, interview, and document atied to develop a care plan for viewed (R35) related to  atted 3/21/17, identified that R35 on of skin integrity due to being d, assistance with ADLs, and had scratches/wounds on ties, left buttock, shoulder, and plan directed facility staff to oning frequently in bed to avoid as. The care plan directed staff per pressure reducing device is sitioned correctly before to wheelchair. Further, the care to "assist with repositioning in an open areas frequently". In ot address R35's suspected to the left heel, unstageable right inner ankle press ulcer, wound. The care plan did not now often R35 needed to be dor what pressure relieving	F 2	Alleged tag could potentially every resident in the facility.  R35 passed away prior to recare plans reviewed on residence ulcers and are currecare ulcers and are currecare ulcers and are currecare plans of 2-3 residents winjury will be audited weekly amonthly thereafter.  Audits results to review no lequarterly at QAPI for determine compliance and need to conticulate.  DON or designee will be respandits.  Date of compliance 5/25/201	ceipt of SOD. dents with ent. odating timely. with tissue 6, then ess than nation of nue. consible for	

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 279	assistance with act R35 did not have a risk. The MDS indiction and a clinical adetermine R35's proposed assistance due to: weakness, coordination, poor and pain. Although identified on the CA for pressure ulcers incontinence, and riseat cushion to red R35 was observed 1:58 p.m. to 4:15 p.m. to 4:15 p.m. to 4:15 p.m. wheelchair without assistance offered minutes.  On 4/11/17, continuconducted in the di 3:19 p.m. R35 had reposition/offload (Inhours, 49 minutes. entered R35's roon changed the incontinucted in the di 3:19 p.m. R35 had reposition/offload (Inhours, 49 minutes. entered R35's roon changed the incontinucted in the di 3:19 p.m. R35 had reposition/offload (Inhours, 49 minutes. entered R35's roon changed the incontinucted in the di 3:19 p.m. R35 had reposition/offload (Inhours, 49 minutes. entered R35's roon changed the incontinucted in the di 3:19 p.m. R35 had reposition/offload (Inhours, 49 minutes. entered R35's roon changed the incontinucted in the di 3:19 p.m. R35 had reposition/offload (Inhours, 49 minutes. entered R35's roon changed the incontinucted in the di 3:19 p.m. R35 had reposition/offload (Inhours, 49 minutes. entered R35's roon changed the incontinucted in the di 3:19 p.m. R35 had reposition/offload (Inhours, 49 minutes. entered R35's roon changed the incontinucted in the di 3:19 p.m. R35 had reposition/offload (Inhours, 49 minutes. entered R35's roon changed the incontinucted in the di 3:19 p.m. R35 had reposition/offload (Inhours, 49 minutes. entered R35's roon changed the incontinucted in the di 3:19 p.m. R35 had reposition/offload (Inhours, 49 minutes. entered R35's roon changed the incontinucted in the di 3:19 p.m. R35 had reposition/offload (Inhours, 49 minutes. entered R35's roon changed the incontinucted in the di 3:19 p.m. R35 had reposition/offload (Inhours, 49 minutes. entered R35's roon changed the incontinucted in the di 3:19 p.m. R35 had reposition/offload (Inhours, 49 minutes. entered R35's roon changed the incontinucted in the di 3:19 p.m. R35 had reposition/offload (Inhours	ivities of daily living (ADLs). ny pressure ulcers but was at cated a formal assessment ssessment were completed to	F 2	79		

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F 279	Tegaderm dressing ulcer and treatmen Prevalon boot was drainage which wa wheelchair cushior inch in height, and not feel adequate." know the last time repositioned.  The next day on 4/ observations were in bed from 7:03 a. offered or assisted At 10:10 a.m. the sthe continuous obs The DON was unarprovided care for Rometimes resisted felt staffing challen timely care for R35 DON of serious corresponded, "Me to room at 10:19 a.m. completed an assecondition. The DOI and provided periothe last time R35 wrepositioned.  During an interview p.m. she explained however, she did nincontinence brief of she was unable to On 4/12/17, at 6:15 was conducted with	gs, right medial ankle pressure to be done at bedtime. R35's soiled with blood and wound as confirmed by the DON. R35's a was approximately one half the DON confirmed it "does NA-F reported she did not R35 had been changed or 12/17, continuous conducted while R35 was lying m. to 10:19 a.m. without being to reposition or use the toilet. Surveyor informed the DON of servation of R35 without care. Ware why care had not R35. The DON stated R35 d care. The DON stated she ges contributed to issues with the care. The DON entered R35's (3 hours, 16 minutes) and sesment of the resident's skin N changed the incontinent brief care. The DON did not know was last changed or 1/1/17, at 3:20 R35 did not like to lie down, ot decline offers to have her changed or to reposition, as	F 27	9		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 279	following the right pressure ulcers. In the left suspected break down on R3 impression the sta and at a minimum to be off the bed, repositioned out of two hours. It was a implement pressure R35's heels, ankled NA-A stated on 4/be checked on evice supposed to ensure bed and she had a which foot or where was unaware if the care plan.  On 4/13/17, at 8:2 expected the NAs because of her skright hip area was wounds were from herself.  On 4/13/17, at 10:R35 had wounds changes had been last week.  However, on 4/13, reported R35 was every two hours in wheelchair reposition when R35 was in between her legs.	medial ankle and right heel MD-A was Dr. was unaware of deep tissue injury and skin 85's buttocks. It was MD-A's aff were elevating R35's heels, would have expected the heels and the resident would be f her wheelchair at least every also expected staff would re relieving interventions for	F 2	279		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		TE SURVEY MPLETED
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	D PLAN OF CORRECTION IDENTIFICATION NUMBER:  245275  AME OF PROVIDER OR SUPPLIER  EDINA CARE & REHAB CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		STREET ADDRESS, CITY, STATE, ZIP C 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423			
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F 279	heels or feet.  On 4/13/17, at 12:3 the "care plan is a DON was in the proconfirmed there we interventions noted survey entrance the thought of putting a bed. The DON expand change R35 at DON expected nur every shift and assand to document fi expected a comprewould be completed. The DON stated R dressing changes. pre-medication for prior to care and distated she felt it should be the felt it should be completed. The positioning and dated, indicated "the turned/positioned in care to prevent ski further indicated the repositioned every accordance with the plan as determined standards of the positioned standards of the positioned every accordance with the plan as determined standards of the positioned every accordance with the plan as determined standards of the positioned every accordance with the plan as determined standards of the positioned every accordance with the plan as determined standards of the positioned every accordance with the plan as determined standards of the positioned every accordance with the plan as determined standards of the positioned every accordance with the plan as determined standards of the positioned every accordance with the plan as determined standards of the positioned every accordance with the plan as determined standards of the positioned every accordance with the plan as determined approaches, and grant every accordance with the plan accord	30 p.m. the DON stated that mess and is not good" and the ocess of updating it. The DON ere no pressure relieving I on the care plan. Prior to the e DON said she had not a different mattress on R35's ected staff to reposition, check t least every two hours. The ses to monitor R35's skin ess once weekly on bath day, ndings. In addition, it was chensive skin assessment d when a new area was found. 35 experienced pain with She was unsure whether pain was provided for R35 ressing changes, but the DON ould have been.  and procedure titled Turning" which was not nat residents are n accordance with the plan of n breakdown." The policy at residents who are unable to wes will be turned and one to two hours in eir needs, using a written care	F 279			

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F 279 F 282 SS=D	weeks of admission the level of risk for factor(s), potential of should be reviewed plan. The policy indicated or wheel chair turned/reposition at indicated on the respolicy stated the carevised based on the treatment, goals, at 483.21(b)(3)(ii) SEPERSONS/PER CAREACTERSONS/PER CARE	n and weekly for the first 4 in to determine the score and skin breakdown. Then, the risk cause(s) and interventions and addressed on the care icated when a resident is in they should be a least every two hours or as sident's care plan. Lastly, the re plan shall be evaluated and the resident's response to and outcomes.  RVICES BY QUALIFIED ARE PLAN	F 2			5/25/17
	care. This REQUIREMEI by: Based on observareview, the facility fof 1 residents (R22 1 of 13 residents (Fin addition, the faci for toileting assistareviewed for activitive Findings include: R22 was not consistance. On 4/11/17, a	qualified persons in ich resident's written plan of NT is not met as evidenced tion, interview and document ailed to follow careplans for 1) reviewed for hearing and for R49) needing meal assistance. Ity failed to follow a careplanice for 1 of 3 residents (R35) es of daily living (ADLs).		All residents requiring assistance ADL's have the potential to be affethisR35 passed away prior to receivir-R22 hearing aid has been replace-R22 care plan has been reviewed currentR49 care plan does have finger for offered per resident preferenceR49 care plan has been reviewed currentStaff have been educated on follocare plans.	ng SOD. ed. and is ood	

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F 282	nurse she talked to was missing his lef R22's left hearing a few months and the he would look into to her.  R22's annual Minin R22's cognition waindicated minimal caides. R22's same makes self understannual MDS also in assistance with dre R22's 1/31/17, Car R22 has impaired haides.  R22's 3/24/16, care in [R22s] earsPla Make sure hearing hearing aids [in the night shift every Th 3/30/17, indicated, Aids in Both Ears E On 4/11/17, at 2:05 on top of his bed eaides in ears observed on 4/11/17, at 2:36 stated R22 had just ago and NA-N had stated R22's hearin cart.  The following morn	today and stated that the today had not known that R22 it hearing aide. FM-C stated aide had been missing for a at the administrator had stated it and had not yet gotten back in the administrator had stated it and had not yet gotten back in the administrator had stated it and had not yet gotten back in the administrator had stated it and had not yet gotten back in the amount of the properties of the armonic and	F 28	-Audits of 2-3residents required assistance with ADL's will be determine compliance with a weekly, x3 then weekly there results to be reviewed at QA determination of compliance continue.  -DON or designee will be resuld audits.  -Date of compliance 5/25/20	e done to care plans 2 x cafter. Audit PI for and need to	

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F 282	table in the dining in observed in R22's bites of his french of the bacon, oatmeath himself out of the chis room door. Surand R22 just looke speak. Surveyor as aides and NA-P sate could hear her and NA-P stated she would the himself out to the him if he wanted just and R22 took a dribrought R22 his her placed in his ear and now hear. R22 the food.  Half hour later at 9 moved up to this unlost his hearing aid RN-F stated R22 in and that family was on 4/12/17, at 10:2 a standing order for was used for R22 in checked residents wax build up and if ear drops would be on the fourth day werified on R22's tr (TAR) that ear drop R22 on 1/28/17, ar	room. No hearing aides were ears. R22 started taking a few toast and then without trying I and liquids started wheeling dining room into the hall next to veyor asked R22 a question d back at surveyor and did not sked NA-P if R22 wore hearing id yes. NA-P then asked R22 if and R22 answered "barely". and not helped R22 up this had assisted R22. NA-P ell the nurse R22 did not have this morning. NA-P wheeled a dining room table and asked ice and poured him a glass nk. Registered nurse (RN)-F earing aide for his right ear and and resident stated he could in proceeded to take bites of his case and pour this unit. Ow only had one hearing aide	F 2	282		

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F 282	also verified that the flush to remove was stated the nurses on the did not know why the been available the stock. RN-F verified there was an order started for flush compractitioner (NP) or nurse working on 1 ear drops for R22 semissed. RN-F stated notified and verified progress notes indinotified. RN-F stated today and if had was the standing order and notify NP and on the standing order and notify NP and on the standing order and been busy giving RN-F stated R22 recalled him by the nagiven name.  On 4/13/17, at 9:57 on top of his bed evalued in right ear.  On 4/13/17, at 10:00 Director (SS) stated hearing aide missing FM-C had told him the hearing aide has S stated he referred.	e TAR did not indicate an ear x had been completed. RN-F anow that the flush comes after the fourth day. RN-F stated she are ear drops would have not 2nd day as there was house don R22's physician order that on 1/27/17, for ear drops to be all the completed by nurse in 1/30/17. RN-F stated the 1/30/17, should have placed since 1/28/17, had been and the NP should have been and no documentation in the cated that the NP had been and NP fax their notes to the dishe would look at R22's ears ax build up she would follow and start ear drops for R22 document this in the progress NA-P had told her this and his hearing aide put in but any out medications at the time. The earlier of the earlier of R22 was observed lying and the preferred and not his and FM-B had told him that and been missing quite awhile. The earlier of the dishibit and the earlier of the administrator dispersion of the admi	F	282			

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F 282	On 4/13/17, at 11:0 nursing (ADON) wh R22's unit stated sh R22's hearing aide it was the nurse's reaide was locked in drops and flush we expected nursing stores for some reason cashould pass on to the nurse to compled drops should have for not being compled ADON also stated the written on the TAR progress notes that and the results. AD to her unit from the talking about his minterdisciplinary teafacility had replaced aides last fall becastated discussion hin the hearing aided drops them. ADON residents' hearing a getting up. ADON sesidents to have the stated she had talk and she had not me putting in R22's hear whereabouts of the	1 a.m. the assistant director of no also was the manager of ne had not been aware of not being in his ear and stated esponsibility as the hearing the cart. ADON stated ear re a standing order and she taff to follow the orders and if an not complete a treatment he next nurse and expected ete it. ADON stated R22's ear been given on the fourth day eted on the second day. The flush should have been and documented in the at the treatment was completed ON stated R22 had come up 2nd floor and had remember issing hearing aide in an m meeting. ADON stated the d another resident's hearing use of new regulations. ADON ad been about if resident puts in or if the staff does or staff stated nurses should put in aides in at 8 a.m. or upon stated it would benefit the ne hearing aides in. ADON ed to FM-C about a week ago entioned to her about staff not	F	282			

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F 282	indicate an ear flus R22. NP note date [hearing loss], bilat hearing aids. Was visit."  R22's nursing progwritten by RN-F incinspected for ear wear and started ear days and irrigation day.  On 4/13/17, at 2:22 (DON) stated R22' out R22's ears and this and to her knodone. DON stated NP notes. DON stawith the 3N unit sirup there and stated education the staff placement as since be upset. DON staprovided in mornin when residents cor R49 was observed at a table in the 3N later R49 was serv R49's plate had a pscrambled eggs. Rher scrambled egg hand. R49 picked uproceeded to take fingers and then pi	nuary 2017 notes did not sh had been completed for d 3/14/17, indicated "HL teral [R22] Wears bilateral only wearing one today during aress note dated 4/12/17, dicated R22's ears were wax with wax built up in the right of drops for right ear for three of ear to follow on the fourth as a she had asked her to clean a she had asked the NP to do wledge thought it had been it should be documented in the ated the family was not happy are R22 being recently moved as the would be doing some the importance of hearing aid the if you can not hear you would ted the hearing aids should be greates and no later than me out to breakfast.  on 4/11/17, at 8:34 a.m. sitting a dining room. Couple minutes the did a plate of food on the table. So ancake, a sausage patty and a spoon in her right up her uncut pancake and bites of her pancake with her cked up her uncut sausage and take bites of the	F 282			

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		
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F 282	At 8:45 a.m. NA-P helped another res was provided to R4 dining room and di  The following morr R49 was observed room on 3N. A couplate of food in fror cut up R49's french syrup. NA-K quickl sausage patty with sections and walke sausage patty was in it but not cut apather right hand stab then unable to cut patty with her left hput in her mouth. Finand and fork in rigpieces. NA-K had righer about the saus she said yes she was a s	sat down at R49's table and ident to eat. No assistance 49. Staff was present in the d not offer to assist R49.  Ining on 4/12/17, at 8:25 a.m. sitting at the table in the dining ple minutes later NA-K set a nt of R49 on the table. NA-K n toast and poured maple y cut couple times into the out cutting through into smaller ed away from table. The observed to have two marks art. R49 picked up her fork in bing at the sausage patty and apart picked up the sausage and and pulled off a piece and 849 holding bacon with left ght hand breaking bacon into not asked R49 if she wanted ato smaller pieces, only asked age and french toast which	F 28			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G		E SURVEY IPLETED
		245275	B. WING _		04/	14/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	R49's quarterly Mir indicated R49 need eating and also indinvolved in activity maneuvering of limassistance.  R49's current care assist for meal setand provide supervareplan also indic much assistance at On 4/13/17, at 10:3 nursing (ADON) steating with fingers should have asked cut up and staff we careplans because	nimum Data Set dated 3/1/17, ded limited staff assistance for licating R49 was highly and staff provided guidance of abs or other non wt-bearing plan indicated staff were to approve the staff were to provide as some ated staff were to provide as some ated with meals.  33 a.m. the assistant director of ated she did not consider dignified. ADON stated staff R49 if she wanted her food are expected to follow that is how the staff know of a for their residents.	F 28	2		
	July 2015, indicate resident/resident refor healthcare" R35 was not offere according to her plated 3/21/17, identwo staff members checked at least exincontinence. The monitor for signs of offer/encourage the and/or after meals, night rounds. Furth to assist with perinchange incontinents.	epresentative input and goals and toileting assistance an of care. R35's care plan atified R35 needed assist of for toileting. R35 was to be				

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F 282	R35's annual Minin 2/7/17, identified R assistance with act R35 was not on a t was frequently inco R35's Care Area As 2/7/17, identified R for ADLs. The CAA chronic health issuincontinence or pai activity participation had urinary urgenc toileting which cont CAA also identified upon rising, after m rounds. R35 wore a her skin and provid R35 was continuous 1:58 p.m. to 4:15 p in wheelchair witho assistance offered minutes. On 4/11/17, continuconducted in the di 3:19 p.m. R35 had reposition/offload (hours, 49 minutes.	num Data Set (MDS) dated 35 required extensive ivities of daily living (ADLs). oileting program, however, ontinent of bladder and bowel. seessment (CAA) dated 35 needed physical assistance further identified R35 had es/conditions, such as n that resulted in reduced n. The CAA identified that R35 y and needed assistance in tributed to incontinence. The that R35 was offered toileting neals, at bedtime, and on an incontinence brief to protect	F 28	, , , , , , , , , , , , , , , , , , ,		
	changed R35's par wearing were wet we wheelchair cushion area of urine and s confirmed the cush attempted to clean	erately wet. NA-F and NA-E hts, as the ones she had been wet with urine. R35's was saturated with a circular melled strongly of urine. NA-F hion was wet with urine, and it with a Sani Wipe. NA-F but know the last time R35 had epositioned.				

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F 282	conducted while F a.m. to 10:19 a.m assisted to reposit had a strong urine surveyor informed observation of R3 unaware why care The DON stated scontributed to the The DON entered hours, 16 minutes brief and provided R35's brief as sati pungent smelling the last time R35 repositioned. The the care plan and at least every two On 4/11/17, at 3:2 not like to lie down offers to have her to reposition, as s NA-F stated R35 times, but was unher incontinence to On 4/12/17, at 6:1 was conducted wi who reported he has following the pressure ulcers. No resident would be wheelchair at least NA-A stated on 4/10.	nuous observations were R35 was lying in bed from 7:03 . without being offered or tion or use the toilet. The room e odor. At 10:10 a.m. the I the DON of the continuous 5 without care. The DON was had not provided care for R35. The felt staffing challenges issues with timely care for R35. R35's room at 10:19 a.m. (3 ) and changed the incontinent I peri-care. The DON described urated with dark colored urine. The DON did not know was last changed or DON expected staff to follow to change and reposition R35	F2	282		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG	, ,	TE SURVEY MPLETED
		245275	B. WING _		04	/14/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CO 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		
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F 282	R35's care plan.  On 4/13/17, at 10:5 repositioned and chorief at 7:00 a.m. No changed R35 at 5:0 after incontinence of 10:00 a.m. and 10:5 but said R35 had result to the said R35 had	if there had been changes to 66 a.m. NA-G stated she had hanged R35's wet incontinence A-G stated the night shift had 00 a.m. R35 stayed in bed hare, and was reapproached at 35 a.m. to offer repositioning, befused. 17, at 11:05 a.m. NA-H hanged R35's incontinence had the resident had been bowel and bladder. NA-H was had been changed prior to that R35 was on a repositioning wo hours in bed, but did not repositioning program. 10 p.m. the DON stated the s and is not good" and the bocess of updating it. The DON heposition, check and change two hours. 11 as a tool for NAs to use to	F 28			
F 309 SS=D	continent of bowel. to monitor for urger the bathroom. R35 bladder and to offer was directed to offer rising, before and/oduring night rounds	) PROVIDE CARE/SERVICES	F 30	9		5/25/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245275	B. WING _		04/14/2017	
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423	,	
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F 309	applies to all care a residents. Each re facility must provide services to attain opracticable physical well-being, consisted comprehensive assessment of a residents received accordance with propractice, the comprehensive and the facility must er provided to resident consistent with prothe comprehensive and the residents who requisely. (I) Dialysis. The faresidents who requiservices, consistent of practice, the concare plan, and the preferences. This REQUIREMED	fe undamental principle that and services provided to facility sident must receive and the e the necessary care and r maintain the highest al, mental, and psychosocial ent with the resident's sessment and plan of care.  are fundamental principle that nent and care provided to ased on the comprehensive esident, the facility must ensure every extreatment and care in refessional standards of rehensive person-centered residents' choices, including the following:  ent.  Insure that pain management is the who require such services, fessional standards of practice, the person-centered care plan, goals and preferences.  cility must ensure that the dialysis receive such that with professional standards in prehensive person-centered residents' goals and  NT is not met as evidenced	F 30			
	review, the facility f	tion, interview and document failed to provide adequate pain of 4 residents (R35, R73)		This deficiency has the potentia any resident has painR35 has passed away prior to re-		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  3		E SURVEY PLETED
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F 309	reviewed with pain. Findings include: R35 was observed 12:30 p.m. to 3:19 assisted or offered pressure) for at lea the DON and NA-E p.m. NA-F and NA- bed. When seated stated. "God almigl over." NA-F lifted R stated, "Ow."  On 4/11/17 at 3:45 (LPN)-C and LPN-I right ankle dressing removed R35's right a sore on her great identified. LPN-C s removed was dated LPN-C reported no ankle. R35 complai was removed. As L with normal saline hurts!" LPN-B appli and edges covered Kerlix, and dated the On 4/12/17, continue conducted while R3 a.m. to 10:19 a.m. assisted to reposition a.m. the surveyor in concerns regarding and pain managem too." The DON enter	continuously on 4/11/17, from p.m. R35 had not been to reposition/offload (remove st 2 hours, 49 minutes. NA-F, entered R35's room at 3:20 E assisted R35 to transfer to on the edge of the bed R35 hty! Help me! I'm leaning way 1:35's legs into bed and R35 p.m., licensed practical nurse B were observed to complete a g change for R35. LPN-C ht sock and reported there was right toe, not previously tated the ankle dressing being 1:4/9/17 (two days prior). Allevyn was present on the fined of pain when the dressing PN-C cleansed the wound R35 screamed out, "That ed Santyl to entire wound bed with Allevyn, wrapped with	F 309	SOD -R73 was interviewed and state ok waiting for medications" he adverse effects from the delatorior to survey exit two sets keys for medication carts were staff have been educated or available in the Omni cell and obtain medication from Omnitostaff educated on alternative methodsStaff educated on process formissing med cart keysAudit of at least 2-3 resident pain or requesting prn pain medication be completed to determine the compliance 2X weekly X3 the bebrought to QAPI for determine the compliance and need to conton-DON or Designee will be resauditsDate of compliance May 25,	e had no ny. of backup re obtained. n medications d process to cell. e pain control or lost or s(at risk for nedication)will mely en weekly, to mination of inue. eponsible for	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		TE SURVEY MPLETED
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F 309	assessment of the DON changed the peri-care. The DON skin condition and lying directly onto t and stated she "hut to turn to her right; her jaw and had fu turn to her left side heel, which she statissue injury measureported the area wout the gripper soc foot, which was dirpressure reliving diconfirmed she was left heel last week, of the wound and harheumatoid arthritis dementia and anximidicated R35 requactivities of daily linnot identified on the to have a schedule However, R35 had offered the as need non-pharmacologic management prior R35's correspondir (CAA) dated 2/7/17 physical assistance due to pain. The Cachronic health issue	resident's skin condition. The incontinent brief and provided N then assessed the resident's reported R35's left heel was he bed. R35 moaned in pain rts everywhere" when assisted side. R35 moaned, tightened rrowed brows when assisted to . The DON observed the left ated was a suspected deep uring 1 cm x 1 cm x 1 cm. R35 was painful to touch. The DON k back onto the resident's left ectly on the mattress without a evice in place. The DON aware of the status of R35's but did not know the severity had not assessed it herself.  Thum Data Set (MDS) dated 35 had moderate cognitive d diagnoses including (known to contribute to pain), ety. In addition, the MDS irred extensive assistance with ring (ADLs). Although pain was annual MDS, R35 was noted a pain medication regimen. The properties of the ded (PRN) medications or a interventions for pain to her dressing changes.  The Gare Area Assessment of the ADLs and had limitations and further identified R35 had es/conditions, such as in that resulted in reduced	F 30	9		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	ON (X3) DATE COMP		
		245275	<b>245275</b> B. WING		04/14/2017		
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423			
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F 309	episodes due to rh left knee pain, short R35's care plan dir monitor/document/signs/symptoms of bearing. The care panticipate need for immediately to any monitor/record pain plan further directe effectiveness of pathrough if ineffective nurse any signs/sy and "keep pain free During an interview p.m. she explained however, she did not incontinence brief of stated R35 request but was unable to hincontinence brief of denied being award buttocks, but had refrom her right anklostated R35 frequer the night.  On 4/12/17, at 9:14 (TMA)-D stated R37 responding to her responding to her responding to the respo		F 309				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245275	B. WING		04/	14/2017	
	PROVIDER OR SUPPLIER  ARE & REHAB CENT		(	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423	, , ,		
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F 309	and legs. NA-A sta check on R35 ever confirmed staff were feet were off of the but NA-A was unsuintervention began.  On 4/13/17, at 11:0 aware R35 had wo and heel and that F would not let NA-H pain. NA-H stated I program of every thave a wheelchair stated when R35 whetween her legs stated was unsure whether provided for R35 progress not identified on 3/6/17 was painful to touc R35's physician ord (Tylenol) 1000 million million of the provided for R35's physician ord (Tylenol) 1000 million million of the provided for R35's physician ord (Tylenol) 1000 million million of the provided for R35's physician ord (Tylenol) 1000 million million of the provided for R35's physician ord (Tylenol) 1000 million million of the provided for R35's physician ord (Tylenol) 1000 million million of the provided for R35's physician ord (Tylenol) 1000 million million of the provided for R35's physician ord (Tylenol) 1000 million million of the provided for R35's physician ord (Tylenol) 1000 million million of the provided for R35's physician ord (Tylenol) 1000 million million million million of the provided for R35's physician ord (Tylenol) 1000 million m	d putting her in the omplained of pain in her feet ted they are supposed to y 15-20 minutes. NA-A re supposed to ensure R35's bed and she had a boot on, are which foot or when this of a.m. NA-H stated she was unds on her thighs, toe, ankle, R35 had "a lot of pain" and touch her right leg due to the R35 was on a repositioning wo hours in bed, but did not repositioning program. NA-H was in bed, she needed a pillow o her ankles did not touch.  Conducted with LPN-A via 17, at 11:12 a.m. LPN-A reen the only nurse on the floor was busy and difficult to get A stated R35 was often "in to fher body is sore."  So p.m. the DON stated R35 with dressing changes. She er pre-medication for pain was rior to care and dressing d she felt it should be.	F 309				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			(X3) DATE SURVEY COMPLETED	
	245275	B. WING		04/14/2017		
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(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION :	SHOULD BE	(X5) COMPLETION DATE	
Pain assessments indicated an increa (1-10, with 10 being pain. In 2/17, R35 if and 5. In 3/17, R35 if evels: 3, 6, and 8. three doses of PRN had pain seven day Facility documentar indicated R35 could and exhibited agita.  The facility policy a Management and A indicated residents comfort to perform R73 informed the sp.m. he had been in requested his oxyc (combination opioic reliever for modera explained he was e (10 being the worst shoulder and lower had requested pain and he had been to because the keys the missing.  R73's care plan damade his own decinated pain controlle providing medication causes of pain and the had been to be a pain controlle providing medication causes of pain and the pain and the pain controlle providing medication causes of pain and the pain controlle providing medication causes of pain and the pain controlle providing medication causes of pain and the pain controlle providing medication causes of pain and the pain controlle providing medication causes of pain and the pain controlle providing medication causes of pain and the pain controlle providing medication causes of pain and the pain controlle providing medication causes of pain and the pain can be pain and the pai	dated 2/1/17 to 4/12/17, se frequency and severity g the most severe pain) of had pain two days rated at a 4 is had pain eight days rated at Further, in March R35 required N acetaminophen. In 4/17, R35 ys rated at levels: 2, 4, and 5. tion for nursing assistants d be aggressive when in pain tion with pain.  Independent of the last hour and odone-acetaminophen d narcotic and non-opioid pain the to severe pain). R73 experiencing 8 out of 10 pain the pain to the narcotic box were  Independent of the last hour and odone-acetaminophen d narcotic and non-opioid pain the to severe pain). R73 experiencing 8 out of 10 pain the possible pain) in his right back. R73 reported when he had medication from the nurse, old he would have to wait to the narcotic box were  Ited 11/30/16, indicated R73 sions and had chronic pain in and back. R73's goal was to d. Interventions included on as ordered, monitoring I notify nursing. R73's	F 30	9			
,	Continued From particles of Pain assessments indicated an increa (1-10, with 10 being pain. In 2/17, R35 land 5. In 3/17, R35 levels: 3, 6, and 8. three doses of PRI had pain seven day Facility documental indicated R35 could and exhibited agita.  The facility policy and Management and A indicated residents comfort to perform R73 informed the sp.m. he had been in requested his oxyco (combination opioid reliever for moderal explained he was explained he was explained he was explained he was explained he keys the missing.  R73's care plan day made his own deciding medication administing indicated he was to causes of pain and medication administing indicated he was to controlled providing medication administing indicated he was to controlled to the cause of pain and medication administing indicated he was to controlled to the cause of pain and medication administing indicated he was to controlled to the cause of pain and medication administing indicated he was to controlled to the cause of pain and medication administing indicated he was to controlled to the cause of pain and medication administing indicated he was to controlled to the cause of pain and medication administing indicated he was to controlled to the cause of pain and medication administing indicated he was to controlled to the cause of pain and medication administing indicated he was to controlled to the cause of pain and medication administing indicated he was to controlled to the cause of pain and the cause of	TOTAL PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 46  Pain assessments dated 2/1/17 to 4/12/17, indicated an increase frequency and severity (1-10, with 10 being the most severe pain) of pain. In 2/17, R35 had pain two days rated at a 4 and 5. In 3/17, R35 had pain eight days rated at levels: 3, 6, and 8. Further, in March R35 required three doses of PRN acetaminophen. In 4/17, R35 had pain seven days rated at levels: 2, 4, and 5. Facility documentation for nursing assistants indicated R35 could be aggressive when in pain and exhibited agitation with pain.  The facility policy and procedure titled "Pain Management and Assessment" dated 7/28/15, indicated residents would receive the necessary comfort to perform activities of daily living. R73 informed the surveyor on 4/11/17, at 1:24 p.m. he had been in pain for the last hour and requested his oxycodone-acetaminophen (combination opioid narcotic and non-opioid pain reliever for moderate to severe pain). R73 explained he was experiencing 8 out of 10 pain (10 being the worst possible pain) in his right shoulder and lower back. R73 reported when he had requested pain medication from the nurse, and he had been told he would have to wait because the keys to the narcotic box were	A BUILDIN  245275  B. WING  PROVIDER OR SUPPLIER  ARE & REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 46  Pain assessments dated 2/1/17 to 4/12/17, indicated an increase frequency and severity (1-10, with 10 being the most severe pain) of pain. In 2/17, R35 had pain two days rated at a 4 and 5. In 3/17, R35 had pain two days rated at levels: 3, 6, and 8. Further, in March R35 required three doses of PRN acetaminophen. In 4/17, R35 had pain seven days rated at levels: 2, 4, and 5. Facility documentation for nursing assistants indicated R35 could be aggressive when in pain and exhibited agitation with pain.  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R73's medication administration record (MAR) for 4/17, indicated he was to receive	TOORNECTION  TO SUPPLIER  ARE & REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 46  Pain assessments dated 2/1/17 to 4/12/17, indicated an increase frequency and severity (1-10, with 10 being the most severe pain) of pain. In 2/17, R35 had pain inght days rated at levels: 3, 6, and 8. Further, in March R35 required three doses of PRN acetaminophen. In 4/17, R35 had pain seven days rated at levels: 3, 6, and 8. Further, in March R35 required three doses of PRN acetaminophen. In 4/17, R35 had pain seven days rated at levels: 3, 6, and 8. Further, in March R35 required three doses of PRN acetaminophen. In 4/17, R35 had pain seven days rated at levels: 2, 4, and 5. Facility documentation for nursing assistants indicated R35 could be aggressive when in pain and exhibited agitation with pain.  The facility policy and procedure titled "Pain Management and Assessment" dated 7/28/15, indicated residents would receive the necessary comfort to perform activities of daily living.  R73 informed the surveyor on 4/11/17, at 1:24 p.m. he had been in pain for the last hour and requested his oxycodone-acetaminophen (combination opioid narcotic and non-opioid pain reliever for moderate to severe pain). In 8/13 relieved to the worst possible pain) in his right shoulder and lower back. R73 reported when he had requested pain medication from the nurse, and he had been told he would have to wait because the keys to the narcotic box were missing.  R73's care plan dated 11/30/16, indicated R73 made his own decisions and had chronic pain in his right shoulder and back. R73's goal was to have pain controlled. Interventions included providing medication as ordered, monitoring causes of pain and notify nursing. R73's medication administration record (MAR) for 4/17, indicated he was to receive	PROVIDER OR SUPPLIER  245275  245275  3 STREET ADDRESS, CITY, STATE, 2IP CODE 200 XERXES AVENUE SOUTH RICHFIELD, MN 55423  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 46  Pain assessments dated 2/1/17 to 4/12/17, indicated an increase frequency and severity (1-10, with 10 being the most severe pain) of pain. In 2/17, R35 had pain two days rated at a 4 and 5. In 3/17, R35 had pain two days rated at a 4 levels: 3, 6, and 8. Further, in March R35 required three doses of PRN acetaminophen. In 4/17, R35 had paint ow with pain and exhibited agitation with pain.  The facility policy and procedure titled "Pain Management and Assessment" dated 7/28/15, indicated residents would receive the necessary comfort to perform activities of daily living. R73 informed the surveyor on 4/11/17, at 1:24 p.m. he had been in pain for the last hour and requested his oxycodone-acetaminophen (combination opioid narcotic and non-opioid pain reliever for moderate to severe pain), R73 explained he was experiencing 8 out of 10 pain (10 being the worst possible pain) in his right shoulder and back. R73's ported when he had been told he would have to wait because the keys to the narcotic box were missing.  R73's care plan dated 11/30/16, indicated R73 made his own decisions and had chronic pain in his right shoulder and back. R73's goal was to have pain controlled. Interventions included providing medication as ordered, monitoring causes of pain and notify nursing. R73's medication administration record (MAR) for 4/17, indicated the was to receive	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245275	B. WING		04/14/2017		
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423				
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 309	tablets for pain rate been administered 4/10/17, at 4:12 p.r. On 4/11/17, at 1:30 misplaced the only narcotic box where kept. RN-A verified oxycodone-acetam RN-A had still not flooking for them. Twhat he planned to management RN-A enough that he car RN-A stated he had were missing. At 1: located, RN-A admoxycodone-acetam On 4/11/17, at 2:01 (ED) stated she we care for residents in pain for over an get their pain media provide another for	hours for pain rated 1-6 or 2 ed 6-10. The last time R73 had the medication was on m.  I p.m. RN-A explained he had set of keys that opened the R73's pain medication was d R73 had requested inophen over an hour ago, but ound the keys and was still he surveyor inquired as to do regarding R73's pain A replied, "I know [R73] well a wait for his pain medication." In dinformed the DON the keys 37 p.m., after the keys were ministered 2 tablets of inophen to R73.  I p.m. the executive director buld have expected the staff to needs. "No resident should go hour and all residents should cation when they ask for it or m of pain relief if appropriate." e if the facility had a second uld check with the	F 309	,			
	DON explained RN picked up his medi because they were was aware the key minutes, as she ha minutes later that to DON verified the far	on 4/11/17, at 3:56 p.m. the I-A asked whether she had cation cart keys by accident, missing. The DON stated she is were only missing a few directived a text a few the keys had been located. The acility did not have a back up arcotic box if the keys went					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		245275	B. WING		04/1	4/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE COMP		
F 312 SS=D	to wait over an hour Instead, the RN shot pharmacist to obtain needed medication storage system) or acetaminophen. In RN-A should have owhen he noticed the The facility's 7/28/1 Assessment policy residents would recept perform activities of 483.24(a)(2) ADL COEPENDENT RES  (a)(2) A resident whactivities of daily liv services to maintain personal and oral hactivities of daily liv services to maintain personal and oral hactivities of daily liv services to maintain personal and oral hactivities of daily liv services were proving the facility faservices were provi	said R73 should not have had reflect to get his pain medication. Sould have called the nermission to take the from the Omnicell (medication provided R73 with addition, the DON verified contacted her immediately except were missing.  5, Pain Management and and procedure indicated erive necessary comfort to fedaily living.  EARE PROVIDED FOR IDENTS  To is unable to carry out ing receives the necessary necessary necessary in good nutrition, grooming, and ygiene.  NT is not met as evidenced sion, interview, and document alled to ensure timely toileting ded for 1 of 1 residents of was completely dependent	F 3.	09	o affect g SOD. ileting d are	5/25/17
	Prevalon boot (soft	d. The resident was wearing a blue boot used to aid in ner right foot. At 2:30 p.m. R35		-Toileting audit of 2-3 residents will l completed 2 x weekly, x 3 and one weekly thereafter. Will be reviewed	time	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245275	B. WING		04/-	04/14/2017	
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / 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 312	remained in the sain nursing assistant (I offer cares. At 3:50 same position where walked past the resermained in wheeled positioning or assist hours, 17 minutes.  The following day of observations were from 12:30 p.m. to wheelen without reposition or toilet, dining room table, I leaned to the right of the prevalon boot on the left with both remained in same cares or repositionicalled out, "Is anyobed." No staff were R35 then yelled, "Consultant (NC)-For provided R35 a gla room. At 2:22 p.m. wanted to go sit by declined. NA-A offen NA-A locked R35's walked away. R35 NA-A replied from the afternoon." R35 NA-A went to the retime and ask if she station. No cares we resident assisted we residents began gaan activity. R35 remained in the afternoon of the retime and ask if she station. No cares we resident assisted we residents began gaan activity. R35 remained in the afternoon of the retime and ask if she station. No cares we resident assisted we residents began gaan activity. R35 remained in the afternoon of the retime and ask if she station. No cares we resident assisted we residents began gaan activity. R35 remained in the afternoon of the retime and ask if she station. No cares we resident assisted we residents began gaan activity. R35 remained in the afternoon of the retime and ask if she station. No cares we resident assisted we residents began gaan activity. R35 remained in the afternoon of the retime and ask if she station.	me position; at 3:15 p.m. a NA) walked by R35 but did not p.m. R35 remained in the in the director of nursing (DON) sident. At 4:15 p.m. R35 chair without a change in tance offered for at least 2 on 4/11/17, continuous conducted in the dining room 3:19 p.m. R35 was seated in a being offered or assisted to At 12:30 p.m. while at the ner eyes were closed and she side. R35 was wearing the ne right foot and a gripper sock in feet touching the floor. R35 cosition with no offers for niguntil 2:08 p.m. when R35 nie around? I'm ready to go to present in the dining room. an I have some water?" Nurse entered the dining room and as of water and then left the NA-A asked R35 if she the nursing station which was ared water and was declined. Tight wheelchair brake and yelled out "What time is it?" he nursing station, "It's 2:25 in again asked the time, and esident to inform her of the wanted to sit by nurses' ere offered nor was the ith any cares. At 2:57 p.m. thering in the dining room for nained at the table in the er head to her head to chest.	F 312	QAPI for determination of oneed to continueDON or designee will be rauditsDate of compliance 5/25/2	esponsible for		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245275	B. WING	i	04	/14/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 312	eyes closed, and enrichment coordi wheelchair slightly another resident. worker (LSW)- Be without offering as (HK)-A then asked responded, "Yes." table and left R35 p.m. R35's tray wawere offered. At 3 of the dining room help change her in been assisted or c (remove pressure minutes.  NA-F, the DON ar 3:20 p.m. NA-F ar transfer to bed. Wheel R35 stated. "O leaning way over." and R35 stated. "O the Prevalon boot and provided peribrief as moderate the resident's skin R35's skin condition open and excoriation is chial tuberosity (non-blanchable. The reddened but blar was blanchable, the sores and scabs wand the right med treatment was do boot was observe confirmed was so	leaning to the right side. Life inator (LEC)-A moved R35's or forward to accommodate At 3:01 p.m. licensed social entered the dining room and left issistance to R35. Housekeeper it R35, "You done eating?" R35. HK-A walked away to another its food in front of her. At 3:06 as removed, but no other cares and informed her she would incontinence brief. R35 had not offered to reposition/offload of the react of	F	312			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	JLTIPLE CONSTRUCTION  DING		(X3) DATE SURVEY COMPLETED	
		245275	B. WING		04/14/2017		
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423	•		
(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 APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 312	with urine. R35's w saturated with a cir smelled strongly of cushion was wet w clean it with a Sani not know the last ti repositioned. R35 is was assisted back.  After the NAs and licensed practical rentered at 3:45 p.n dressing change. It sock and reported right toe, not previously to the strong urine odor. It is a subject to the strong urine odor. It is a subject to position until at 9:5 door, looked in and room. At 10:02 a.m. locate an available 10:10 a.m. the subject to position under the previously to the strong urine observed to the s	d been wearing were wet wet heelchair cushion was cular area of urine and urine. NA-F confirmed the ith urine, and attempted to Wipe. NA-F reported she did me R35 had been changed or requested to get up again, and into her wheelchair.  The DON left the room, nurse (LPN)-C and LPN-B n. to complete a right ankle penden as a sore on her great ously observed. The soiled and gauze that was saturated rellow/blood-tinged drainage, he wound as "reddened with eedges" and measured 5	F 312				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED	
		245275	B. WING		04/	14/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT			STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423	•	
(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 APPROPRICIENCY)	D BE	(X5) COMPLETION DATE
F 312	16 minutes) and coresident's skin conincontinent brief and DON described R3 colored pungent sinknow the last time repositioned. The It the care plan and the tat least every two has least	s room at 10:19 a.m. (3 hours, ampleted an assessment of the dition. The DON changed the ad provided peri-care. The 35's brief as saturated with dark melling urine. The DON did not R35 was last changed or DON expected staff to follow o change and reposition R35 hours.  The DON did not R35 was last changed or DON expected staff to follow o change and reposition R35 hours.  The DON did not R35 had moderate cognitive diagnoses including (and known to contribute to pain), ety. R35 required extensive divities of daily living (ADLs), colleting program, however, continent of bladder and bowel.  The Care Area Assessment and the for ADLs and had limitations limited range of motion, poor balance, visual impairment, and further identified R35 had es/conditions, such as in that resulted in reduced that R35 yand needed assistance in tributed to incontinence. The lithat R35 was offered toileting heals, at bedtime, and on an incontinence brief to protect de dignity.  The Care R35 had on an incontinence brief to protect de dignity.	F 312	2		
		vo staff members for toileting. cked at least every two hours				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245275	B. WING		04	/14/2017	
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, 2 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423			
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F 312	for incontinence. The monitor for signs of offer/encourage the and/or after meals, night rounds. Furth to assist with perind change incontinent check brief for incompleted brie	he care plan directed staff to fincontinence decline and to e toilet upon rising, before and at bedtime and during er, the care plan directed staff eal hygiene after toileting, briefs when soiled and to entinence with rounding.  In p.m. NA-F explained R35 did however, she did not decline incontinence brief changed or e was unable to move herself, equested to use the toilet at ble to bear weight, therefore, rief was changed in bed. NA-Fince of open areas on R35's noticed red/yellow drainage er on the bed sheet. NA-Fintly complained of pain during to her requests for help. The proposed in the wound physician (MD)-A ext seen R35 on 4/7/17 and was medial ankle and right heel D-A was Dr. was unaware of deep tissue injury and skin 5's buttocks. It was MD-A's fin was elevating R35's heels, would have expected the heels and the resident would be	F3	12			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245275	B. WING		04/	14/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		
(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 APPROPROPRIES OF THE APPROPRIES OF T	D BE	(X5) COMPLETION DATE
F 312	two hours. It was a implement pressur. R35's heels, ankle, NA-A stated on 4/1 supposed to check Staff were suppose off of the bed and swas unsure which began. NA-A was uchanges to R35's con 4/13/17, at 10:5 repositioned and clorief at 7:00 a.m. Nother changed R35 at 5:0 "screamed in pain" R35 stayed in bed was reapproached to offer repositioning. However, on 4/13/17 reported she had continent of both unsure when R35 is time. NA-H stated by program of every to have a wheelchair stated when R35 whether her legs son NA-H did not place heels or feet.	her wheelchair at least every lso expected staff would e relieving interventions for and buttocks.  3/17, at 8:17 a.m. staff was on R35 every 15-20 minutes. ed to ensure R35's feet were she had a boot on, but NA-A foot or when this intervention maware if there had been care plan.  66 a.m. NA-G stated she had hanged R35's wet incontinence IA-G stated the night shift had 20 a.m. NA-G reported R35 when assisted to reposition. after incontinence care, and at 10:00 a.m. and 10:35 a.m. ag, but said R35 had refused.  17, at 11:05 a.m. NA-H hanged R35's incontinence nd the resident had been bowel and bladder. NA-H was nad been changed prior to that R35 was on a repositioning wo hours in bed, but did not repositioning program. NA-H was in bed, she needed a pillow o her ankles did not touch. a pillow under the resident's	F 312			
	"care plan is a mes DON was in the pro	30 p.m. the DON stated the ss and is not good" and the ocess of updating it. The DON ere no pressure relieving				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	G	(X3) DATE SURVEY COMPLETED		
		245275	B. WING _		04/14/2017	
	ROVIDER OR SUPPLIER  ARE & REHAB CENTI	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		
(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
	expected staff to re R35 at least every to The care tracker was know R35's plan of continent of bowel. to monitor for urgen the bathroom. R35 bladder and to offer was directed to offer rising, before and/o	on the care plan. The DON position, check and change wo hours.  as a tool for NAs to use to care which indicated R35 was The care tracker directed staff acy and give suitable time in was frequently incontinent of toileting with rounds. Staff rencourage to use toilet upon r after meals at bedtime and	F 31	2		
F 313 SS=D	MAINTAIN HEARIN  (a) Vision and heari To ensure that resic and assistive device hearing abilities, the assist the resident-  (1) In making appoi  (2) By arranging for office of a practition treatment of vision of fice of a profession provision of vision of this REQUIREMEN by: Based on observat review, the facility fa placement, to comma a lost hearing aid, a	EATMENT/DEVICES TO IG/VISION  ng Idents receive proper treatment es to maintain vision and es facility must, if necessary,	F 31	This tag could potentially affect any resident that is hearing impairedR22 hearing aid has been replaced-R22 care plan has been reviewed current.	d.	5/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245275	B. WING_		04/	04/14/2017	
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, Z 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 313	Findings include:  R22's family membat 10:15 a.m. did not periodically." FM-A stronger hearing ail but one had been lefth-C reportedly was the administrator applanned to replace staff had not put R2 meant R22 could not wisit with the reside.  On 4/11/17, at 2:05 not have his hearing The nurse FM-B had unaware R22 was FM-B explained the missing for a few madministrator said in the state of the	per (FM)-C reported on 4/11/17, of always clean out R22's ears. It is ear to be cleaned "at least explained R22 had new ds purchased just last year, post at the facility "awhile ago." as waiting for a decision from it is to whether the facility it. In addition, FM-C said often 22's hearing aid in, which of hear when FM-C tried to int.  In p.m. FM-B reported R22 did in at 1:00 p.m. that day. It is additionally and talked to that day was missing his left hearing aid. It is left hearing aid had been nonths. Although the ine would look into the	F 31	-Hearing aid placement a residents requiring assist hearing aids will be done weekly then one time we until reviewed at QAPI fo of compliance and need -DON or designee resportate of compliance 5/25	tance with 2 x weekly, 3 ekly thereafter or determination to continue. nsible for audits.		
	situation, she had not heard back.  The following morning at 9:15 a.m. R22 was assisted to the table for breakfast by NA-K. R22 was not wearing hearing aids. R22 ate a few bites of french toast and then without trying the bacon, oatmeal and liquids started wheeling himself out of the dining room into the hallway. The surveyor asked R22 a question, but the resident just looked at the surveyor and did not answer. NA-P confirmed R22 wore hearing aids. NA-P then asked R22 if he could hear her and he answered, "barely." NA-P stated she had not helped R22 up that's morning but NA-K had. NA-P said she would inform the ruse was not wearing his hearing aid in at breakfast. NA-P assisted R22 back into the dining room and offered him juice.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
<b>245275</b> B. WING	04/14/2017
NAME OF PROVIDER OR SUPPLIER  EDINA CARE & REHAB CENTER  STREET ADDRESS, CIT 6200 XERXES AVENU RICHFIELD, MN 5:	TY, STATE, ZIP CODE JE SOUTH
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORF	R'S PLAN OF CORRECTION (X5) EECTIVE ACTION SHOULD BE EENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
F 313  Continued From page 57  Registered nurse (RN)-F then brought R22 his hearing aid and placed it in his right hear. R22 confirmed he could hear and proceeded to eat his breakfast.  On 4/11/17, at 2:05 p.m. R22 was observed lying on top of his bed eyes closed with no hearing aid was observed in his ear. At 2:36 p.m. nursing assistant (NA)-P stated R22 had just moved to the current unit two or three weeks prior. NA-N had assisted R22 to get up that morning. NA-K said R22's hearing aid was kept in the nursing cart.  R22's 1/31/17, Minimum Data Set (MDS) indicated R22 had moderately impaired cognition, wore hearing aids and heard with minimal difficulty. R22 also made himself understood and understood others. R22 required staff's assistance to dress and perform personal hygiene. R22's 1/31/17, corresponding Care Area Assessment indicated R22 had impaired hearing and wore hearing aids.  R22's 3/24/16, care plan directed staff to "Check for wax in earsPlace hearing aids in both ears. Make sure hearing aids are workingclean hearing aids [in the top drawer of medication cart] every night shift every Thursday." R22's careplan dated 3/30/17, indicated, "Hearing Aids: Insert Hearing Aids in Both Ears Every Morning."  RN-F explained on 4/12/16, at 9:34 a.m. R22 had moved up to the unit from another unit, and his hearing aid had been missing prior to the move.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245275	B. WING			04/14/2017	
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		6	STREET ADDRESS, CITY, STATE, ZIP CODE S200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE
F 313	R22 in 1/17. RN-F sears every three monecessary, ear drop the wax for three dathe ears would be fon R22's treatment ear drops had been 1/28/17 and 1/30/17 the ear drops were unavailable. RN-F anot indicate the droflush to remove wax knew that the flush fourth day following unsure why the drounavailable on the shouse stock. RN-F orders there was ardrops to be started completed by the notation of the started completed by the notation of the started completed by the notation was notes indicating the reported she would and if there was was standing orders to somotify the NP and deprogress notes. RN told her that morning put in, but had been medications at the fresponded to her words.	ge 58 stated she checked residents' on the for wax build up and if os would be instilled to soften ays, and then on the fourth day lushed of wax. RN-F verified administration record (TAR) administered to R22 on 7, but on 1/29/17, it was noted not given as they were also verified that the TAR did ps were followed by an ear x. RN-F stated the nurses was to be performed on the the ear drops. RN-F was ps would have been second day, as there was verified on R22's physician's norder dated 1/27/17, for ear and a flush would then be urse practitioner (NP) on the the nurse working on the placed ear drops in R22's a was missed. RN-F stated the en notified, and verified no available in the progress and the nocument in the resident's large resident large resid	F3	313			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	` ,	(X3) DATE SURVEY COMPLETED  04/14/2017				
		245275	B. WING _		04					
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZI 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		-				
(X4) ID PREFIX TAG	ÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU				ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 313	On 4/13/17, at 10:0 director stated FM-of weeks prior R22 missing for quite a referred FM-C to the licensed social wor informed the admir On 4/13/17, at 11:0 nursing (ADON) who R22's unit stated shaid had not been in responsibility, as the medication cart and flushes were norders, and the nur complete the treatment possible to do so, so the other oncoming R22's ear drops shouth day for not be day. Notes about content the flushes were to progress notes. The transferred from the discussing the missinterdisciplinary teaplace regarding who put in the hearing a staff dropped them should have been paids at 8:00 a.m. or and would benefit to The ADON reporter week prior and she hearing aids not be	In the social services C had informed him a couple Is hearing aid had been While. The director said he had be administrator, but thought ker (LSW)-A had already be also was the manager of the was unaware R22's hearing be and said it was the nurse's the hearing aid was locked in the ADON stated ear drops toted on residents' standing the ses were expected to the nents, and if it was not thould have then passed it on the nurse. The ADON stated could have been given on the the eing completed on the second completion and the results of the recorded on the TAR and the ADON stated when R22 was the other unit, she had recalled the sing hearing aid in an the meeting. Discussion took to was responsible if the staff thick or the resident did, and if the etc. The ADON stated nurses to the the pot up for the day, the resident to wear the aids. The ADON stated to FM-BC about a thad not mentioned the ting provided for R22 by staff.	F 3	13						

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI		(X3) DATE SURVEY COMPLETED			
		245275	B. WING			04/14/2017	
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 313	information indicating completed for R22. indicated "HL [hear bilateral hearing aid today during visit."  Nursing Progress Nassident had none evening. Resident had none evening. Resident had none evening. Resident had none evening to the inthe room and unateral progression. Resident had none evening to the inthe room and unateral progression. Resident had none evening to the room and unateral progression. Resident had read and started ear days and irrigation day.  On 4/13/17, at 2:22 (DON) stated R22's out R22's ears. She care of it, and though DON stated it shout the NP's notes. The unhappy with R22's The DON said she education for the started are residually as a side of the started for the started for R22's the DON said she education for the started for R22's the DON said she education for the started for R22's f	ge 60 ng an ear flush had been A NP note dated 3/14/17, ing loss], bilateral [R22] Wears ds. Was only wearing one  lote dated 3/15/17, indicated, e of the hearing aids in this not able to articulate the hearing aids. Writer searched able to relocate them."  ress note dated 4/12/17, icated R22's ears were ax with wax built up in the right drops for right ear for three of ear to follow on the fourth  p.m. the director of nursing a family had asked her to clean e had requested the NP take ght it had been completed. The ld have been documented in e DON stated the family was a new unit since the transfer. planned to provide some aff regarding the importance ement, and added, "since if	F 3	13			
	you cannot hear yo stated the hearing a provided during mo when the resident of 483.25(b)(1) TREA PREVENT/HEAL P	u would be upset." The DON aids should have been rning cares, but no later than came out for breakfast.  TMENT/SVCS TO	F 3	14			5/25/17
	(b) Skin Integrity -						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245275	B. WING		04/14/2017	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP C 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423	•	-
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF COL X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 314	(1) Pressure ulcer comprehensive as facility must ensu.  (ii) A resident receprofessional standpressure ulcers a ulcers unless the demonstrates that (ii) A resident with necessary treatmprofessional standhealing, prevent in from developing. This REQUIREMI by:  Based on observentiemely manner for the facility monitoring and interest at a timely manner for eviewed with preactual harm, detedevelopment of necessary treatmely manner for the facility monitoring and interest at a timely manner for the facility monitoring and interest and the facility monitoring a	rs. Based on the ssessment of a resident, the	F3	,	receipt of SOD juries were ventions are as rder. MD/NP ent status of all pressure and are nent has been weekly skin ocumentation rainage, odor, as well as esident/and or for any younds. Staff ver next 3	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245275	B. WING _	B. WING		04/14/2017	
NAME OF F	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		1-1/2017
				620	00 XERXES AVENUE SOUTH		
EDINA C	ARE & REHAB CENT	TER		RIC	CHFIELD, MN 55423		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX TAG	<b>,</b>	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<b>‹</b>	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE RIATE	COMPLÉTION DATE
F 314	Continued From pa	age 62	F 3	14			
	•	out the 2 hour and 17 minute			adherence and education.		
	continuous observa				-An audit tool has been developed	to	
	Commission Control				ensure proper documentation and		
	On 4/11/17, continu	uous observations were			treatment of wounds as well as		
		ining room from 12:30 p.m. to			notification of appropriate parties a	nd to	
		seated in a wheelchair without			ensure proper care is delivered to r		
		sisted to reposition or toilet. At			the needs of those at risk for press	ures	
	12:30 p.m. approxi	mately half of R35's meal			sores. These audits will be complete	ed on	
	remained, her eyes were closed and she leaned				all residents with pressure injuries		
		35 was wearing a Prevalon			well a sample of those high risk res		
	boot on the right fo			weekly and will continue for the nex			
	left foot, and both f			months. The results will be reviewe			
	R35 remained in the same position with no repositioning until 2:08 p.m. when R35 called out,				QAPI for determination of complian	ce	
		? I'm ready to go to bed." No			need to continue.	blo for	
		in the dining room. R35 then			<ul> <li>DON or designee will be responsi compliance</li> </ul>	DIE IOI	
		some water?" Nurse			- Date of compliance 5/25/17		
		entered the dining room and			Date of compilation of 20/17		
		iss of water and left the room.					
		asked R35 if she wanted to go					
		tation, and R35 declined. NA-A					
		drink of water which the					
	resident also declir	ned. NA-A locked R35's right					
		ind walked away. R35 yelled					
		?" NA-A replied from the					
		s 2:25 in the afternoon." R35					
		ne, and NA-A went to the					
		the resident of the time and					
		anted to sit by the nurses'					
		o cares were offered. At 2:57					
		an gathering in the dining room remained at the table in the					
		er head to her chin, eyes					
		as leaning to her right side. The					
		ment coordinator (LEC)-A					
		elchair forward slightly to					
		ther resident. At 3:01 p.m.					
		ker (LSW)- B entered the					
		out offering assistance to R35.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245275	B. WING		04/14/2017		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		1-1/2011	
(X4) ID PREFIX TAG			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	eating?" R35 responsively away to another tare of her. At 3:06 p.m no other care was and 49 minutes aft had started, NA-F room and informed her incontinence but the company of the compan	b-A then asked R35, "You done onded, "Yes." HK-A walked ble and left R35's food in front . R35's tray was removed, but offered. At 3:19 p.m., 2 hours er the continuous observation assisted R35 out of the dining d her she would help change	F 31	,			
	blanches; right iscl lower extremity-so Tegaderm dressing pressure ulcer with bedtime. R35's Pre the bed which the	ft lower buttock- reddened but hial tuberosity- blanchable; right res and scabs which have gs on them; right medial anklentreatment scheduled for evalon boot was observed on DON verified was soiled with trainage. R35's wheelchair					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		245275	B. WING			04/14/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT			STREET ADDRESS, CITY, STATE, ZI 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 314	cushion was noted in thick and the DC adequate." During she did not know the changed or reposit requested to get up into her wheelchair.  After the NAs and practical nurse (LP 3:45 p.m. to comple change. LPN-C an hygiene and applie R35's right sock ar on her great right the LPN-C stated the awas dated 4/9/17 (dressing was Kerlix with foul smelling yher LPN-C reported not ankle. R35 compla was removed. LPN having "slough" (ye consists of fibrin, pmaterial) and said wound bed. LPN-C described the discoloration on the measured 5 centin LPN-B placed a bas supplies on the bas wound with normal "That hurts!" LPN-I wound bed and ed an Allevyn dressing Kerlix, and dated the consist of the same consists of the part of the par	to be only about one half inch on stated, "it does not feel the observation, NA-F reported he last time R35 had been cioned. After the care, R35 or again, and was assisted back."  DON left the room, licensed PN)-C and LPN-B entered at ete a right ankle dressing d LPN-B performed hand and gloves. LPN-C removed and reported there was a sore one, not previously observed. The soiled of and gloves and gauze that was saturated and gauze that was saturated are low/blood-tinged drainage. The soiled of pain when the dressing Lack described the wound as ellow fibrinous tissue that was, and proteinaceous she could not visualize the could not visualize the could not visualize the could not when she is in bed." The wound as "reddened with the edges" and stated the wound neters (cm) x 4 cm x 1.5 cm. The wound as sellow fibrinous tissue that was acquired as touch when she is in bed. The wound as "reddened with the edges" and stated the wound neters (cm) x 4 cm x 1.5 cm. The wound as sellow fibrinous tissue the could not visualize the cou	F3	314		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245275	B. WING			04/14/2017	
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		۱ (	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	a.m. to 10:19 a.m. R35 was not offered repositioning or tolk resting in bed with he to her right side. The odor. At 9:53 a.m. Nooked in and conting R35 remained in the a.m. at which time to locate an available 10:10 a.m. the surve continuous observed DON stated she was been provided for Foresisted care. The I challenges contribus surveyor informed to regarding R35 and DON entered R35's 16 minutes) and consident's skin concent R35's incontinence The DON described dark colored punge acknowledged she R35 had been charthen assessed the reported R35's left bed. R35 moaned in everywhere" when a side. The DON stathad superficial skin identified Stage I for tightened her jaw and assisted to turn to hobserved the left he suspected deep tissuspected deep tissuspected deep tissuspected in the side.	ge 65 85 was lying in bed from 7:03 Throughout the observation, d any assistance with eting. At 7:03 a.m. R35 was her eyes closed, slightly tilted e room had a strong urine NA-F stopped at R35's door, hued to walk past the room. e same position until at 10:02 the surveyor attempted to staff person to intervene. At eyor informed the DON of the ation of R35 without care. The less unaware why care had not less unaware why care had not less unaware why care for R35. The he DON of serious concerns she responded, "Me too." The form at 10:19 a.m. (3 hours, impleted an assessment of the littion. The DON changed brief and provided peri-care. It R35's brief as saturated with int smelling urine. The DON was unaware of the last time linged or repositioned. The DON resident's skin condition and heel was lying directly on the in pain and stated she "hurt lessisted to turn to her right led the left ischial tuberosity loss over the previously om 4/11/17. R35 moaned, and had furrowed brows when her left side. The DON then leel, and stated there was a leve injury measuring 1 cm x 1 loorted the area was painful to	F	314			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245275	B. WING	B. WING		/14/2017	
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP COD 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423			
(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 CORRE  (EACH CORRECTIVE ACTION SHORE)  CROSS-REFERENCED TO THE AP  DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 314	the resident's left for mattress without a place. The DON constatus of R35's left know the severity of reassessed it. The comprehensive assumpleted or document to the comprehensive and left DON stated she were issues to have been discovery. In additional comprehension, and and change and resident and change and resident and the undated admission with a physician profacility following the 4/14/17. Progress of the undated admission with a physician profacility following the 4/14/17. Progress of the undated admission with a physician profacility following the 4/14/17. Progress of the undated 1/6/17 through a history of intermit cares which include assessments, physical progress of the prog	at the gripper sock back onto bot, which was directly on the pressure relieving device in onfirmed she was aware of the heel last week, but did not of the wound and had not DON confirmed a sessment had not been mented related to R35's buttocks, Stage I on left ischial heel deep tissue injury. The buld have expected these skin in assessed immediately upon on, the DON stated she billow the resident's care plan position R35 at least every two atted the resident had multiple uding: chronic kidney disease, avioral disturbances, existly per her diagnosis list on sion record, and consistent ogress note provided by the executification survey exit notes and ent administration records gh 4/13/17, indicated R35 had tently refusing treatments and ed skin care treatment, sician appointments, and	F3	14			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245275	B. WING			04/	14/2017	
	PROVIDER OR SUPPLIER			6200 X	T ADDRESS, CITY, STATE, ZIP CODE ERXES AVENUE SOUTH FIELD, MN 55423	•	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 314	inconsistent, rangi goals were identific maintain hydration. There was no furth R35's annual Minit 2/7/17, identified Fimpairment and harheumatoid arthriti dementia and anxi R35 required externof daily living (ADL was at risk. The Massessment tool a completed to determ R35's correspondi (CAA) dated 2/7/1 physical assistance due to: weakness, coordination, poor and pain. The CAA to be at risk for ski comprehensive as contributing to the CAA for cognition problems with shoresident had daily assistance and cardanger or disrupt of printed 4/12/17, arcurrent identified a interventions identified on the event R3 Additionally, there to minimize the risi identified risk factors.	ng from 26-100%. Nutritional ed as: maintain stable weight, and no skin breakdown. The nutritional update.  mum Data Set (MDS) dated as had moderate cognitive ad diagnoses including: s (known to contribute to pain), fety. The MDS further indicated ansive assistance with activities as), had no pressure ulcers but DS indicated a formal nd a clinical assessment were rmine R35's pressure ulcer risk.  Ing Care Area Assessment and a clinical assessment were rmine R35's pressure ulcer risk.  Ing Care Area Assessment and a clinical assessment of R35 needed for ADLs and had limitations limited range of motion, poor balance, visual impairment, and dated 2/15/17, identified R35 in breakdown. There was no sessment of R35's risk factors potential for breakdown. The dated 2/7/17, indicated and long term memory, behavior of calling out for moderate and long term memory, behavior of calling out for moderates. Although the care plantage of cares, there were no iffied to assist staff on what to 5 refused cares/treatments. Were no specific interventions k for skin breakdown based on	F3	314				

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245275	B. WING			04/	14/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		
(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 314	cognitively impaired neurodermatitis, and both lower extremit chest. R35's care plassist with reposition to help R35 avoid lacare plan directed spressure reducing wheelchair, and that when transferring to plan directed staff to bed to avoid laying. The care plan did not deep tissue to left heel, right inner and toe wound. The care interventions definite turned/reposition include other press interventions.  During an interview p.m. she explained however, NA-F staff to have her incontint to assist her repositionable to move her although R35 requested assistance brief. NA-F stated in alteration, she would time. NA-F denied R35's buttocks, but red/yellow drainage.	of skin integrity due to being d, assistance with ADLs, and had scratches/wounds on ies, left buttock, shoulder, and plan directed facility staff to oning frequently in bed in order aying on the open areas. The staff to ensure that proper devices were in the at R35 was positioned correctly of wheelchair. Further, the care to "assist with repositioning in on open areas frequently". The address R35's suspected the el, unstageable ulcer to right activate plan did not include the plan did not include the plan did not include the plan did not like to lie down the draft did not decline offers the R35 did not like to lie down the R35 did not decline offers the else to use the toilet at times, the bear weight therefore, she are to change her incontinence of she observed a new skin and inform the nurse at that the being aware of open areas on a stated she had noticed a from her right ankle on the lated R35 frequently	F3	314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245275	B. WING		04	/14/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP ( 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423	ADDRESS, CITY, STATE, ZIP CODE ERXES AVENUE SOUTH IELD, MN 55423 PROVIDER'S PLAN OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	(X5) COMPLETION DATE
F 314	On 4/12/17, at 9:14 (TMA)-D said R35 respond to her requistated R35 receive got up for the day, or 11:00 a.m.  On 4/12/17, at 1:44 stated she was new with R35. NP-A stated staff would contact skin alterations, but informed of any proshe'd begun seeing said if skin alterations would implement plif a new wound had potentially order a left on 4/12/17, at 6:15 was conducted with He reported he saw 4/7/17 and was foll and right heel presunaware of the left and skin break downwards. It was also changes would be ankle. MD-A report ulcer, and would had without appropriate MD-A's impression	a.m. trained medication aide yelled when staff did not uests for help. TMA-D also d Tylenol for pain when she but not usually until 10:00 a.m.  p.m. nurse practitioner (NP)-A we to the facility and unfamiliar ted it was an expectation the the NP regarding any new to verified she had not been oblems with R35's skin since of the resident on 4/3/17. NP-A was were observed, NP-A was to off load pressure and ressure relieving interventions. If developed, she would we was attempted with the day voicemail message was	F 31	4		

AND DIAN OF CORRECTION IDENTIFICATION NUMBER			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245275	B. WING	<del></del>	04/14/201	17
	NAME OF PROVIDER OR SUPPLIER  EDINA CARE & REHAB CENTER  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 314  Continued From page 70 the heels to be off the bed, and the resident would be repositioned out of her wheelchair at least every two hours. It was also expected stawould implement pressure relieving interventic for R35's heels, ankle, and buttocks.  NA-A stated on 4/13/17, at 8:17 a.m. R35 "alw says she is in pain" and was "cussing when getting dressed and putting her in the wheelchair." R35 complained of pain in her fee and legs. NA-A stated they are supposed to check on R35 every 15-20 minutes. Staff was supposed to ensure R35's feet were off the be and she had a boot on, but NA-A was unsure which foot or when this intervention began. NA was unaware if there had been changes to R3 care plan.  On 4/13/17, at 8:28 a.m. LPN-D reported she was unaware R35 had sores on her legs and hip. R35 slept from 10:00 a.m. to 1:00 p.m. but it was si expected the NAs would check on the residen because of her skin issues. LPN-D believed the right hip area was due to pressure, and the otd wounds were from scratching and picking at herself. LPN-D was unfamiliar with other wounds they had not been passed on during shift to			STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423	·	
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPL	(5) LETION ATE
F 314	the heels to be off would be reposition least every two how would implement pfor R35's heels, and NA-A stated on 4/1 says she is in pain' getting dressed and wheelchair." R35 cand legs. NA-A statcheck on R35 ever supposed to ensur and she had a bood which foot or when was unaware if the care plan.  On 4/13/17, at 8:28 aware R35 had son slept from 10:00 a. expected the NAs because of her skir right hip area was a wounds were from herself. LPN-D was as they had not be shift reporting.  On 4/13/17, at 10:5 repositioned and cobrief at 7:00 a.m. Nothinged R35 at 5:1 "screamed in pain" R35 stayed in bed was reapproached to offer repositionin NA-G was unsure in the state of the stay of th	the bed, and the resident ned out of her wheelchair at urs. It was also expected staff pressure relieving interventions kle, and buttocks.  3/17, at 8:17 a.m. R35 "always" and was "cussing when diputting her in the omplained of pain in her feet ted they are supposed to by 15-20 minutes. Staff was e R35's feet were off the bed ton, but NA-A was unsured this intervention began. NA-A are had been changes to R35's materials. LPN-D reported she was resident on the resident in issues. LPN-D believed the due to pressure, and the other scratching and picking at sunfamiliar with other wounds,	F 314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		(X3) DATE SURVEY COMPLETED	
		245275	B. WING	·	04	/14/2017
AND PLAN OF CORRECTION    A. BUILDING				STREET ADDRESS, CITY, STATE, ZIP 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423	SS, CITY, STATE, ZIP CODE AVENUE SOUTH	
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 314	care plan in the last However, on 4/13/1 reported she had cobrief at 7:30 a.m. a incontinent of both unsure when R35 It time. NA-H was aw thighs, toe, ankle, a pain" and would not due to the pain. NA repositioning program. NA-H staneeded a pillow be did not touch. NA-H the resident's heels An interview was contelephone on 4/13/1 he worked on 4/10/1 completing a dress stated when dressinhe usually dated artimes was "busy ard done so. LPN-A ex nurse on the floor of and difficult to get to R35 was "in pain a sore." LPN-A was usually dated artimes was "busy ard done so. LPN-A ex nurse on the floor of and difficult to get to R35 was "in pain a sore." LPN-A was usually dated artimes was "busy ard done so. LPN-A ex nurse on the floor of and difficult to get to R35 was "in pain a sore." LPN-A was usually dated artimes was "busy ard done so. LPN-A ex nurse on the floor of and difficult to get to R35 was "in pain a sore." LPN-A was usually dated artimes was "busy ard done so. LPN-A ex nurse on the floor of and difficult to get to R35 was "in pain a sore." LPN-A was usually dated artimes was "busy ard done so. LPN-A ex nurse on the floor of and difficult to get to R35 was "in pain a sore." LPN-A was usually dated artimes was "busy ard done so. LPN-A ex nurse on the floor of and difficult to get to R35 was "in pain a sore." LPN-A was usually dated artimes was "busy ard done so. LPN-A ex nurse on the floor of and difficult to get to R35 was "in pain a sore." LPN-A was usually dated artimes was "busy ard done so. LPN-A ex nurse on the floor of and difficult to get to R35 was "in pain a sore." LPN-A was usually dated artimes was "busy ard done so. LPN-A ex nurse on the floor of and difficult to get to R35 was "in pain a sore." LPN-A was usually dated artimes was "busy ard done so. LPN-A ex nurse on the floor of and difficult to get to R35 was "in pain a sore." LPN-A was usually dated artimes was "busy ard done so. LPN-A ex nurse of the sore of	It week.  It week.  It week.  It, at 11:05 a.m. NA-H hanged R35's incontinence nd the resident had been bowel and bladder. NA-H was nad been changed prior to that ware R35 had wounds on her and heel. R35 had "a lot of it let NA-H touch her right leg it. H stated R35 was on a sam of every two hours in bed, wheelchair repositioning ted when R35 was in bed, she tween her legs so her ankles it did not place a pillow under it or feet.  It is onducted with LPN-A via 17, at 11:12 a.m. LPN-A stated in the did not recall sing change that day. LPN-A ng changes were performed ind initialed the dressing, but at and rushed" so may not have	F 314			

CLIVILI	13 I ON WEDICANE	. WILDICAID SLIVICES				IVID IVO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY IPLETED
		245275	B. WING	·		04/	14/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
EDINA C	ADE 9 DELIAD CENT	TD.		6	200 XERXES AVENUE SOUTH		
EDINA C	ARE & REHAB CENT	EK		R	RICHFIELD, MN 55423		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF		COMPLÉTION DATE
IAG	NEGOL WORT ON E		140		DEFICIENCY)		
F 314	Continued From pa	ige 72	F3	314			
	been monitored we	ekly the record lacked					
		ring. The DON was aware of					
		r on 4/12/17, but it was not					
		umentation. The DON stated					
	that the "care plan i	is a mess and is not good" and					
	the DON was in the	process of updating it. The					
	DON confirmed the	ere were no pressure relieving					
	interventions noted	on the care plan. Prior to the					
		e DON said she had not					
	thought of putting a	different mattress on R35's					
	bed. The DON expe	ected staff to reposition, check					
	and change R35 at	least every two hours. The					
	DON expected nurs	ses to monitor R35's skin					
	every shift and asse	ess once weekly on bath day,					
	and to document fir	ndings. In addition, it was					
	expected a compre	hensive skin assessment					
	would be completed	d when a new area was found.					
	This included a hea	ad to toe assessment of skin,					
	documentation of the	ne location of wounds, wound					
	measurements, wit	h completion of a risk					
	management form.	The DON stated the current					
	order for R35's righ	it ankle was to apply Santyl,					
	calcium alginate, co	over with Allevyn and wrap with					
	Kerlix. The expecta	ition was for nurses to read the					
	orders prior to com	pleting the dressing change.					
		e right and left heel were to					
		lied, but verified this					
	intervention was no	t identified on the Treatment					
		ord (TAR) or Medication					
	Administration Rec	ord (MAR). The DON did not					
		-service material showing staff					
	had been provided	education on wound training.					
	The DON expected	I the nurse to immediately					
		the skin alteration was					
	observed, and the I	NP ultimately oversaw care for					
		ted R35 experienced pain with					
		She was unsure whether					
		pain was provided for R35					
		essing changes, but the DON					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED			
		245275	B. WING		04	/14/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		
(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 314	stated she felt it she Review of R35's pr 4/11/17, identified of malleolus was pain there was no notat physician. On 4/1/1 completed with docheel-pressure stag (inner) pressure- siskin areas. The foldocumentation ide to right ankle was amount of yellowis site. Documentation provider had been progress note iden change was compl bigger, had a white and was odorous, lidocumentation that updated.  Review of R35's wifrom 3/2/17, right inner adate by nurse man x 2.5 cm and class Documentation ide on this date, depth slough, a moderate and pain associate.	rogress notes from 3/6/17, to on 3/6/17, R35's right inner offul to touch and tender and ion regarding an update to 17, a skin check was cumentation of: "Other right e unstagable, right ankle tage II" and identified no new lowing day on 4/2/17, notified that the dressing charge completed and had a large the drainage from the wound in lacked evidence that the notified. On 4/6/17, the tified the right ankle dressing eted and the wound looked a substance in the wound site thowever, the record lacked the physician had been eekly wound documentation 1/17.  Tankle was identified on this ager with measurements of 2.0 ified as an unstagable. Intified that area was debrided is superficial, has 100% a amount of serous drainage, d with wound.	F 31	4		
	3/23/17, and 3/31/2 ankle measuremer classified as a stag	17, all indicated right inner hts of 2.0 x 2.0 x cm and ge IV. Documentation identified erficial with 100% slough and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245275	B. WING_		04	/14/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC 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	moderate serous with wound. Documarked that indica Professional and fursing weekly worecord did not reflex Review of R35's we evaluation documerevealed::  1) 3/2/17: unstage tissue) of the right duration with meanot measurable deexudate and 100% necrotic tissue. Thusing surgical techand necrotic SQ (sat a depth of 0.1 capain associated with moderatick adherent devaluation with moderatick adherent devaluments of depth with moderatick adherent devaluments and necrotic fibers were removed and with tissue and necrotic fibers were removed associated with 3/16/17: unstage pressure wound with Documentation idea.	drainage, and pain associated mentation had a radio button ated MD/Physician/NP/Medical amily were notified. However, bund documentation and R35's ect the right medial heel.  Weekly wound care specialist entation from 3/2/17 to 4/7/17  able (due to necrosis or dead, medial ankle of at least 5 days surements of 2 cm x 2.5 cm x epth cm with light serous thick adherent devitalized are wound was cleansed and anique was devitalized tissue subcutaneous) fat was removed m. There is no indication of ith this condition.  able right medial ankle with 2 cm x 2 cm x not measurable ate serous exudate and 90% witalized necrotic tissue with ssue. Documentation identified and progress. The wound was surgical technique devitalized comuscle and surround fascial ed. There is no indication of	F 3:	14		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245275	B. WING_			04/	/14/2017	
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, 6200 XERXES AVE RICHFIELD, MN		,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECT DRRECTIVE ACTION SHOU FERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 314	wound progress de have associated paright, medial heel, of There is no exudate cm x 1.3 cm x not ridentified 100% this tissue. Skin prep wankle was docume cm x 3.5 cm x 0.2 dexudate, 85% grantissue, and tendon associated with cor 6) 4/7/17: right med 2.0 cm x 2.0 cm x thick adherent black change in wound pankle was measure with maceration at sero-sanguinous exgranulation tissue a Documentation ide wound progress, no pain associated with The facility's undate policy and procedu turned/positioned in care to prevent skin are unable to repositioned exaccordance with the plan as determined Nurse is responsible approaches, and general services and general gene	steriorated. R35 appeared to ain evidenced by agitation.  Peable (due to necrosis) of the of at least 1 day in duration. The with measurements of 1.5 measurable. Documentation of adherent black necrotic as ordered daily. Right medial anted of measurements of 4.0 cm with light sero-sanguinous ulation tissue, 15% other visible. No indication of pain andition.  The dial heel with measurements of the not measurable with 100% is necrotic tissue and no rogress. R35's right medial and at 4.0 cm x 4.0 cm x .02 cm periwound radius, moderate and tendon observed. The not measurable in or was there an indication of	F 3	14				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		TE SURVEY MPLETED
		245275	B. WING	· · · · · · · · · · · · · · · · · · ·	04	/14/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		
(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 SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314 F 334 SS=D	document indicated completed upon refor the first 4 weeks the score and the let Then, the risk factor interventions should on the care plan. That when a resider should be turned/reshours or as indicated the care plan shall based on the reside goals, and outcome 483.80(d)(1)(2) INFPNEUMOCOCCAL (d) Influenza and procedures to a finite the care plan shall based on the residence of the care plan shall based on the reside goals, and outcome 483.80(d)(1)(2) INFPNEUMOCOCCAL (d) Influenza and procedures to a finite the care in the care is the care is the contrained or the contrained cated or the contrained cated or the contrained is the contrained the opportunity (iv) The resident's resident'	d a Braden Scale was to be sident's admission and weekly of admission to determine evel of risk for skin breakdown. In (s), potential cause(s) and do be reviewed and addressed the document further indicated that is in bed or wheelchair they exposition at least every two end on the resident's care plan. The evaluated and revised ent's response to treatment, esc.  ELUENZAAND  IMMUNIZATIONS  The influenza immunizations accility must develop policies ensure that—  The influenza immunization, are resident's representative regarding the benefits and the of the immunization;  offered an influenza of the immunization is medically the resident has already been	F 314			5/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		245275	B. WING _		04	/14/2017	
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CO 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423	· · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 334	was provided eductand potential side of immunization; and  (B) That the resider immunization or dictimunization due to refusal.  (2) Pneumococcal develop policies and  (i) Before offering the immunization, each representative received.	nt or resident's representative ation regarding the benefits effects of influenza at not received the influenza of medical contraindications or disease. The facility must diprocedures to ensure that-	F 33	4			
	immunization, unler medically contrained already been immulated.  (iii) The resident or has the opportunity.  (iv) The resident's adocumentation that following:  (A) That the resident was provided educated and potential side of immunization; and	offered a pneumococcal set the immunization is icated or the resident has nized; the resident's representative to refuse immunization; and medical record includes indicates, at a minimum, the ont or resident's representative ation regarding the benefits effects of pneumococcal					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  IG		E SURVEY PLETED
		245275	B. WING _		04/	14/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423	1 34/14/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 334	pneumococcal imrithe pneumococcal contraindication or This REQUIREME by: Based on interview facility failed to ens R109) reviewed fo and provided the pvaccine (PCV13) at the Influenza vacci Findings include: The Center for Dis (CDC) identified, "who have not previous of PPSV23 [pneum vaccine 23] should The dose of PCV1 year after receipt of dose."  R89's date of birth Immunization Repedocumented evide had been offered. R109's date of birth facility supplied Millinformation Conneidentified R109 rechowever had no do PCV13 had been of	nunization or did not receive immunization due to medical refusal.  INT is not met as evidenced w and document review, the sure 2 of 5 residents (R89, r immunizations were offered ineumococcal conjugate and 1 of 5 residents (R74) for	F 33	All residents have the potential affected by this issue.  -R89 consent has been updated PCV 13 vaccine has been given -R09 consent has been updated PCV 13 has been given.  -R74 consent has been updated influenza vaccine was given pricadmission so consent denied.  -Immunization policy and proced been reviewed and is current peguidelines.  -The facility completed an audit vaccination records using multip sources using EPIC, MIIC and EMR. Resident found not be in their vaccination (influenza, P and PPSV 23, were offered and consented.  -New vaccination consent form created and is in the admission and reviewed with new residents admission and at quarterly care conferences.  -Education completed with facili immunization, charting, tracking administration.  -Immunization audits will be conwithin 10 days of admission and quarterly care conferences.	I and the I and the I and the I and or to dure has er CDC of ole ee current CV 13 given if was packet s upon ty staff on g and appleted with	
	documented evide had been offered.  R109's date of birt facility supplied Mil Information Conneidentified R109 rechowever had no do PCV13 had been of administered.  R74's date of birth	the PPSV23 and PCV13 declined, or administered.  The is 7/7/45. Review of the nnesota Immunization ection flowsheet, run 4/11/17, belived the PPSV23 in 2011, becumented evidence the		and reviewed with new residents admission and at quarterly care conferencesEducation completed with facili immunization, charting, tracking administrationImmunization audits will be conwithin 10 days of admission and	ty staff on g and higher and with higher an ion of e.	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245275	B. WING		04/	14/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		-
(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 SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 334	been offered, decline On 4/11/17, at 1:52 (DON) stated immurprior to admission a if the resident had to admission. However, administration immurprior admission the resident consented, and adron DON confirmed all immunization status no further information further information. The "Seasonal Influt 8/1/15, indicated the residents and offer contraindicated. The Information statemed consent form shall order prior to admir monitored for 48 hours of the "Pneumococca 8/1/15, indicated refered in the pneumon aphysician's of the vaccine will be gotten to admir the pneumon aphysician's of the vaccine will be gotten to admir the pneumon aphysician's of the vaccine will be gotten to admir the pneumon aphysician's of the vaccine will be gotten to admir the pneumon aphysician's of the vaccine will be gotten to admir the pneumon approximation and the pneumon approximation approximation approximation and the province of the pneumon approximation approximati	p.m. director of nursing inization status was screened and would be in medical record he immunization prior to er, if there was no unization records upon lents had been offered, ministered at the facility. The documentation related to s was provided, and there was	F 334	responsible for auditsDate of compliance 5/25/2017.		
F 353 SS=F	and PCV13.	IFFICIENT 24-HR NURSING	F 35	3		5/25/17
		vices  ve sufficient nursing staff with petencies and skills sets to				
	appropriate con	ipotoriolog aria ditilio doto to				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245275	B. WING _		04	/14/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP COL 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 353	resident safety and practicable physical well-being of each president assessment and considering the diagnoses of the fall accordance with the at §483.70(e). [As linked to Facility be implemented be (Phase 2)]  (a) Sufficient Staff. (a)(1) The facility must sufficient numbers of personnel on a 2 nursing care to all resident care plans.  (i) Except when was this section, licensed (ii) Other nursing polimited to nurse aid (a)(2) Except when this section, the fact nurse to serve as a duty.  (a)(3) The facility must nurses have the spects necessary to didentified through redescribed in the planting polimited to nurse to serve as a duty.	d related services to assure attain or maintain the highest I, mental, and psychosocial resident, as determined by ints and individual plans of care enumber, acuity and cility's resident population in a facility assessment required by Assessment, §483.70(e), will ginning November 28, 2017 and provide services by of each of the following types each of the following	F 35	3		
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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	FIPLE CONSTRUCTION  NG		E SURVEY PLETED
		245275	B. WING		04/	14/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CO 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 353	assessing, evaluating resident care plansing needs. This REQUIREME by: Based on observareview, the facility of staffing was provided residents regarding care, check and chemanagement, and deficient practice of the potential to affect the facility.  Findings include: R86's family members on 4/11/17, at 9:55 (3N) every other daresidents here nee "Since the new own enough nursing as: On 4/11/17, at 10:1 moved up to 3N frostated on the secontake R22 to the base help assist him, stadirty clothes on him FM-C stated FM-B clothes for R22 to would have the sar stated staff do not not trim R22's nails hearing aid in. FM-	ing, planning and implementing and responding to resident's  NT is not met as evidenced tion, interview and document railed to ensure sufficient ed to meet the needs of grepositioning, pressure ulcer lange programs, pain assistance with ADLS. This aused harm to R35. This had ect all 69 residents residing in the early after work, I think those diactivities." FM-E stated, hers there is less staff, not sistants (NAs)."  5 a.m. FM-C stated R22 had om the second floor. FM-C and floor staff did not always throom so the family would aff seemed to put the same and he had long toe nails. Would lay out different clean wear the next day but staff me dirty clothes on him. FM-C clean out his ears, and staff do is. Staff do not always place his C stated they were still waiting liministrator about R22's	F3	All residents could be affected alleged tagR35 passed away prior to re-Residents with high acuity of a daily at morning meeting Mornand for potential changes on weekend with determination appropriate staffing ratios and changes determined at that the transport of all new residents will continue for 4 weeks and of a random least 5 residents residing at the greater than 4 weeks will be week to determine ADL cares and pain manager are being met and have been occupancy of individual units adjusted to reflect proper restratiosAudit of the staffing ratios via roster will be done daily Mondate Administrator with adjustration as needed to ensure adequal ratiosDON or designee will attend council meetings and/or meetings and/	cceipt of SOD. skilled are reviewed nday-Friday Friday for the of d need for ime. ents ng those erviewed to re met and ely. Interviews nue weekly sample of at he facility done per s, pressure ment needs n care reviewed and have been ident to staff a the staffing day-Friday by ments made te staffing resident	

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F 353	On 4/11/17, at 1:4 member fell abour abrasion. FM-F s someone new wo stated there used here that stayed of more games and activities have decorated there are that stayed of more games and activities have decorated activities have decorated about the 35 minutes for stated member's call light sight. FM-E found member to the bas soaked and "reek he was the only N day. FM-E stated happens about for stated she found in 10 inches under the when coming to vide to the state of the wast of	lage 82  1 p.m. FM-F stated his family to of bed last week and had an tated apparently it was rking on the night shift. FM-F to be a full time social worker in the unit most of the time and activities happened, but now creased on the unit.  11/17, at 1:52 p.m. stated on a ree weeks ago she had waited ff to answer her family it and there was no staff in NA-N and he helped her family throom. His bed had been ed of urine". NA-N told FM-E A who showed up for work that that working with one NA ur times a week here. FM-E the call light stuck approximately he mattress a couple of times is it R89. FM-E stated she found but a dry pad a couple of times. It 2:36 p.m. stated, "I have to up to an hour for my night is quarterly Minimum Data Set /17, indicated R16's cognition  1 2:39 p.m. stated, "After three not come in anymore. No one is quarterly MDS dated 3/15/17, orginition was intact.  10/17, at 4:18 p.m. stated, "They are hour for help to get me there stated "When you nut your the stated "	F3	resident council president resident concernsAn audit tool was created ADL's, call lights and report done timely. These will be per week for 6 weeks and thereafter for 3 months. Edone on 2 random residents per day)Administrator/DON or de responsible for auditsDate of compliance 5/25/	d to ensure positioning are e conducted 3X d weekly each audit will be ents per floor (6	

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F 353	call light on you have staff have told me to quarterly MDS date cognition was intace.  R87 on 4/10/17, at short of NAs, our net R87 stated they have today and the admit any money. The net R87's quarterly MD R87's cognition was R53 on 4/10/17, at always understaffer and nights are short has had to wait a long time whom they had been short only been one NA cownership. R67's quindicated R67's cognition was me that put on have just poked in the room when I had move straffic." R89's quarterly mas sitting on the etraffic." R89's quarterly mas intace.	we to wait about 15 minutes, hey are short staffed." R47's d 12/28/17, indicated R47's t.  4:30 p.m. stated, "We are urses are leaving like flies." d a resident council meeting nistrator did not want to spend w SS is taking over today. S dated 1/11/17, indicated impaired.  5:36 p.m. stated, "We are d, evening shift is the toughest t staffed also." R53 stated he and time for pain medications. dated 3/7/17, indicated R53's t.  6:15 p.m. stated, "I will put my we to wait for one half hour or to come in." R67 also stated to f staff lately and there had on the floor since the new uarterly MDS dated 1/25/17,	F 35	53		

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F 353	On 4/10/17, at 2:27 weekend there was residents and one get up in the morni weekend there was well.  RN-A standing near insurance was not working on other jothey were cutting a staff did not feel it stated they are veronly one person in RN-A stated staffin often short staffed had been only one floor. There were residents.  On 4/11/17, at 1:25 stated there were for the whole buildieverything up on the basement room. Heep the basemen stated they had tal but they were not of the janitor hours. Housekeeping staff the evenings and the waxing. HK-C stated down because of real waxing and the complex control of the staff. Went up a lot receive a new job. RN-F staff.	7 p.m. NA-K stated this last sone one NA on 3S for 17 NA can not help 17 residents ng. NA-K stated this last sonly one NA on 2nd floor as arby stated the medical good here and staff was obs. The facility was sold and ctivities and housekeeping and was fair to the residents. RN-A y short staffed here. There was the kitchen today out of four. g was getting worse and more RN-A stated one night there person, a nurse, on the whole to NAs, just the nurse to pass and provide cares for 17 only two housekeepers today ng and it's hard to keep the three resident floors and the K-C stated it was difficult to the bathrooms' clean. HK-C ked to management about it doing anything but cutting down lK-C stated there was now the resident room floors needed and the facility was trying to cut	F3	353			

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F 353	shift because they stated they were al sometimes only on NAs needed per should be stated sometimes to NA-P stated dietary meals, the NAs did needed meal assis on 4/12/17, at 9:54 was short of staff in stated a lot of the sign job since staff foun medical insurance on 4/12/17, at 2:00 (MD) stated he rechad worked at the maintenance. MD semployment and the replacing him. MD to do and had to provide they often got pulle in charge of four dehousekeeping, janistated last week he absences in each of they had been tryin year as well as keep repairs but they con On 4/13/17, at 9:52 up today instead of On 4/12/17, at 11:53 and on the stated of On 4/12/17, at 11	can not fill all the shifts. RN-F so short of NAs. RN-F stated e NA works instead of the two nift.  I a.m. NA-P stated two NAs shift for the 3N unit. NA-P they only worked with one NA. I did not pass out the residents and there were residents who	F 35	33		

AND PLAN OF CORRECTION   (X1) PROVIDER/SUPPLIER/CLIA   (X2) MULTIPLE CONSTRUCTION   A. BUILDING			COMPLETED				
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F 353	no NA working on the (RN-B) working on The administrator were working on the staffing coordinate period had forty plus assistants and forty they were unable to Five minutes later came back and stanot Saturday night floor for the night stated on Monday only one NA on secone NA on third floadministrator state NAs overnight one floor, and one NA ostated the facility cagency as of 3/31/was in place.  On 4/13/17, at 10:2 nursing (ADON) stated the facility cagency as of 3/31/was in place.  On 4/13/17, at 10:2 nursing (ADON) stated the facility the nurse manager for (TCU). The ADON now since she had nurse manager for new owners revam the ADON instead stated the facility the nurse manager ADON stated the Information the other three ADON stated she of	the floor and only one nurse first floor with 13 residents. was asked how many NAs be other floors that night. The r (SC) stated this last pay us openings for nursing y plus openings for nurses that		353			

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F 353	new ownership the only one NA and no had. The ADON statuse the float pool/a agency for three further change of ownershinterviewing staff all unit because she day and TCU nure currently having 13 the TCU is very time.  On 4/13/17, at 2:22 (DON) stated she had the TCU is very time.  On 4/13/17, at 2:22 (DON) stated she had been the nurse manager for TCU, been the nurse marger for TCU, been the nurse marger for TCU. been the nurse marger for TCU, been the nurse marger for TCU. been the nurse marger for the DON stated the factorial control of the doing all nurse marger facility, but did not a responsible for control of the DON stated the doing all nurse marger facility, but did not a responsibilities. She wanted to do three been previously do DON added the AD with the facility nex residents in the lon floor come to her we staff to the state of the total control of the total control of the pool of	facility had been working with of the two NAs they usually ated the facility can no longer gency. They had been utilizing all time positions before the ip. The ADON stated she was cout the residents on the 3N id not know the residents yet. BN presently has 14 residents mber of residents vary, residents. The ADON stated e consuming.  It p.m. the director of nursing had been DON for two weeks he had previously been the the two units on second floor. The ADON stated RN-G had hager of two units on the third haployment with the facility in DON had left employment stated RN-E had become the he became the new DON. The stated RN-E had become the he became the new DON. The stated the previous 3/17 and she would be hagement duties for the whole	F3	53			

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 353	assessments. The have two ADON's versponsibilities. The going to help hire a R60 During an family into p.m. R60's family moticed some staff explained R60 requand the use of a hoon transportation to metro mobility. How wait 5-10 minutes to without you. FM-As day the floor is only had to be the second with the hoyer lift or with metro mobility. Staff have not been use a hoyer lift become fast due to the second staff have the second staff	DON stated she is going to with nurse manager e DON stated the consultant is	F 3		=FICIENCY)		
	p.m. residents were with no condiments residents was the requested ketchup, able to get up on hit the refrigerator. The their hamburger with nurse was observe onto the elevator at Four residents sat at them to eat. At 6:06	ervation on 4/10/17, at 5:55 e served a plain hamburger s. The only staff serving the nurse, however three residents, but only one resident was is own and get a packet out of e other two residents finished thout getting ketchup. The d helping another resident and left the floor in the elevator. at the table with no meal for 5 p.m. the two NAs entered the ought the four resident's their					

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F 353	On 4/11/17, at 9:20 State is here manabut usually there warings I don't answer [facility] wants me to work the floor all On 4/12/17, at 7:34 regular on the floor only one NA when to get the work don stated the licensed answer call lights. It is she was the only Nobeing trained in who person training her get the training she On 4/12/17, at 10:1 staffing challenges timely cares on R33 attempted a staff to however, felt the sedue to having more Although, the facilit NAs on the second DON was made awalack of care for R35 The DON stated the charge nurse duties she stated she had nurses to assist with are in the process of cannot do both role was "unable to talk Pass-Over Holiday, she had not been as to work the second to be the second to be the second to both role was "unable to talk Pass-Over Holiday, she had not been as to work the second to be the second to be the second to be the second to both role was "unable to talk Pass-Over Holiday, she had not been as the second to be the	a.m. NA-N stated when the gement scheduled two NAs as only one NA. "If my phone rer it because I know the pick up a shift and I will have alone."  a.m. NA-O stated she was a and sometimes there was there should be two, "it's hard e on time." NA-O further nursing staff does not help to NA-O explained just last Friday A on the floor and NA-L was en management pulled the to another floor so she did not	F 3	53			

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F 353	On 4/12/17, at 9:14 to schedule rides, coordinate care be residents. She furt usually pulled from per week to be a number of building depending HUC-A stated it de enough time to get explained she doe medications to corresponsibilities. Hu usually short due to staffing coordinate are usually 25% su occurs. HUC-A stated and staff complain Further, explained having enough time the needs of DON and administ staffing and had in last week. HUC-A hiring people and so orientation. HUC-A stay for approximal because the job is facility had done at hiring like adds, job On 4/12/17, at 1:4-occurred last week conversation with staffing. NP-A inforpartner with her for department, NAs, stated the facility hrecent change of contents.	A a.m. HUC-A stated her role is appointments, referrals, and etween doctors for the her explained that she was a that role one to three times nedication aid throughout the gon staffing "if they are short". The pends on the day if she has a both jobs completed. HUC-A is get pulled away from passing implete medical record JC-A stated the facility is o call ins which are handled by it or the night supervisor and accessful at filling a shift if that ited she had heard residents ing of being short staffed. The NAs complained about not be to get cares done and to the residents. HUC-A felt the trator know about the short fact discussed with the DON stated the facility is working on sees new employees start in a explained new employees tely a month and then leave too hard. HUC-A is unsure if in the next in the property in the property is a state of the property in the property in the property is unsure if in the property in the property in the property is unsure if in the property in the property is unsure if in the property in the property in the property is the property in the property in the property is a property in the property in the property in the property is a property in the pr	F3	353			

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F 353	usually worked on to pulled down to the second floor but an emergency. This there were two NAssecond floor. She sto stay overtime to Registered nurse (Fa.m. she stated the so had a hard time facility had trouble with 4/12/17, RN-D cover 26 residents during was overwhelmed to were two residents supposed to get out happen every day with staff.  R35's Minimum Daidentified R35 was impaired.  On 4/11/17, at 8:17 out "help me" from staff in the area. With Coordinator (HUC) me" continuously from the contorted and still contorte	p.m. NA-A stated that she the third floor but today was second floor due to short staff. to be three NAs working on tone left at 10:00 a.m. due to is staff was not replaced and is for all of the residents on the stated that today she will have chart.  RN)-D, on 4/12/17, at 10:48 re was not adequate staffing finishing work. She stated the with staff retention. On ered two medication carts and her shift. She stated that she that day. RN-D stated there on the second floor that were to fobed daily but this did not when there was not enough  ta Set (MDS) dated 2/7/17, moderately cognitively  a.m. writer heard R35 calling behind a closed door without riter advised Health Unit -A R35 was calling out "help om her room with door closed. or revealing R35 in her bed er right side with face calling out "help me". When he stated "where were you? I or a half hour and I am scared.	F 35	3		

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F 353	On 4/11/17, at 8:20 HUC-A she stated room she was facilibutton and could not said she had been when no one came was hanging from bed and she probated and she p	of a.m. during an interview with when she walked in R35's and away from her call light of reach it. HUC-A stated R35 calling for a long while and a she was scared. The call light a grab bar attached to R35's bly could not reach it.  23 a.m. during an interview with a had been yelling help for 1/2 one came. R35 stated she was be thought the staff forgot dishe wanted to get up but a call light so she started calling ated the staff never responded them or when she presses the could be a could work the rest of the today. It takes a long time to so up in the morning and are only two of us on second we need more staff because of the residents like we are lights can take a long time to so stated they do not get their or they had to wait a long time	F 35	3		

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F 353	nurses and NA's. Wigoing to be able to before the sale of the On 4/12/17, at 10:3 stated they were not for the facility at this open NA shifts and two weeks. If an enfacility instituted madetermined the numprovide safe care to mandate overtime working double shift staff the shifts adec Sometimes there will floor on the night should be	Ve did not know we were not use pool staff until one week	F	353			

stay over from night shift because it would have

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F 353	been difficult for just medications on the short staffed the reask for things they are not answered at they have had to was on 4/12/17, at 10:0 morning there was which is not enough order to do things wheeded three NA's evening shifts. NAto work short for the On 4/12/17, at 3:08 stated the facility whadmissions.  On 4/13/17, at 8:23 was a concern. Wheele were staffing after 3/31/1 time and kept three members. Our staff been a struggle and especially with the filling staffing holes having them wait loanswered but I thin now the director of worked as a charge second floor. I assist members. On 3/27/DON. I know the dat the charge nurse bijob is only DON and	the day nurse to give all the second floor. When we are sidents know and they don't may usually ask for. Call lights s quickly and residents state ait.  6 a.m. NA-B stated this only one scheduled nurse of for this many residents. In well for the residents they working on both the day and B further stated they have had	F 35	3		

NAME OF PROVIDER OR SUPPLIER  EDINA CARE & REHAB CENTER    STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 56423		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	NG		E SURVEY IPLETED
STREET ADDRESS, CITY, STATE, ZIP CODE			245275	B. WING		04/	14/2017
PRÉFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 353  Continued From page 95  On 4/13/17, at 12:17; p.m. the executive director stated the DON started on 3/25/17, and she has not worked as a nurse manager after that day. The Daily Staffing Schedules were wrong and the DON is in charge of the building but the ADON is the actual charge nurse of all 3 floors on the day shift. We do not have call light logs but we do audits on dining and call lights every weekend which we put into a summary. While auditing we also handle any staff or resident concerns or grievances that arise. We round throughout the facility, help serve a meal and monitor call lights. We stopped doing the audits on 3/617, but will be starting them back up next weekend. My expectation is a seven minute response time for call lights, and if this is not accomplished, we will do staff education and corrective action. On 4/3/17, at 12:22 p.m. the staffing coordinator stated the policy used for staffing was the previous owners policy.  F 371 483.60(i)(1)-3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.  (ii) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.  (iii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.  (iii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.  (iii) This provision does not preclude residents			ER		6200 XERXES AVENUE SOUTH	•	
On 4/13/17, at 12:17: p.m. the executive director stated the DON started on 3/25/17, and she has not worked as a nurse manager after that day. The Daily Staffing Schedules were wrong and the DON is in charge of the building but the ADON is the actual charge nurse of all 3 floors on the day shift. We do not have call light logs but we do audits on dining and call lights every weekend which we put into a summary. While auditing we also handle any staff or resident concerns or grievances that arise. We round throughout the facility, help serve a meal and monitor call lights. We stopped doing the audits on 3/6/17, but will be starting them back up next weekend. My expectation is a seven minute response time for call lights, and if this is not accomplished, we will do staff education and corrective action. On 4/3/17, at 12:22 p.m. the staffing coordinator stated the policy used for staffing was the previous owners policy.  F371 483.60(i)(1)-3) FOOD PROCURE, F371 483.60(i)(1)-3) FOOD PROCURE, F371 483.60(i)(1)-3) FOOD PROCURE, F371 5/25/17  SS=E STORE/PREPARE/SERVE - SANITARY  (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.  (ii) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.  (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.  (iii) This provision does not preclude residents	PRÉFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	COMPLETION
from consuming foods not procured by the facility.	F 371	On 4/13/17, at 12:1 stated the DON star not worked as a nu. The Daily Staffing SDON is in charge of the actual charge in shift. We do not have audits on dining and which we put into a also handle any star grievances that arist facility, help serve at the west opped doing the starting them be expectation is a second lights, and if this do staff education at On 4/3/17, at 12:22 stated the policy us previous owners post 483.60(i)(1)-(3) FORE/PREPARE.  (i)(1) - Procure food considered satisfact authorities.  (ii) This may include from local producer and local laws or reference in the provision defacilities from using gardens, subject to safe growing and for (iii) This provision defacilities from gand for (iii) This provision defacilities from using gardens, subject to safe growing and for (iii) This provision defacilities from using gardens, subject to safe growing and for (iii) This provision defacilities from using gardens, subject to safe growing and for (iiii) This provision defacilities from using gardens, subject to safe growing and for (iiii) This provision defacilities from using gardens, subject to safe growing and for (iiii) This provision defacilities from using gardens, subject to safe growing and for (iiii) This provision defacilities from using gardens, subject to safe growing and for (iiii) This provision defacilities from using gardens, subject to safe growing and for (iiii) This provision defacilities from using gardens, subject to safe growing and for (iiii) This provision defacilities from using gardens, subject to safe growing and for (iiii) This provision defacilities from using gardens, subject to safe growing and for (iiii) This provision defacilities from using gardens, subject to safe growing and for (iiii) This provision defacilities from using gardens, subject to safe growing and for (iiii) This provision defacilities from using gardens, subject to safe growing and for (iiii) This provision defacilities from using gardens, subject to safe growing and for (iiii) This provision defacilities	7: p.m. the executive director rted on 3/25/17, and she has rse manager after that day. Schedules were wrong and the f the building but the ADON is urse of all 3 floors on the day we call light logs but we do d call lights every weekend summary. While auditing we are seen we receive the amount of the amount o				5/25/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE COMP	SURVEY PLETED
		245275	B. WING		04/1	4/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423	<u> </u>	
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	accordance with preservice safety.  (i)(3) Have a policy foods brought to revisitors to ensure shandling, and constrained to ensure safelled to en	re, distribute and serve food in ofessional standards for food regarding use and storage of sidents by family and other afe and sanitary storage,	F 371		from from from from from from from from	
		d over to the garbage can and ands pushed down the cover of an cover.		<ul> <li>Staff have been educated on proper food storage on unit.</li> <li>Refrigerator cleaning schedule has updated and staff trained.</li> </ul>		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		E SURVEY PLETED
		245275	B. WING _		04/	14/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CO. 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 371	gloved left hand, the and mashed potator her same gloved lebehind her and with touched her clothin. The cook picked uphand, used tongs to plate. With the glovhamburger around touched the bun for hands. The cook wassistants take the when the surveyor Director (DD) was it the gloves touching touching residents' gloved hands. DD it her gloves and put cook to throw the tradiso stated the cool individual residents residents touched the been a cook for alm was trained to wear gloves off after goir Policy provided by with Food and Use indicated "Plastic ghandling food direct bacteria are not tradinallers' hands to Bare hand contact hands are consider can get contaminate.	nolding a plate in the same e cook scooped ground rice bes for R20. The cook placed ft hand on the yellow wet sign in the gloved right hand g and pulled up her slacks. In a plate with the gloved left of a bun with the gloved right of place a hamburger on the red left hand turned the conthe plate for R55 and for R17 with the same gloved as going to have nursing plates out to the residents intervened. The Dietary informed of observation with the dirty garbage can cover food with the same dirty instructed the cook to take off new gloves on and instructed them. Cook stated she had nost one month and a half, or gloves and would take the ing downstairs to the kitchen.  The facility Bare Hand Contact of Plastic Gloves dated 2010, loves will be worn when the food product being served. With food is prohibited. Gloved a food contact surface that ed or soiled. Anytime a ince is touched, the gloves must	F 37	-Refrigerators have been cleater -Refrigerators will be monitoritems that do not meet with fawill be discardedFood policy has been review current Audits will be completed on dining audits and gloving aud X3 then weekly. Audits to be QAPI for determination of conneed to continueDietary manager or designed responsible for auditsDate of compliance 5/25/201	ed daily and acility policy ed and is refrigerators, its 2X weekly reviewed at appliance and e will be	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION  IG		E SURVEY MPLETED
		245275	B. WING _		04/	/14/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 371	services with the D a refrigerator. The contained a bowl of There is a darker of drawers and there creamer containers drawers. In the sewere two sealed conshelf not dated or larefrigerator, the frencherry pie on a plat dated. All three refiwere not clean. The was responsible for On 4/11/17, at 8:24 (MD) stated he was department was remaintenance super	age 98 B4 p.m. during a tour of dietary D, it was noted each floor had third floor refrigerator of oatmeal, not dated or sealed. Followed liquid spilled in the were butter packs and milk is sitting in this liquid in the cond floor refrigerator, there ontainers of spaghetti on the abeled. In the first floor ezer had what looked like the not covered, sealed or frigerators had spilled food and the DD stated that maintenance or the cleaning of these units.  Fig. a.m. the maintenance director is not aware that his sponsible for this and he would estated he had been the revisor for approximately one is know who was responsible,	F 37	71		
F 431 SS=D	refrigerators were than they had been did obtain a cleaning provided to the sure 483.45(b)(2)(3)(g)(LABEL/STORE DRATE The facility must produce and biological them under an agres \$483.70(g) of this produced than the sure of the sure o	is a.m. the DD stated the che housekeeping responsibility cleaned. The MD stated he ng schedule and it was veyor.  h) DRUG RECORDS, RUGS & BIOLOGICALS rovide routine and emergency als to its residents, or obtain eement described in part. The facility may permit nel to administer drugs if State	F 43	:1		5/25/17

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245275	B. WING_		04	/14/2017
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		-
(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 431	law permits, but on supervision of a lice  (a) Procedures. A pharmaceutical ser that assure the accidispensing, and ad biologicals) to mee  (b) Service Consult employ or obtain the pharmacist who  (2) Establishes a sed disposition of all codetail to enable an  (3) Determines that that an account of a maintained and permitted and permitted in accordar professional princip appropriate access instructions, and the applicable.  (h) Storage of Drug (1) In accordance with the facility must stolocked compartment controls, and permithave access to the  (2) The facility must	If a cility must provide revices (including procedures curate acquiring, receiving, ministering of all drugs and to the needs of each resident.  Itation. The facility must be services of a licensed records of receipt and particular accurate reconciliation; and to drug records are in order and all controlled drugs is riodically reconciled.  If and Biologicals are in order and all controlled drugs is riodically reconciled.  If and Biologicals are in order and all controlled drugs is riodically reconciled.  If and Biologicals are in order and all controlled drugs is riodically reconciled.  If and Biologicals are in order and all controlled drugs is riodically reconciled.  If and Biologicals are in order and all controlled drugs is riodically reconciled.  If and Biologicals and include the sory and cautionary the expiration date when are all drugs and biologicals in ants under proper temperature it only authorized personnel to	F 4:	31		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		E SURVEY IPLETED
		245275	B. WING _		04/	14/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 431	controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except wher package drug distrit quantity stored is mbe readily detected. This REQUIREMEN by:  Based on observat review, the facility facarts were locked to diversion for 1 of 7.  Finding include:  On 4/12/17, at 7:41 cart was observed unlocked medication the dining room are the unit nursing ass proceeded with their egistered nurse (Rout of R60's room a unlocked medication the nurse working of immediately stated when she went into the facility policy an every time you leav cart was unlocked medications.  On 4/13/17, at 8:47 stated her expectat	ed in Schedule II of the ag Abuse Prevention and and other drugs subject to a the facility uses single unit oution systems in which the inimal and a missing dose can all is not met as evidenced ion, interview and document ailed to ensure medication or minimize the risk of drug	F 4:	This issue has the potential to residents in the facilityUnlocked medication cart was and no medications were miss -Policy regarding medication cabeen reviewed and is currentRN C -Nursing staff was educated or medication carts when unatten -2-3 Audits on locking medication will be completed 2 x weekly, x then weekly thereafter. Result QAPI for determination of comneed to continueDON or designee will be responsible to complianceDate of compliance 5/25/2017	assessed ing. art has locking ded. on carts 3 weeks s brought to pliance and	

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			TE SURVEY MPLETED
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	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423	·	
(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
On 4/13/17, at approbserved wanderin reached the medica on the drawers whi reached into the trapulled out a plastic in the trash.  The facility's policy "Medication Storag compartments compartments compartments compartments wandering of the compartment of the	roximately 9:30 a.m. R43 was g around 3 North. When R43 ation cart she attempted to pull ch were locked. She then she ash on the side of the cart, cup, looked at it placed it back and procedure titled e" dated 8/1/15, indicated taining medication should be	F 4	31		
483.80(a)(1)(2)(4)(1)(2)(4)(1)(2)(4)(1)(2)(4)(1)(4)(1)(4)(1)(4)(1)(4)(1)(4)(1)(4)(1)(4)(1)(4)(1)(4)(1)(4)(1)(4)(1)(4)(1)(4)(1)(2)(4)(1)(4)(1)(2)(1)(4)(1)(2)(1)(4)(1)(1)(2)(1)(4)(1)(1)(1)(2)(1)(4)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	e)(f) INFECTION CONTROL, D, LINENS  ation and control program.  Atablish an infection prevention in (IPCP) that must include, at owing elements:  Eventing, identifying, reporting, controlling infections and cases for all residents, staff, and other individuals under a contractual di upon the facility assessment ing to §483.70(e) and following standards (facility assessment Phase 2);  Ids, policies, and procedures inch must include, but are not reillance designed to identify table diseases or infections	F 4	41		5/25/17
	Continued From particles on the drawers whireached into the trapulled out a plastic in the trash.  The facility's policy "Medication Storag compartments conflocked when not it used to the transpulled out a plastic in the trash.  The facility's policy "Medication Storag compartments conflocked when not it used to the transpulled out a plastic in the trash.  The facility's policy "Medication Storag compartments conflocked when not it used to the transpulled out a plastic in the trash.  The facility's policy "Medication Storag compartments conflocked when not it used to the transpulled out a plastic in the trash.  The facility spolicy "Medication Storag compartments conflocked when not it used to the transpulled to the program a minimum, the foll (1) A system for present the program of the program, which is the program of the program, which is the program of the program, which is the program of the progr	ARE & REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 101  On 4/13/17, at approximately 9:30 a.m. R43 was observed wandering around 3 North. When R43 reached the medication cart she attempted to pull on the drawers which were locked. She then she reached into the trash on the side of the cart, pulled out a plastic cup, looked at it placed it back in the trash.  The facility's policy and procedure titled "Medication Storage" dated 8/1/15, indicated compartments containing medication should be locked when not it use.  483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS  (a) Infection prevention and control program.  The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);  (2) Written standards, policies, and procedures for the program, which must include, but are not	PROVIDER OR SUPPLIER  ARE & REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 101  On 4/13/17, at approximately 9:30 a.m. R43 was observed wandering around 3 North. When R43 reached the medication cart she attempted to pull on the drawers which were locked. 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	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CO 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		
(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 A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	communicable disereported;  (iii) Standard and to be followed to prove (iv) When and how resident; including  (A) The type and depending upon the involved, and  (B) A requirement to least restrictive postic cumstances.  (v) The circumstan must prohibit employed sease or infected contact with reside contact will transmit (vi) The hand hygie by staff involved in (4) A system for required the facility's actions taken by the (e) Linens. Person	nom possible incidents of ease or infections should be ransmission-based precautions revent spread of infections; risolation should be used for a but not limited to:  uration of the isolation, e infectious agent or organism that the isolation should be the ssible for the resident under the resident estable of the resident under the resident contact it the disease; and reprocedures to be followed direct resident contact.  Cording incidents identified IPCP and the corrective e facility.  Incl. must handle, store, port linens so as to prevent the	F 44	1		
		The facility will conduct an IPCP and update their				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		E SURVEY PLETED
		245275	B. WING		04/	14/2017
	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	by: Based on interview review, the facility for the spread of infect the blood glucose in the potential to affe second floor who side second floor with an alcohol wipe. Lift used saniwipes to second floor with an alcohol wipe. Lift used saniwipes to second se	-	F 44'	This has the potential to affect a residents I=with diabetes I the fare Facility now using individual glus for diabetic residents.  - the procedure for cleaning and disinfecting glucometer machine available on each unit facility will ensure that an adequate supply of germicidal cleaning classical cleaning classical available on each unit and restoneded.  -individual education completed A factorial completed with staff.  -2-3 Audits on glucometer use a cleaning completed with staff.  -2-3 Audits on glucometer use a cleaning to be completed 2x weethen monthly and reviewed at Quantity compliance and need to continuulate or designee to be responsite compliance.  -Date of compliance 5/25/2017	icility. icometers is is iate oths is oked as with LPN ind ind ind okly x3 API for e	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245275	B. WING		04/	14/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441	Blood Glucose Met disinfect the meter, of 1 ml or 5-6% soo (household bleach) 1:10 dilution final cosodium hypochlorite 483.90(i)(5) SAFE/FUNCTION/E ENVIRON  (i) Other Environme The facility must presanitary, and comforesidents, staff and (5) Establish policie applicable Federal, regulations, regardiand smoking safety non-smoking residents and smoking safety non-smoking residents and smoking safety non-smoking residents and smoking safety non-smoking residents. This REQUIREMENT by:  Based on observation failed to provide a fenvironment. This accomfortable temper	ed policy "Maintaining the ers" identified to clean and use pre-moistened wipe/towel dium hypochlorite solution and 9 ml water to achieve a concentration of 0.5-0.6% e.  AL/SANITARY/COMFORTABL  ental Conditions  ovide a safe, functional, ortable environment for the public.  es, in accordance with State, and local laws and ng smoking, smoking areas, or that also take into account	F 4	41	room paired	5/25/17
	director (MD) stated month ago and the	p.m. the maintenance d he became the director a re was another maintenance all time. MD stated staff notified		and the bottom drawer of this clo been replacedthe cracked ceramic tile in bathr 311 and ceiling tile in 311 have be replaced - room 319 room door and bathro	oom of een	

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		L COMP	
245275	B. WING		04/	14/2017
		STREET ADDRESS, CITY, STATE, ZIP CODE		-
		6200 XERXES AVENUE SOUTH		
		RICHFIELD, MN 55423		
ENT OF DEFICIENCIES BT BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE
ther on his cell phone or e computer.  Ital tour on 4/12/17, at 2:00 cular gouge on the room d not been aware of.  If room 221 and laser gun window and 70.5 degrees "I think I know why it is vent over to the window to the window to the window do come to him last week the days and wanted to be w. MD stated it took a tool to stated now with the sed up tight the room at. MD stated he did not of how to close the window ted the temperature in the con 4/13/17, at 10:26 a.m. d the temperature with a ses under the window and MD stated the boilers and off for the day. Window had eliminated the om. MD stated it still felt book temperature of the con the right side and 64 degrees on each was felt on the right side fied what looked like old ow. MD stated looks like block tape felt and could draft out of the room.	F 4	were repaired and wall between repeated and repainted new counters and sink in 3n kitch were replaced and closet door in 307 was repaired and closet door was replaced soap dispenser in 307 has been replaced and repaired and repaired windows in 221 were closed and room returned to normal range sheet rock on walls between 108 have been repaired, gouged hole sheetrock across from room 107 scratched walls by room 100 have repaired chip marks on 3N unit have been repaired plaster spots on 1st floor by east have been repaired facility will have a prevenative maintenance plan in place by 5/2 maintenance dept will conduct 2 weekly of resident care areas an repaired items and noted above staff educated on how to report reds to maintenance.date of Co 25, 2017 Audit results to be reviewed no le quarterly and taken to QAPI for determination of compliance and continue	nenette eplaced repaired ed is been temp of and 109 s in and e been door  5/17 3 audits d epair mpliance ss than need to	
The state of the s	245275  ENT OF DEFICIENCIES ET BE PRECEDED BY FULL ENTIFYING INFORMATION)  05 ther on his cell phone or experiments of the room design of the room	245275  B. WING  245275  B. WING  A. BUILDI  245275  B. WING  B. WING  B. WING  B. WING  D. PREFID  TAG  D. PREFID  TAG  TAG  TAG  TAG  TAG  TAG  TAG  TA	245275  245275  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423  ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCE ACTION SHOULD CROSS-REFERENCED TO T	245275  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423  ID PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  D5  ther on his cell phone or e computer.  al tour on 4/12/17, at 2:00 cold not been aware of.  If come 221 and laser gun window and 70.5 degrees If think I know why it is rent over to the window y closed and that he knew do come to him last week is days and wanted to be window to do the memory of fow to close the window ted the temperature with a sea under the window and MD stated the boilers in the temperature with a sea under the window and MD stated the boilers in the temperature of the off the room and it read is and 64 degrees on each was felt on the right side leid what looked like old by MD Stated looks like old draft out of the room MD

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245275	B. WING			04/	14/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		6200 X	ET ADDRESS, CITY, STATE, ZIP CODE KERXES AVENUE SOUTH FIELD, MN 55423	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPOLICIENCY)	D BE	(X5) COMPLETION DATE
F 465	the residents wanted window in the room the room. R5 was wher room 221 and so was still cold this more roommate's window hated feeling cold awindow had been of that to staff or to M with her window in put a covering on how the draft. (R5 in her room on 4/12 surveyor for the lass was aware. R5 also in her room and try up the thermostat has it just blew cold. On 4/12/17, at 2:00 the bottom drawer leaving a metal brata a large gouge on the had not been aware baseboard tile alon bathroom and large almost in half holding he had not been aware of the holds and a large residents had miss not been aware of thad been aware of that the room and the room	e but stated it should be what ed. MD stated he would fix the and that should help warm up wheeling self down the hall to stated to MD that her room torning. MD told R5 about her who being drafty. R5 stated she and had wondered if that that the last time he had helped the room. MD stated he would the room. MD stated he would the room. MD stated he would the room and that staff to stated that NAs would come to heat up the room by turning but R5 would tell the NAs no, air.)  In p.m. in room 311, MD verified of the closet was missing cket exposed. MD also verified the bottom of the closet door he to f. MD verified cracked g the bathroom floor wall in the cracked splitting ceiling tile and the vent which MD stated ware of. MD stated it looked	F	465			

		. A MEDICAID SERVICES			,	JIVID INO	. 0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		E SURVEY IPLETED
		245275	B. WING			04/	14/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FDINA C	ARE & REHAB CENT	FR			200 XERXES AVENUE SOUTH		
				R	RICHFIELD, MN 55423		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 465	On the 3N unit, MD in cardboard boxes stated the plan was and sink in. MD stated that been taken out was hoping to get to week. MD stated the been removed to unake it look nicer. about a month and least get back to it. In room 307, MD wand the soap dispetrickles of soap working to the soap dispetrickles of soap working to the soap dispetrickles of soap working to the soap dispetrickles of soap working the to get to needed more wood put on as it would be During the tour, Farof room 307 and to room did not work, had stopped working told staff. MD states staff and that he would staff that he work and needed refacility television the replace it.  On the 3S unit, by the missing wallpaper also wallpaper few right of room 319. If any plans for the 35 and sink the staff or the 35 any plans for the 35 and sink plans for t	e verified cabinets were sitting by a plastered wall. MD to put new cabinets, counter ted the old cabinets and sink to four weeks ago and that he he new counter put in next the old cabinets and sink had plate the dining room and MD stated it had unfinished for hoped he could find time to at next week. The properties of the policy of the	F	465			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		245275	B. WING		04	/14/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP COD 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		-
(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 CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 465	discharged. MD staupdating the facility were noticed. MD stated he had a list stated he had no withings looked at on On 4/13/17, at 10:2 verified plaster on and 108 plastered plaster across from walls in the hall by needed continual to In room 221, MD vice putty sticking out a the wall and stated and it did not look in room 223, MD vice stating he could us added last week he department under janitorial, maintenal in 3N unit, MD verified touch up due to reson 4/13/17, at 12:15 spots in halls on fir and at back stairways was needed on that he would need facility no longer he plan, had had one with remodeling. Mould now be two three fulltime main stated the previous employment and with remodeling and well and well and well and one with remodeling. Mould now be two three fulltime main stated the previous employment and well and the stated the previous employment and the stated the previous entry the stated the p	ated they had been busy and trying to do things as they stated they were called off to d had to prioritize the work. MD to of things to get done. MD work requests for any of the athe tour. 26 a.m. on first floor MD the walls between rooms 109 holes and a gouged hole in the a room 107, and scratched room 100. MD stated hall walls bouch-up. 26 erified four holes with blue bove the sanitizer dispenser on it had always been that way	F 4	65		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l	IPLE CONSTRUCTION IG		E SURVEY IPLETED
		245275	B. WING _		04/	14/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		-
(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 SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 468	Preventative Mainte have any work order environmental issue not aware of any erpolicies for the facil 483.90(i)(3) CORR SECURED HANDER (i)(3) Equip corridor on each side; and This REQUIREMENT by:  Based on observatified to secure har affecting 26 resider.  Findings include:  On 4/12/17, at 2:00 director (MD) stated director and there who worked full time of work requests eited. Tells order on the During environment p.m. MD verified or 25 halls, the hand rait were unable to be the from the wall. One in 213 and the other of MD stated he would as the screws had I would need to prior	ed to put a plan in place for enance. MD stated he did not er requests for the es verified. MD stated he was avironmental/maintenance ity. IDORS HAVE FIRMLY ALLS IS with firmly secured handrails INT is not met as evidenced ition and interview, the facility adrails on 2nd floor potentially ats and visitors.  In p.m. the maintenance is the had recently become the was another maintenance staff e. MD stated staff notified him ther on his cell phone or with a	F 46		epaired by enance onducted ults on of e	5/25/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245275	B. WING			04/	14/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	ER		62	REET ADDRESS, CITY, STATE, ZIP CODE 00 XERXES AVENUE SOUTH CHFIELD, MN 55423		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 468	stated these handral long as he had beed was three years. Me with normal use from and possibly visitors may need to take the of the wall as it was during use. MD states the handrails were loos audits of checking if the handrails were they had not; he had an list of their as they noticed it. In the had a list of thin stated he was promount hago. MD stated he was promount hago. MD stated he was promount hago. MD stated he plan was not he plan was not he other handrail or oom 213 but states the sheetrock/cem a monthly check for was a safety precase.  On 4/13/17, at 12:10 no longer had a Prim MD stated going for plan in place. He was not had been supplied to sheet the sheetrock/cem a monthly check for was a safety precase.	ails were the same ones as en working at the facility which ID stated handrails wear out on the pressure of residents is using them. MD stated he he handrail by the dayroom off is too loose and may come off ited he was not aware the se. MD stated he performed no handrails. He would only know ite loose if staff notified him and and no work requests for artment had been keeping facility and trying to do things in MD stated they got interrupted and had to prioritize. MD stated and had to prioritize. MD stated and had to prioritize interrupted and had to prioritize interrupted and had to prioritize. He further noted to director about a sted the previous director left not to replace him.  26 a.m. MD stated he had been a handrail to the left of the day for. MD attempted to tighten on second floor to the right of a dit would not last because of the ent. MD stated he would set up or all handrails acknowledging it	F4	468			

Printed: 04/18/2017 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

245275

B. WING

04/11/2017

NAME OF PROVIDER OR SUPPLIER

**EDINA CARE & REHAB CENTER** 

STREET ADDRESS, CITY, STATE, ZIP CODE

**6200 XERXES AVENUE SOUTH** 

EDINA	DINA CARE & REHAB CENTER		RICHFIELD, MN 55423			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS		K 000			
	FIRE SAFETY					
	A Life Safety Code Survey was conducted Minnesota Department of Public Safety, Fire Marshal Division on April 11, 2017. A time of this survey, Edina Care Center win compliance with the requirements for participation in Medicare/Medicaid at 42 Subpart 483.70(a), Life Safety from Fire, 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Scode (LSC), Chapter 19 Existing Health	State At the vas found CFR, , and the				
	This 3-story building was determined to Type II (222) construction. It has a full be and is fully fire sprinklered. The facility halarm system with smoke detection in country and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of and had a census of 72 at the time of the	asement as a fire orridors f 85 beds				
	The requirement at 42 CFR, Subpart 48 MET.	3.70(a) is		v.		
LABORATO	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESE	NTATIVE'S SIG	SNATURE	TITLE	(X6) DATE	

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



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

Electronically delivered May 4, 2017

Mr. John Doughty, Administrator Edina Care & Rehabilitation Center 6200 Xerxes Avenue South Richfield, MN 55423

Re: State Nursing Home Licensing Orders - Project Number S5275027

Dear Mr. Doughty:

The above facility was surveyed on April 10, 2017 through April 14, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules . At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the licensing orders cited herein are not corrected, a civil fine for each licensing order not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

Edina Care & Rehabilitation Center May 4, 2017 Page 2

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Maria King at (507) 344-2716 or email: mark.meath@state.mn.us.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: <u>mark.meath@state.mn.us</u>

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

PRINTED: 05/18/2017 FORM APPROVED

(X6) DATE

Minnesota Department of Health

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/1	4/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU .D, MN 5542			
(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	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the corrected requires of requirements of the number and MN Ru When a rule contain	nether a violation has been compliance with all rule provided at the tag lle number indicated below. ns several items, failure to				
	lack of compliance. re-inspection with a result in the assess	the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

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

**Electronically Signed** 05/11/17

STATE FORM 6899 If continuation sheet 1 of 107 B3HD11

TITLE

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00740	B. WING		04/1	4/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	you electronically. is necessary for State enter the word "corrected. You must then State licensure procompletion date, the corrected prior to elements of Minnesota Departments of Minnesota Depart	Althorders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be ectronically submitting to the nent of Health.  Veyors of this Department's ve provider and the following re issued. Please indicate in of correction that you have ers, and identify the date when	2 000			
2 265	A nursing home mupolicies to guide staphysicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, at attending physician development of the have criteria which appropriate notifica.  A. an accident results in injury and physician interventions.	ast develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's or an interested family ent's acute illness, serious. At a minimum, the director of and the medical director or an must be involved in the se policies. The policies must address at least the tion times for:  involving the resident which has the potential for requiring	2 265			5/25/17

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.	A. BUILDING:		
		00740	B. WING		04/1	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU .D, MN 5542			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 265	Continued From pa	nge 2	2 265			
	physical, mental, o example, a deterior	or psychosocial status, for ration in health, mental, or s in either life-threatening				
	example, a need to	ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment;				
	D. a decision tresident from the n	to transfer or discharge the ursing home; or				
	E. expected and unexpected resident deaths.  This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to promptly notify the physician when a pressure ulcer developed and worsened for 1 of 1 residents (R35) reviewed.					
				Corrected		
	Findings include:					
	identified on 3/6/17 was painful to touch notation regarding a 4/1/17, a skin check documentation of: 'stage unstagable, r stage II" and identification following day on 4/2 that the dressing characteristic completed and had drainage from the value of the stage of t	es from 3/6/17, to 4/11/17, , R35's right inner malleolus h and tender and there was no an update to physician. On k was completed with 'Other right heel-pressure right ankle (inner) pressure- fied no new skin areas. The 2/17, documentation identified hange to right ankle was I a large amount of yellowish wound site. Documentation at the provider had been the progress note identified esing change was completed				

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423  [X41] ID PROVIDER'S STATEMENT OF DEFICIENCIES TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 265  Continued From page 3 and the wound looked bigger, had a white substance in the wound site and was odorous, however, the record lacked documentation that the physician had been updated.  Weekly wound care specialist evaluation documentation reviewed from 3/2/17, to 4/7/17 indicated the provider was aware of R35's right medial ankle pressure ulcer on 3/2/17 and right medial ankle pressure ulcer on 3/2/17 and right medial ankle pressure ulcer on 3/2/16 is bial exconiated from moisture; left ischial tuberosity is boggy and non-blanchable; the left bottom buttock is reddened but blanches; right ischial tuberosity is blanchable; right lower extremity has sores and scabs which have Tegaderm dressings on them; right medial ankle pressure ulcer and treatment was done at bedtime. R35's Prevalon boot was observed on the bed which the DON verified was soiled with blood and wound		NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
EDINA CARE & REHAB CENTER  6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 265  Continued From page 3  and the wound looked bigger, had a white substance in the wound site and was odorous, however, the record lacked documentation that the physician had been updated.  Weekly wound care specialist evaluation documentation reviewed from 3/2/17, to 4/7/17 indicated the provider was aware of R35's right medial ankle pressure ulcer on 3/2/17 and right medial heel on 3/31/17.  On 4/11/17, at 3:20 p.m. the DON assessed R35's skin as: right upper buttock was open and excoriated from moisture; left ischial tuberosity is boggy and non-blanchable; the left bottom buttock is reddened but blanches; right ischial tuberosity is blanchable; right lower extremity has sores and scabs which have Tegaderm dressings on them; right medial ankle pressure ulcer and treatment was done at bedtime. R35's Prevalon boot was observed on the bed which the DON			00740	B. WING		04/1	4/2017
(A) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY) (EACH DEFICIENCY)  2 265  Continued From page 3  and the wound looked bigger, had a white substance in the wound site and was odorous, however, the record lacked documentation that the physician had been updated.  Weekly wound care specialist evaluation documentation reviewed from 3/2/17, to 4/7/17 indicated the provider was aware of R35's right medial ankle pressure ulcer on 3/2/17 and right medial heel on 3/31/17.  On 4/11/17, at 3:20 p.m. the DON assessed R35's skin as: right upper buttock was open and excoriated from moisture; left ischial tuberosity is boggy and non-blanchable; the left bottom buttock is reddened but blanches; right lischial tuberosity is blanchable; right lower extremity has sores and scabs which have Tegaderm dressings on them; right medial ankle pressure ulcer and treatment was done at beddime. R35's Pevalon boot was observed on the bed which the DON	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 265  Continued From page 3  and the wound looked bigger, had a white substance in the wound site and was odorous, however, the record lacked documentation that the physician had been updated.  Weekly wound care specialist evaluation documentation reviewed from 3/2/17, to 4/7/17 indicated the provider was aware of R35's right medial ankle pressure ulcer on 3/2/17 and right medial heel on 3/31/17.  On 4/11/17, at 3:20 p.m. the DON assessed R35's skin condition. The DON described R35's skin as: right upper buttock was open and excoriated from moisture; left ischial tuberosity is boggy and non-blanchable; the left bottom buttock is reddened but blanches; right ischial tuberosity is blanchable; right lower extremity has sores and scabs which have Tegaderm dressings on them; right medial ankle pressure ulcer and treatment was done at bedtime. R35's Prevalon boot was observed on the bed which the DON	EDINA (	CARE & REHAB CENT	FR				
and the wound looked bigger, had a white substance in the wound site and was odorous, however, the record lacked documentation that the physician had been updated.  Weekly wound care specialist evaluation documentation reviewed from 3/2/17, to 4/7/17 indicated the provider was aware of R35's right medial ankle pressure ulcer on 3/2/17 and right medial heel on 3/31/17.  On 4/11/17, at 3:20 p.m. the DON assessed R35's skin condition. The DON described R35's skin as: right upper buttock was open and excoriated from moisture; left ischial tuberosity is boggy and non-blanchable; the left bottom buttock is reddened but blanches; right ischial tuberosity is blanchable; right lower extremity has sores and scabs which have Tegaderm dressings on them; right medial ankle pressure ulcer and treatment was done at bedtime. R35's Prevalon boot was observed on the bed which the DON	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	ILD BE	COMPLETE
After the NAs and the DON left the room, licensed practical nurse (LPN)-C and LPN-B entered at 3:45 p.m. to complete a right ankle dressing change. LPN-C described the wound as "reddened with discoloration on the edges" and measured 5 (centimeters) cm x 4 cm x 1.5 cm. R35 screamed out, "That hurts!" during the dressing change.  On 4/12/17, at 10:19 a.m. the DON completed an assessment of the resident's skin condition. The DON stated the left ischial tuberosity had superficial skin loss over the previously identified Stage I on 4/11/17. The DON stated although she	2 265	and the wound look substance in the we however, the record the physician had be weekly wound care documentation revi indicated the provious medial ankle press medial heel on 3/3. On 4/11/17, at 3:20 R35's skin conditions skin as: right upper excoriated from moboggy and non-blar buttock is reddened tuberosity is blanch sores and scabs whon them; right med treatment was done boot was observed verified was soiled drainage.  After the NAs and the licensed practical in entered at 3:45 p.m. dressing change. L. "reddened with discomeasured 5 (centin R35 screamed out, dressing change.  On 4/12/17, at 10:1 assessment of the DON stated the left superficial skin loss	ked bigger, had a white bound site and was odorous, dilacked documentation that been updated.  The specialist evaluation lewed from 3/2/17, to 4/7/17 are was aware of R35's right lure ulcer on 3/2/17 and right 1/17.  The DON assessed in The DON described R35's buttock was open and bisture; left ischial tuberosity is inchable; the left bottom dibut blanches; right ischial liable; right lower extremity has hich have Tegaderm dressings ial ankle pressure ulcer and at bedtime. R35's Prevalon on the bed which the DON with blood and wound  The DON left the room, burse (LPN)-C and LPN-B in to complete a right ankle PN-C described the wound as coloration on the edges" and meters) cm x 4 cm x 1.5 cm.  That hurts!" during the	2 265			

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AND DIAN OF CORRECTION INDENTIFICATION NUMBER		1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BOILDING.			
		00740	B. WING		04/1	4/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU .D, MN 5542			
(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) COMPLETE DATE
2 265	Continued From pa		2 265			
	paperwork at that ti her jaw and had fur turn to her left side left heel, which she tissue injury measu reported the area w On 4/12/17, at 1:44	or complete any related me. R35 moaned, tightened rowed brows when assisted to The DON then observed the stated was a suspected deep uring 1 cm x 1 cm x 1 cm. R35 was painful to touch.				
	stated she was new to the facility and unfamiliar with R35. NP-A stated it was an expectation the staff would contact the NP with new skin alterations, but had not been informed of any problems with R35's skin since she began seeing the resident on 4/3/17. If skin alterations were observed, NP-A would institute orders to off load pressure and implement pressure relieving					
		new wound had developed, ly order a Mepilex dressing.				
	was conducted with He reported he saw 4/7/17 and was follound right heel press	p.m. a telephone interview in the wound physician (MD)-A. or R35 for the first time on owing the right medial ankle sure ulcers. MD-A was				
	and skin break dow expected to be noti wounds. It was also	suspected deep tissue injury on R35's buttocks. MD-A fied of significant decline in be expected daily dressing performed on R35's right				
	ankle. MD-A report ulcer, and would ha without appropriate MD-A's impression	ed R35 had a Stage IV ankle ave increased in size/severity dressing changes. It was the staff were elevating R35's				
	the heels to be off t would be reposition least every two hou	imum would have expected he bed, and the resident led out of her wheelchair at litrs. It was also expected staff ressure relieving interventions led and buttocks.				

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Minnesota Department of Health STATE FORM

AND BLAN OF CORRECTION TO TRENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED	
		00740	B. WING		04/1	4/2017
	PROVIDER OR SUPPLIER	6200 XER	DRESS, CITY, S XES AVENU D, MN 5542		, , ,	
(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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	On 4/13/17, at 12:3 expectation was the notify the NP when observed, as the NI	ge 5  0 p.m. the DON stated her e nurse should immediately the skin alteration was Pultimately oversaw care for ed R35 experienced pain with	2 265			
	dressing changes.  The facility's 4/21/1 Wound Care Prograindicated the facility treatment upon ider	4, Chalet Living and Rehab am policy and procedure would "initiate wound care ntification of the wound with and to refer to the wound care				
	Director of Nursing develop policies and resident's physician promptly notified of and/or changes in the policies/proceduthe policies and proceduthe proceduthe policies and proceduthe proceduthe policies and proceduthe procedu	HOD OF CORRECTION: The (DON) or designee could d procedures to ensure each and representative are all changes in condition reatments. The DON or cate all appropriate staff on ures, and monitor to ensure and share those results with tee for further				
	TIME PERIOD FOF (21) Days.	R CORRECTION: Twenty One				
2 302	MN State Statute 14 or related disorder t	44.6503 Alzheimer's disease train	2 302			5/25/17
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144.					
1	(a) If a nursing facil Alzheimer's	ity serves persons with				

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Minnesota Department of Health STATE FORM

AND DIAN OF CORRECTION INDENTIFICATION NUMBER		, ,	E CONSTRUCTION	(X3) DATE COMP		
	00740		B. WING		04/14/2017	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 04/1	-7/2017
	ARE & REHAB CENT	6200 XER	XES AVENU	E SOUTH		
	Г	RICHFIEL	D, MN 5542			
(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)	.D BE	(X5) COMPLETE DATE
2 302	Continued From pa	ge 6	2 302			
	disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care.					
	<ul> <li>(b) Areas of required training include:</li> <li>(1) an explanation of Alzheimer's disease and related disorders;</li> <li>(2) assistance with activities of daily living;</li> <li>(3) problem solving with challenging behaviors; and</li> <li>(4) communication skills.</li> <li>(c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered.</li> <li>(d) The facility shall document compliance with this section.</li> </ul>					
	by: Based on interview facility failed to ens information regardir required. In addition dementia and relate employees annually	and document review, the ure consumers were provided ng dementia training as n, the facility failed to provide ed behavioral training to all y. This had the potential to its and their representatives.		Corrected		
	Findings include:					
	training program, the consumers (resider were provided a de	the facility's Alzheimer's here was no evidence hts and their representatives) scription of the facilitiy's program, categories of				

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AND DIAN OF CORRECTION . IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU .D, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 302	employees trained, basic topics covered basic topics covered licensed social work been providing Alzh to staff for the past explained the facilitishe only provided to time of their oriental and director of social last annual staff trainal been on 12/2/1 on 4/11/17, at apprexecutive director (surveyor with the fact gave to all newly acrepresentatives. Thinclude an overview Alzheimer's/dementation shop provided in writing and description of the Acategories of employeraining and the basing the ED, DON or diregarding staff train packet so consumer information and prostaff. The ED, DON staff.	frequency of training and the ed.  on 4/11/17, at 9:28 a.m. the ker (LSW) stated she had neimer's and dementia training two to three years. The LSW by is under new ownership and the training to new staff at the action to the facility. The LSW hal services (DSS) verified the ining on Alzheimer's/dementiants.  coximately 11:00 a.m. the ED) and DSS provided the acility admission packet they demitted residents and their new admission packet did not a vof the facility's the training.  on 4/12/17, at 8:33 a.m. the collity did not have a wing consumers were for in electronic form a a slzheimer's training program, by est trained, frequency of sic topics covered.	2 302			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DAT			SURVEY LETED	
7110 1 2711	or connection	BENTH TO A TOTAL ON BELL.	A. BUILDING:			
		00740	B. WING		04/1	4/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 302	Continued From pa	ge 8	2 302			
	ensure compliance					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 560	MN Rule 4658.0409 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			5/25/17
	comprehensive plate objectives and time long- and short-term and mental and psylidentified in the contassessment. The compassion of the contast include the incompassion of the contast include the incompassion objects.	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, who cocial needs that are apprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).				
	by: Based on observati review the facility fa	ent is not met as evidenced on, interview, and document illed to develop a care plan for iewed (R35) related to		Corrected		
	Findings include:					
	had actual alteratio cognitively impaired neurodermatitis, an both lower extremit chest. R35's care p assist with repositio laying on open area to ensure that propin the chair and positive consure that propin the chair and positive consumer cons	ed 3/21/17, identified that R35 n of skin integrity due to being d, assistance with ADLs, d had scratches/wounds on ies, left buttock, shoulder, and lan directed facility staff to bring frequently in bed to avoid as. The care plan directed staff or pressure reducing device is sitioned correctly before wheelchair. Further, the care				

Minnesota Department of Health

AND DIAN OF CODDECTION INDENTIFICATION NUMBER		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU .D, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	plan directed staff to bed to avoid laying. The care plan did reposition of the plan to and right great toe direct facility staff the turned/reposition of devices were to be result of turned t	to "assist with repositioning in on open areas frequently". Not address R35's suspected to the left heel, unstageable right inner ankle press ulcer, wound. The care plan did not now often R35 needed to be dor what pressure relieving in place.  The mum Data Set (MDS) dated 35 had moderate cognitive diagnoses including to known to contribute to pain), ety. R35 required extensive ivities of daily living (ADLs). In pressure ulcers but was at cated a formal assessment ussessment were completed to	2 560			

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	ota Department of He		0.00		Loss	
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
, "ID I LAN	J. JOHNEOHOW	IDENTIFICATION NOISIDEIX.	A. BUILDING:	<del></del>		
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AN	DRESS CITY S	STATE, ZIP CODE		
IVAIVIL OI	TROVIDER OR GOLF EIER		XES AVENU			
EDINA C	ARE & REHAB CENT	FR				
			D, MN 5542			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
2 560	Continued From pa	ge 10	2 560			
2 300	Continued From pa	ge 10	2 300			
		not been assisted or offered to				
	reposition/offload (r	emove pressure) for at least 2				
	hours, 49 minutes.	NA-F, the DON and NA-E				
	entered R35's room	at 3:20 p.m. NA-F and NA-E				
		inent brief and provided				
	•	scribed R35's brief as				
		e DON then assessed the				
		dition. The DON described				
		upper buttock was open and				
		isture, left ischial tuberosity				
		d non-blanchable. The left				
		reddened but blanched, right				
		as blanchable, right lower				
		and scabs which had				
		s, right medial ankle pressure				
		to be done at bedtime. R35's				
		soiled with blood and wound				
		s confirmed by the DON. R35's				
		was approximately one half				
		the DON confirmed it "does				
		NA-F reported she did not				
		R35 had been changed or				
	repositioned.					
	The next day on 4/1	12/17, continuous				
	,	conducted while R35 was lying				
		m. to 10:19 a.m. without being				
		to reposition or use the toilet.				
		urveyor informed the DON of				
		ervation of R35 without care.				
	The DON was unaware why care had not					
		35. The DON stated R35				
	•	care. The DON stated she				
		ges contributed to issues with				
		The surveyor informed the				
		ncerns regarding R35 and she				
		." The DON entered R35's				
		(3 hours, 16 minutes) and				
		ssment of the resident's skin				
		I changed the incontinent brief				

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AND DIAN OF CORRECTION . IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
00740	B. WING		04/1	4/2017
NAME OF PROVIDER OR SUPPLIER STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FDINA CARE & REHAB CENTER	XES AVENUI D, MN 5542			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
and provided peri-care. The DON did not know the last time R35 was last changed or repositioned.  During an interview with NA-F on 4/11/17, at 3:20 p.m. she explained R35 did not like to lie down, however, she did not decline offers to have her incontinence brief changed or to reposition, as she was unable to move herself.  On 4/12/17, at 6:15 p.m. a telephone interview was conducted with the wound physician (MD)-A reported he had first seen R35 on 4/7/17 and was following the right medial ankle and right heel pressure ulcers. MD-A was Dr. was unaware of the left suspected deep tissue injury and skin break down on R35's buttocks. It was MD-A's impression the staff were elevating R35's heels, and at a minimum would have expected the heels to be off the bed, and the resident would be repositioned out of her wheelchair at least every two hours. It was also expected staff would implement pressure relieving interventions for R35's heels, ankle, and buttocks.  NA-A stated on 4/13/17, at 8:17 a.m. R35 was to be checked on every 15-20 minutes. Staff were supposed to ensure R35's feet were off of the bed and she had a boot on, but NA-A was unsure which foot or when this intervention began. NA-A was unaware if there had been changes to R35's care plan.  On 4/13/17, at 8:28 a.m. LPN-D reported it was expected the NAs would check on the resident because of her skin issues. LPN-D believed the right hip area was due to pressure, and the other wounds were from scratching and picking at herself.				

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Minnesota Department of Health STATE FORM

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  \$200 XERXES AVENUE SOUTH RICHFIELD, MN 59423    PREPRIX   RICHFIELD, MN 59423   PREPRIX   RICHFIELD, MN 59423   PREPRIX   RICHFIELD, MN 59423   PREPRIX   RICHFIELD, MN 59423   PREPRIX   RICHFIELD, MN 59423   PREPRIX   RICHFIELD, MN 59423   PROVIDER'S PLAN OF CORRECTION SHOULD BE PRECEDED BY FULL   PREPRIX   RICHFIELD, MN 59423   PREPRIX   RICHFIELD, MN 59423   PREPRIX   RICHFIELD, MN 59423   PROVIDER'S PLAN OF CORRECTION SHOULD BE PRECEDED BY FULL   PREPRIX   RICHFIELD, MN 59423   PROVIDER'S PLAN OF CORRECTION SHOULD BE PRECEDED BY FULL   PREPRIX   RICHFIELD, MN 59423   PROVIDER'S PLAN OF CORRECTION SHOULD BE PROVIDER'S PLAN OF CORRECTION SH	AND BLAN OF CORRECTION \ \ \ \ IDENTIFICATION NUMBER: \ \ \ \ \ \		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED		
NAME OF PROVIDER OR SUPPLIER  EDINA CARE & REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL FREETX TAG  CONTINUED FROM THE APPROPRIATE  2 560  Continued From page 12  2 560  A 4/13/17, at 10:56 a.m. NA-G was unsure if R35 had wounds on her feet, or whether any changes had been made to her care plan in the last week.  However, on 4/13/17, at 11:05 a.m. NA-H reported R35 was on a repositioning program of every two hours in bed, but did not have a wheelchair repositioning program of every two hours in bed, she did not have a wheelchair repositioning program of every two hours in bed, she did not have a wheelchair repositioning program of every two hours are plan in the last week.  On 4/13/17, at 12:30 p.m. the DON stated that the "care plan is a mess and is not good" and the DON was in the process of updating it. The DON confirmed there were no pressure relieving interventions noted on the care plan. Prior to the survey entrance the DON said she had not thought of putting a different mattress on R35's bed. The DON expected staff to reposition, check and change R35 at least every two hours. The DON expected nurses to monitor R35's skin every shift and assess once weekly on bath day, and to document findings. In addition, it was expected a comprehensive skin assessment would be completed when a new area was found. The DON stated R35 experienced pain with dressing changes. She was unsure whether pre-medication for pain was provided for R35 prior to care and dressing changes, but the DON stated she felt it should have been.  The facility's policy and procedure titled "Repositioning and Turning" which was not dated, indicated "that residents are								
CALL   DEPLOY   CALL   DEPLOY   DEPLO			00740	B. WING		04/1	4/2017	
PATE   PROVIDER'S PLAN OF CORRECTIVE   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEPRICENCY MUST BE PRECEDED BY PLL)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEPRICENCY MUST BE PRECEDED BY PLL)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEPRICENCY)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEPRICENCY)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH SEAR PREFIXER)   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH SEAR PREFIXER)   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH SEAR PREFIXER)   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH SEAR PREFIXER)   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH SEAR PREFIXER)   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH SEAR PREFIXER)   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH SEAR PREFIXER)   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH SEAR PREFIXER)   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH SEAR PREFIXER)   PROVIDER'S PLAN OF COMPANY OF TAG SEAR PREFIXER PREFIXER PROVIDER'S PLAN OF COMPANY OF TAG SEAR PREFIXER PROVIDER ACTION SHOULD BE (EACH SEAR PREFIXER)   PROVIDER'S PLAN OF COMPANY OF TAG SEAR PREFIXER PROVIDER ACTION SHOULD BE (EACH SEAR PREFIXER)   PROVIDER'S PLAN OF COMPANY OF TAG SEAR PREFIXER PROVIDER ACTION SHOULD BE (EACH SEAR PROVIDER ACTION SHOULD BE (EACH SEAR PREFIXER)   PROVIDER ACTION SHOULD BE (EACH SEAR PROVIDER ACTION SHOULD B	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
PREFEX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  2 560  Continued From page 12  On 4/13/17, at 10:56 a.m. NA-G was unsure if R35 had wounds on her feet, or whether any changes had been made to her care plan in the last week.  However, on 4/13/17, at 11:05 a.m. NA-H reported R35 was on a repositioning program of every two hours in bed, but did not have a wheelchair repositioning program. NA-H stated when R35 was in bed, she needed a pillow between her legs so her ankles did not touch. NA-H did not place a pillow under the resident's heels or feet.  On 4/13/17, at 12:30 p.m. the DON stated that the "care plan is a mess and is not good" and the DON was in the process of updating it. The DON confirmed there were no pressure relieving interventions noted on the care plan. Prior to the survey entrance the DON said she had not thought of putting a different mattress on R35's bed. The DON expected staff to reposition, check and change R35 at least every two hours. The DON expected at sesses more weekly on bath day, and to document findings. In addition, it was expected a comprehensive skin assessment would be completed when a new area was found. The DON stated R36 experienced pain with dressing changes. She was unsure whether pre-medication for pain was provided for R35 prior to care and dressing changes, but the DON stated R36 experienced pain with dressing changes. She was unsure whether pre-medication for pain was provided for R35 prior to care and dressing changes, but the DON stated R36 experienced pain with dressing changes. She was unsure whether pre-medication for pain was provided for R35 prior to care and dressing changes, but the DON stated R36 experienced pain with dressing changes, but the DON stated R36 experienced pain with dressing changes, but the DON stated R36 experienced pain with dressing changes, but the DON stated R36 experienced pain with dressing changes.	EDINA C	ARE & REHAB CENT	FR					
On 4/13/17, at 10:56 a.m. NA-G was unsure if R35 had wounds on her feet, or whether any changes had been made to her care plan in the last week.  However, on 4/13/17, at 11:05 a.m. NA-H reported R35 was on a repositioning program of every two hours in bed, but did not have a wheelchair repositioning program. NA-H stated when R35 was in bed, she needed a pillow between her legs so her ankles did not touch. NA-H did not place a pillow under the resident's heels or feet.  On 4/13/17, at 12:30 p.m. the DON stated that the "care plan is a mess and is not good" and the DON was in the process of updating it. The DON confirmed there were no pressure relieving interventions noted on the care plan. Prior to the survey entrance the DON said she had not thought of putting a different mattress on R35's bed. The DON expected nurses to monitor R35's skin every shift and assess once weekly on bath day, and to document findings. In addition, it was expected a comprehensive skin assessment would be completed when a new area was found. The DON stated R35 experienced pain with dressing changes. She was unsure whether pre-medication for pain was provided for R35 prior to care and dressing changes, but the DON stated she felt it should have been.  The facility's policy and procedure titled "Repositioning and Turning" which was not dated, indicated "that residents are	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETE	
care to prevent skin breakdown." The policy	2 560	On 4/13/17, at 10:5 R35 had wounds of changes had been last week.  However, on 4/13/17 reported R35 was devery two hours in wheelchair reposition when R35 was in between her legs s NA-H did not place heels or feet.  On 4/13/17, at 12:3 the "care plan is a reported there we interventions noted survey entrance the thought of putting abed. The DON expand change R35 at DON expected nurse every shift and asseand to document fire expected a compression would be completed. The DON stated R3 dressing changes. pre-medication for prior to care and drestated she felt it she The facility's policy "Repositioning and dated, indicated "the turned/positioned in the result of the position of the result of the	in her feet, or whether any made to her care plan in the lar, at 11:05 a.m. NA-H on a repositioning program of bed, but did not have a coning program. NA-H stated ed, she needed a pillow o her ankles did not touch. a pillow under the resident's large on the care plan. Prior to the end of the care plan with sees to monitor R35's skin essence weekly on bath day, and the care weekly on bath day, and the care was found. The care was found as the care was found and the care plan with she was unsure whether pain was provided for R35 essing changes, but the DON ould have been.  and procedure titled Turning" which was not that residents are an accordance with the plan of	2 560	DETICIENCY)			

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AND DIAN OF CORRECTION . IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		7. Bolebino.				
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(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) COMPLETE DATE
2 560	repositioned every accordance with the plan as determined standards of the po Nurse was respons approaches, and go A second policy title "Wound Care Progithe Braden Scale h resident's admission weeks of admission the level of risk for factor(s), potential of should be reviewed plan. The policy indicated on the respolicy stated the carevised based on the treatment, goals, and SUGGESTED MET The director of nurse policies and proceded comprehensive caresidents. The direct could educate all approach as the policy stated the care could educate all approach as the policy stated the care idents. The direct could educate all approach as the policy stated the care idents. The direct could educate all approach as the policy stated the care idents. The direct could educate all approach as the policy stated the care identification of the policy stated the policy stated the care identification of the policy stated the po	ves will be turned and one to two hours in eir needs, using a written care by licensed staff. The blicy indicated the Charge sible for incorporating the plan, oal on the care plan.  ed Chalet Living and Rehab ram" dated 4/21/14, indicated ad to be completed upon n and weekly for the first 4 n to determine the score and skin breakdown. Then, the risk cause(s) and interventions I and addressed on the care licated when a resident is in they should be a least every two hours or as sident's care plan. Lastly, the re plan shall be evaluated and ne resident's response to	2 560			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU .D, MN 5542			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON O	(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)		COMPLÉTE DATE
2 565	Continued From pa	ge 14	2 565			
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			5/25/17
		omprehensive plan of care personnel involved in the .				
	by: Based on observati review, the facility for 1 residents (R22 1 of 13 residents (R In addition, the facil for toileting assistant	ent is not met as evidenced on, interview and document ailed to follow careplans for 1 ) reviewed for hearing and for (49) needing meal assistance. ity failed to follow a careplanace for 1 of 3 residents (R35) es of daily living (ADLs).		Corrected		
	Findings include:					
	aide. On 4/11/17, at (FM)-C stated R22 in his ear at 1 p.m. nurse she talked to was missing his left R22's left hearing a few months and tha	tently provided his hearing to 2:05 p.m. Family Member did not have his hearing aide today and stated that the today had not known that R22 hearing aide. FM-C stated ide had been missing for a to the administrator had stated to and had not yet gotten back				
	R22's cognition was indicated minimal d aides. R22's same makes self underst annual MDS also in	num Data Set (MDS) indicated is moderately impaired, hearing ifficulty, and wears hearing annual MDS indicated R22 bood and understands. The dicated R22 needed staff ssing and personal hygiene.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/	14/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENUE			
		RICHFIEL	D, MN 55423	3		
(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 AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 15	2 565			
		e Area Assessment indicated nearing and wears hearing				
	in [R22s] earsPla Make sure hearing hearing aids [in the night shift every Th 3/30/17, indicated, Aids in Both Ears E On 4/11/17, at 2:05	p.m. R22 was observed lying es closed with no hearing				
	On 4/11/17, at 2:36 p.m. nursing assistant (NA)-P stated R22 had just come to this unit 2-3 weeks ago and NA-N had gotten R22 up today. NA-P stated R22's hearing aide was kept in the nursing cart.					
	pushed in his whee table in the dining robserved in R22's ebites of his french to the bacon, oatmeal himself out of the dhis room door. Survand R22 just looked speak. Surveyor as aides and NA-P saides and NA-P stated she hamorning that NA-K stated she would te his hearing aide in R22 back up to the	ing at 9:15 a.m. R22 was Ichair (w/c) NA-K up to the oom. No hearing aides were ears. R22 started taking a few oast and then without trying and liquids started wheeling ining room into the hall next to veyor asked R22 a question d back at surveyor and did not ked NA-P if R22 wore hearing d yes. NA-P then asked R22 if and R22 answered "barely". In anothelped R22 up this had assisted R22. NA-P wheeled dining room table and asked ce and poured him a glass				

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IENCIES CTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			SURVEY PLETED
		A. BUILDING:			
	00740	B. WING		04/	14/2017
R SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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SUMMARY STA				CORRECTION	(X5)
H DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	COMPLETE DATE
ed From pa	nge 16	2 565			
took a drii R22 his he his ear ar	nk. Registered nurse (RN)-F aring aide for his right ear and nd resident stated he could				
ip to this ui nearing aid ated R22 n	nit from another floor and had e before coming to this unit. ow only had one hearing aide				
ng order for d for R22 in residents' d up and if severally won R22's treat ear drop 1/28/17, and severally when the remove was an order or flush concer (NP) or or king on 1 severally or 12 severally or 12 severally or 1 severally o	r ear drops and flushing which in January. RN-F stated she ears every three months for wax build up was observed a place for three days and then rould flush the ears. RN-F eatment administration record as had been administered to ad 1/30/17, and that on 1/29/17, given as unavailable. RN-F e TAR did not indicate an ear x had been completed. RN-F anow that the flush comes after the fourth day. RN-F stated she had ear drops would have not 2nd day as there was house don R22's physician order that on 1/27/17, for ear drops to be all did be completed by nurse in 1/30/17. RN-F stated the 1/30/17, should have placed since 1/28/17, had been ad the NP should have been don documentation in the located that the NP had been				
	EHAB CENT  SUMMARY STA H DEFICIENCY JLATORY OR L  ed From pa 2 took a drin R22 his he in his ear ar ar. R22 ther  It later at 9: up to this un hearing aid ated R22 n family was  /17, at 10:2 ng order fo id for R22 if d up and if is would be ourth day w on R22's tr hat ear drop 1/28/17, an is were not iffied that th remove wa he nurses k drops on th know why th ailable the in-F verified as an order for flush col ner (NP) or orking on 1 is for R22 is and verified is notes indi RN-F state and verified is notes indi RN-F state	O0740  OR SUPPLIER  STREET AD  6200 XER  RICHFIEL  SUMMARY STATEMENT OF DEFICIENCIES IN DEFICIENCY MUST BE PRECEDED BY FULL INLATORY OR LSC IDENTIFYING INFORMATION)  OR SUMMARY STATEMENT OF DEFICIENCIES INLATORY OR LSC IDENTIFYING INFORMATION)  OR SUMMARY STATEMENT OF DEFICIENCIES INLATORY OR LSC IDENTIFYING INFORMATION)  OR SUMMARY STATEMENT OF DEFICIENCIES INLATORY OR LSC IDENTIFYING INFORMATION)  OR SUMMARY STATEMENT OF DEFICIENCIES INLATORY OR LSC IDENTIFYING INFORMATION)  OR SUMMARY STATEMENT OF DEFICIENCIES INLATORY OR LSC IDENTIFYING INFORMATION)  OR SUMMARY STATEMENT OF DEFICIENCIES INLATORY OR LSC IDENTIFYING INFORMATION)  OR SUMMARY STATEMENT OF DEFICIENCIES INLATORY OR LSC IDENTIFYING INFORMATION)  OR SUMMARY STATEMENT OF DEFICIENCIES INLATORY OR LSC IDENTIFYING INFORMATION)  OR SUMMARY STATEMENT OF DEFICIENCIES INLATORY OR SUMMARY OR LICENCIES INLATORY OR SUMMARY OF DEFICIENCIES INLATORY OR SUMMARY OR LICENCIES INLATORY OR SUMMARY	OR SUPPLIER  STREET ADDRESS, CITY, S  6200 XERXES AVENU RICHFIELD, MN 5542  SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL JUATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  2 565  2 took a drink. Registered nurse (RN)-F R22 his hearing aide for his right ear and in his ear and resident stated he could ar. R22 then proceeded to take bites of his  ar later at 9:34 a.m. RN-F stated R22 had up to this unit from another floor and had nearing aide before coming to this unit. ated R22 now only had one hearing aide family was aware.  717, at 10:23 a.m. RN-F stated there was ng order for ear drops and flushing which and for R22 in January. RN-F stated she residents' ears every three months for d up and if wax build up was observed as would be place for three days and then burth day would flush the ears. RN-F con R22's treatment administration record ant ear drops had been administered to 1/28/17, and 1/30/17, and that on 1/29/17, as were not given as unavailable. RN-F then nurses know that the flush comes after drops on the fourth day. RN-F stated she know why the ear drops would have not aliable the 2nd day as there was house N-F verified on R22's physician order that as an order on 1/27/17, for ear drops to be for flush could be completed by nurse ner (NP) on 1/30/17. RN-F stated the orking on 1/30/17, should have placed as for R22 since 1/28/17, had been RN-F stated the NP should have been anotes indicated that the NP had been RN-F stated NP fax their notes to the	OTION    DENTIFICATION NUMBER:   B. WING	OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423  SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL LIATORY OR LSC IDENTIFYING INFORMATION)  Ed From page 16  2 fook a drink. Registered nurse (RN)-F R22 his hearing aide for his right ear and n his ear and resident stated he could ur. R22 then proceeded to take bites of his unit from another floor and had rearing aide before coming to this unit ated R22 now only had one hearing aide family was aware.  1/17, at 10:23 a.m. RN-F stated there was ng order for ear drops and flushing which d for R22 in January, RN-F stated she ir residents' ears every three mornths for d up and if wax build up was observed is would be place for three days and then burnth advoid flush the ears. RN-F on R22's treatment administration record tat ear drops had been administered to 1/28/17, and 1/30/17, and that on 1/29/17, is were not given as unavailable. RN-F enurses know that the flush comes after through the flush co

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , , , , , , , , , , , , , , , , , , ,			
	00740	B. WING		04/	14/2017
NAME OF PROVIDER OR SUPPL	LIER STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
EDINA CARE & REHAB C	ENTER 6200 XE	ERXES AVENUE	SOUTH		
EDINA CARL & REHAD C	RICHFII	ELD, MN 55423	3		
PREFIX (EACH DEFICI	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
the standing or and notify NP a notes. RN-F statemorning R22 notes had been busy RN-F stated R2 called him by the given name.  On 4/13/17, at son top of his beaide in right ear On 4/13/17, at Director (SS) stated in right ear on the hearing aide mis FM-C had told at the hearing aide so stated he rebut thought lice already done the On 4/13/17, at nursing (ADON R22's unit state R22's hearing ait was the nurse aide was locked drops and flush expected nursir for some reaso should pass on the nurse to coldrops should had for not being cold ADON also state written on the T progress notes	d wax build up she would follow der and start ear drops for R22 and document this in the progress ated NA-P had told her this eeded his hearing aide put in but giving out medications at the time 22 responded to her when she are name he preferred and not his described by the ename here are observed lying degrees closed with no hearing at the was aware of R22's saing a couple of weeks ago when and FM-B had told him that the had been missing quite awhile. If erred FM-C to the administrator nsed social worker (LSW)-A had	en.			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
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2 565	to her unit from the talking about his mi interdisciplinary tea facility had replaced aides last fall becastated discussion hin the hearing aide drops them. ADON residents' hearing a getting up. ADON sesidents to have the stated she had talk and she had not me putting in R22's hear Nursing Progress Nesident had none evening, Resident man whereabouts of the in the room and unan Review of NP's Jan indicate an ear flus R22. NP note dated [hearing loss], bilated hearing aids. Was distinct."  R22's nursing programment with the room and unandered for ear wear and started ear days and irrigation of day.  On 4/13/17, at 2:22 (DON) stated R22's out R22's ears and	2nd floor and had remember ssing hearing aide in an m meeting. ADON stated the d another resident's hearing use of new regulations. ADON ad been about if resident puts in or if the staff does or staff stated nurses should put in hides in at 8 a.m. or upon tated it would benefit the hearing aides in. ADON and to FM-C about a week ago entioned to her about staff not	2 565			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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2 565	NP notes. DON stawith the 3N unit sinup there and stated education the staff placement as since be upset. DON stated provided in morning when residents correctly was observed at a table in the 3N later R49 was served R49's plate had a pscrambled eggs. Refer scrambled eggs. Refer scrambled egghand. R49 picked uproceeded to take fingers and then picture patty with her hand sausage patty with At 8:45 a.m. NA-Phelped another reswas provided to R4dining room and did The following morn R49 was observed room on 3N. A couplate of food in froncut up R49's french syrup. NA-K quickly sausage patty with sections and walke sausage patty was in it but not cut apaher right hand stab then unable to cut apatty with her left had stab then unable to cut apatty with had stab then unable to cut apatty with her left had stab then unable to cut apatty with the stab then unable to cut apatty with the stab th	Ited the family was not happy ce R22 being recently moved if she would be doing some the importance of hearing aid if you can not hear you would ted the hearing aids should be greares and no later than the ne out to breakfast.  On 4/11/17, at 8:34 a.m. sitting dining room. Couple minutes and a plate of food on the table. Seancake, a sausage patty and 49 proceeded to take bites of so with a spoon in her right up her uncut pancake and bites of her pancake with her coked up her uncut sausage is and take bites of the	2 565			

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	NT OF DEFICIENCIES NOF CORRECTION			SURVEY PLETED		
		00740	B. WING		04/	14/2017
	PROVIDER OR SUPPLIER	6200 XER	DRESS, CITY, S XES AVENU D, MN 5542			
(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) COMPLETE DATE
2 565	hand and fork in rig pieces. NA-K had not her bacon cut up in her about the sausashe said yes she was the said yes she was at the same table work proceeded to attem up with her fork and up the sausage with of. NA-K walked up wanted anything more proceeded to pour away. R49 took sor hand of scrambled pieces of egg on he and set down on plabeverages.  R49's quarterly Minimidicated R49 neede eating and also indicated reasonable involved in activity a maneuvering of liminassistance.  R49's current carepassist for meal setand provide supervolved in activity and assistance as On 4/13/17, at 10:3 nursing (ADON) stating with fingers of should have asked cut up and staff well.	the hand breaking bacon into not asked R49 if she wanted to smaller pieces, only asked age and french toast which could like cut up.  Seat down by another resident where R49 sat. R49 then apt to cut up her sausage patty differ many attempts picked in her left hand and took bites to R49 and asked if R49 ore to eat and NA-K apple juice and then walked me bites with fork in her right eggs and dropped some er towel and picked up pieces ate. R49 ate all her food and imum Data Set dated 3/1/17, led limited staff assistance for facting R49 was highly and staff provided guidance of be or other non wt-bearing to other non wt-bearing of the same ated staff were to provide as a needed with meals.  3 a.m. the assistant director of ated she did not consider dignified. ADON stated staff R49 if she wanted her food are expected to follow that is how the staff know of	2 565			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
EDINA C	ARE & REHAB CENT	FR	XES AVENU .D, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Continued From pa	age 21	2 565			
	July 2015, indicated resident/resident refor healthcare.  R35 was not offered according to her pladated 3/21/17, identwo staff members checked at least explication in the continence. The composition for signs of offer/encourage the and/or after meals, night rounds. Furth to assist with perind change incontinent check brief for incontine	d toileting assistance an of care. R35's care plan atified R35 needed assist of for toileting. R35 was to be very two hours for care plan directed staff to fincontinence decline and to e toilet upon rising, before and at bedtime and during er, the care plan directed staff eal hygiene after toileting, briefs when soiled and to entinence with rounding.				
	R35 was not on a t was frequently inco R35's Care Area As 2/7/17, identified R for ADLs. The CAA chronic health issu incontinence or pai activity participation had urinary urgeno toileting which cont CAA also identified upon rising, after m rounds. R35 wore a her skin and providence.	usly observed on 4/10/17, from				
		.m. At 4:15 p.m. R35 remained				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND FLAN	OF CONNECTION	IDENTIFICATION NOINBER.	A. BUILDING:		COMP	LLTLD
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	in wheelchair without assistance offered in minutes. On 4/11/17, continut conducted in the direct assistance offered in the direct assistance offered in the direct assistance of the direct assista	out a change in positioning or for at least 2 hours, 17  ous observations were ning room from 12:30 p.m. to not been assisted or offered to emove pressure) for at least 2 NA-F, the DON and NA-E at 3:20 p.m. NA-F described erately wet. NA-F and NA-E ts, as the ones she had been wet with urine. R35's was saturated with a circular melled strongly of urine. NA-F ion was wet with urine, and it with a Sani Wipe. NA-F t know the last time R35 had epositioned.  It will be a servations were so was lying in bed from 7:03 without being offered or on or use the toilet. The room odor. At 10:10 a.m. the he DON of the continuous without care. The DON was nad not provided care for R35. The felt staffing challenges is uses with timely care for R35. The sues with dark colored rated with dark colored rated with dark colored rine. The DON did not know as last changed or DON expected staff to follow or change and reposition R35	2 565			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY
00740	B. W	VING		04/1	4/2017
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS	S, CITY, ST	ATE, ZIP CODE	-	
EDINA CARE & REHAB CENTER	6200 XERXES A		SOUTH		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY I REGULATORY OR LSC IDENTIFYING INFORMAT	FULL PF	ID REFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
not like to lie down, however, she did not offers to have her incontinence brief cha to reposition, as she was unable to move NA-F stated R35 requested to use the to times, but was unable to bear weight, the her incontinence brief was changed in bear was conducted with the wound physician who reported he had first seen R35 on 4 was following the right medial ankle and pressure ulcers. MD-A stated he expecte resident would be repositioned out of her wheelchair at least every two hours.  NA-A stated on 4/13/17, at 8:17 a.m. star supposed to check on R35 every 15-20 in NA-A was unaware if there had been char R35's care plan.  On 4/13/17, at 10:56 a.m. NA-G stated is repositioned and changed R35's wet incombined and changed R35's wet incombined at 7:00 a.m. NA-G stated the night is changed R35 at 5:00 a.m. R35 stayed in after incontinence care, and was reapport 10:00 a.m. and 10:35 a.m. to offer repositioned she had changed R35's incontinuation brief at 7:30 a.m. and the resident had be incontinent of both bowel and bladder. Nowever, on 4/13/17, at 11:05 a.m. NA-F reported she had changed R35's incontinuation brief at 7:30 a.m. and the resident had be incontinent of both bowel and bladder. Nowever, on 4/13/17, at 12:30 p.m. the DON state "care plan is a mess and is not good" an DON was in the process of updating it. T	enged or e herself. eilet at erefore, ed.  erview (MD)-A /7/17 and right heel ed the from the first had been been been been been been been bee	565			

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE (X3) DATE (X4) PLAN OF CORRECTION (X5) DATE (X6) DENTIFICATION NUMBER: (X6) DENTIFICATION NUMBER: (X6) DENTIFICATION NUMBER: (X7) DATE (X8) DATE (X8) DATE (X9) DATE (X		SURVEY			
		00740	B. WING		04/1	4/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU .D, MN 5542			
(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 APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 565	R35 at least every to The care tracker was know R35's plan of continent of bowel. to monitor for urger the bathroom. R35 bladder and to offer was directed to offer rising, before and/oduring night rounds SUGGESTED MET The director of nurse systems to ensure is followed. The director of the plate designee could devongoing compliance the QA/QI committee recommendations.	position, check and change wo hours.  as a tool for NAs to use to care which indicated R35 was The care tracker directed staff acy and give suitable time in was frequently incontinent of toileting with rounds. Staff ar/encourage to use toilet upon a rafter meals at bedtime and the comprehensive care plan ector of nursing or designee opropriate staff on the nof care. The DON or elop systems to monitor for e and share those results with	2 565			
2 800	Staffing requirement Subpart 1. Staffing home must have or number of qualified registered nurses, I nursing assistants to residents at all nurs in all buildings if mo	o Subp. 1 Nursing Personnel; ats  requirements. A nursing an duty at all times a sufficient nursing personnel, including idensed practical nurses, and o meet the needs of the les' stations, on all floors, and one than one building is lides relief duty, weekends,	2 800			5/25/17

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00740	B. WING		04/1	4/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ige 25	2 800			
	by: Based on observation review, the facility of staffing was provided residents regarding care, check and chemical care, check and chemical care of the potential to affect the facility.	ent is not met as evidenced ion, interview and document ailed to ensure sufficient ed to meet the needs of g repositioning, pressure ulcer ange programs, pain assistance with ADLS. This aused harm to R35. This had ct all 69 residents residing in		Corrected		
	on 4/11/17, at 9:55 (3N) every other daresidents here need "Since the new own enough nursing ass On 4/11/17, at 10:1 moved up to 3N frostated on the secontake R22 to the bathelp assist him, sta	per (FM)-E when interviewed a.m. stated, "I come up here by after work, I think those d activities." FM-E stated, hers there is less staff, not sistants (NAs)."  5 a.m. FM-C stated R22 had arm the second floor. FM-C and floor staff did not always hroom so the family would off seemed to put the same a, and he had long toe nails.				
	FM-C stated FM-B clothes for R22 to would have the san stated staff do not on trim R22's nails hearing aid in. FM-to hear from the admissing hearing aid On 4/11/17, at 1:41	would lay out different clean wear the next day but staff ne dirty clothes on him. FM-C clean out his ears, and staff do Staff do not always place his C stated they were still waiting ministrator about R22's				

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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		
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(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 APPRI DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 800	abrasion. FM-F sta someone new work stated there used to here that stayed on more games and a activities have decr.  R89's FM-E on 4/17 Tuesday about thre 35 minutes for staff member's call light sight. FM-E found I member to the bath soaked and "reeke he was the only NA day. FM-E stated th happens about four stated she found th 10 inches under the when coming to vis R89 on a wet bed be R16 on 4/10/17, at wait 30 minutes, up medication." R16's (MDS) dated 2/14/17 was intact.  R27 on 4/10/17, at times the staff do nhere cares." R27's indicated R27's cog R47 stated on 4/10 are so short on help and have to wait ar dressed." R47 furth call light on you hav staff have told me to work and the staff have to work and th	ated apparently it was sing on the night shift. FM-F o be a full time social worker the unit most of the time and ctivities happened, but now eased on the unit.  1/17, at 1:52 p.m. stated on a see weeks ago she had waited to answer her family and there was no staff in NA-N and he helped her family aroom. His bed had been dof urine". NA-N told FM-E who showed up for work that hat working with one NA times a week here. FM-E e call light stuck approximately e mattress a couple of times it R89. FM-E stated she found out a dry pad a couple of times.  2:36 p.m. stated, "I have to to an hour for my night quarterly Minimum Data Set 17, indicated R16's cognition  2:39 p.m. stated, "After three ot come in anymore. No one quarterly MDS dated 3/15/17,	2 800			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/1	4/2017
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	short of NAs, our name R87 stated they had today and the admin any money. The ne R87's quarterly MD R87's cognition was R53 on 4/10/17, at always understaffed and nights are short has had to wait a loghest second to a short on the short on the short on they had been short only been one NA cownership. R67's quanticated R67's cognition was methat put on have just poked in room when I had more staffic." R89's quartindicated R89's cognition was sitting on the etraffic." R89's quartindicated R89's cognition was somethat put on have just poked in the staffic." R89's quartindicated R89's cognition was sitting on the etraffic." R89's quartindicated R89's cognition was sitting on the etraffic."	4:30 p.m. stated, "We are urses are leaving like flies." d a resident council meeting inistrator did not want to spend w SS is taking over today. S dated 1/11/17, indicated impaired.  5:36 p.m. stated, "We are d, evening shift is the toughest at staffed also." R53 stated he ong time for pain medications. dated 3/7/17, indicated R53's t.  6:15 p.m. stated, "I will put my ve to wait for one half hour or to come in." R67 also stated at of staff lately and there had on the floor since the new uarterly MDS dated 1/25/17, gnition was intact.  9:18 a.m. stated, "I have to sen I put my call light on, and and help my roommate and the with him I will say, Hey that the call light. Four times they their head and just left the ay call light on, even when I edge of the bed watching terly MDS dated 3/15/17, gnition was impaired.	2 800			
	weekend there was residents and one !	p.m. NA-K stated this last sone one NA on 3S for 17 NA can not help 17 residents ng. NA-K stated this last				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(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	(X5) COMPLETE DATE
2 800	weekend there was well. RN-A standing near insurance was not go working on other jothey were cutting as staff did not feel it was not staff did not feel it was staff did not feel it was not staff did	rby stated the medical good here and staff was bs. The facility was sold and ctivities and housekeeping and was fair to the residents. RN-A r short staffed here. There was the kitchen today out of four. It was getting worse and more RN-A stated one night there person, a nurse, on the whole on NAs, just the nurse to passed provide cares for 17.  p.m. housekeeper (HK)-C and the kitchen today out of four. It was getting worse and more RN-A stated one night there person, a nurse, on the whole on NAs, just the nurse to passed provide cares for 17.  p.m. housekeeper (HK)-C and the kitchen to keep ethree resident floors and the kitchen to be an anagement about it one an anything but cutting down kitchen kitc	2 800			

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  2 800 Continued From page 29  On 4/12/17, at 8:44 a.m. NA-P stated two NAs	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
EDINA CARE & REHAB CENTER  6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  10 PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)  2 800 Continued From page 29  2 800  On 4/12/17, at 8:44 a.m. NA-P stated two NAs		00740	B. WING		04/1	14/2017
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  2 800 Continued From page 29 On 4/12/17, at 8:44 a.m. NA-P stated two NAs	NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  2 800  Continued From page 29  On 4/12/17, at 8:44 a.m. NA-P stated two NAs	EDINA CARE & REHAB CENTER					
On 4/12/17, at 8:44 a.m. NA-P stated two NAs	PREFIX (EACH DEFICIENCY MU	JST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUNDS) CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETE
were needed each shift for the 3N unit. NA-P stated sometimes they only worked with one NA. NA-P stated dietary did not pass out the residents meals, the NAs did and there were residents who needed meal assistance.  On 4/12/17, at 9:54 a.m. HK-C stated the facility was short of staff in every department. HK-C stated a lot of the staff were looking for another job since staff found out in February the cost of medical insurance increased so much.  On 4/12/17, at 2:00 p.m. maintenance director (MD) stated he recently became the director and had worked at the facility for three years in maintenance. MD stated the director recently left employment and the facility was not planning on replacing him. MD stated they had a list of things to do and had to prioritize what to complete as they often got pulled off flasks. MD stated he was in charge of four departments: laundry, housekeeping, janitorial and maintenance. MD stated last week he had to fil in for staff absences in each of the departments. MD stated they had been trying to update the facility this last year as well as keeping up with maintenance and repairs but they could not get to everything.  On 4/13/17, at 9:52 a.m. RN-F stated they picked up today instead of being mandated to double.  On 4/12/17, at 11:56 a.m. the administrator confirmed that this last Saturday night there was no NA working on the floor and only one nurse (RN-B) working on first floor with 13 residents. The administrator was asked how many NAs were working on the other floors that night. The staffing coordinator (SC) stated this last pay period had forty plus openings for nursing	On 4/12/17, at 8:44 a.r were needed each shirstated sometimes they NA-P stated dietary did meals, the NAs did anneeded meal assistant.  On 4/12/17, at 9:54 a.r was short of staff in evistated a lot of the staff job since staff found or medical insurance incr.  On 4/12/17, at 2:00 p.r (MD) stated he recently had worked at the facing maintenance. MD state employment and the face replacing him. MD state to do and had to priority they often got pulled or in charge of four departs of the pulled or in charge of four departs at the diast week he had absences in each of the they had been trying to year as well as keeping repairs but they could.  On 4/13/17, at 9:52 a.r up today instead of be on 4/12/17, at 11:56 a confirmed that this last no NA working on the or staffing coordinator (Signature).	m. NA-P stated two NAs ft for the 3N unit. NA-P y only worked with one NA. d not pass out the residents d there were residents who ce.  m. HK-C stated the facility very department. HK-C f were looking for another ut in February the cost of reased so much.  m. maintenance director ly became the director and lity for three years in ed the director recently left acility was not planning on ted they had a list of things tize what to complete as ff tasks. MD stated he was rtments: laundry, al and maintenance. MD ad to fill in for staff he departments. MD stated to update the facility this last g up with maintenance and not get to everything.  m. RN-F stated they picked sing mandated to double.  m.m. the administrator t Saturday night there was floor and only one nurse at floor with 13 residents. Saked how many NAs ther floors that night. The C) stated this last pay	2 800			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00740	B. WING		04/1	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	Five minutes later a came back and star not Saturday night floor for the night s stated on Monday ronly one NA on secone NA on third floor, and one NA or stated the facility or agency as of 3/31/2 was in place.  On 4/13/17, at 10:2 nursing (ADON) stated the facility or agency as of 3/31/2 was in place.  On 4/13/17, at 10:2 nursing (ADON) stated the facility the nurse manager for (TCU). The ADON now since she had nurse manager for new owners revam the ADON instead stated the facility the nurse manager ADON stated the TADON stated the TADON stated the Don stated she of 3N very well yet. The new ownership the only one NA and not had. The ADON stated the float pool/a agency for three further end.	y plus openings for nurses that of fill.  at 12:01 p.m. administrator ted it was Monday night and when there was no NA on first hift. The administrator further night there was one nurse and cond floor and one nurse and for Monday overnight. The dithere should have been two econd floor, two NAs on third on first floor. The administrator could not use float pool or 17, when the new ownership  22 a.m. the assistant director of ated she worked at the facility 1 and a half years as the the transitional care unit stated it had been 2-3 weeks been asked to also be the the 3N unit. It was when the ped and she was now called of nurse manger. The ADON links it's manageable for her to of 3N and the TCU. The CU can be very busy. The DON was the nurse manager units of long term care. The did not know the residents of the ADON stated since having facility had been working with of the two NAs they usually ated the facility can no longer gency. They had been utilizing II time positions before the	2 800	DEFICIENCY		
		ip. The ADON stated she was bout the residents on the 3N				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETE DATE
2 800	The ADON stated 3 on 3N and TCU nurcurrently having 13 the TCU is very time. On 4/13/17, at 2:22 (DON) stated she in the DON stated shourse manager for The DON stated the manager for TCU. been the nurse man floor but had left en 2/17. The previous 3/27/17. The DON stated the factories of education educator had left in responsible for companies. Show and the doing all nurse man facility, but did not a responsibilities. Show and the dother end of the doing all nurse man facility, but did not a responsibilities. Show and the dother end of the floor added the AD with the facility next residents in the long floor come to her work nurses on the floor assessments. The have two ADON's work responsibilities. The going to help hire a R60 During an family into the floor and fl	id not know the residents yet. BN presently has 14 residents mber of residents vary, residents. The ADON stated e consuming.  p.m. the director of nursing had been DON for two weeks. He had previously been the the two units on second floor. ADON was now the nurse the DON stated RN-G had hager of two units on the third haployment with the facility in DON had left employment stated RN-E had become the he became the new DON. The illity used to have someone in h. She stated the previous 3/17 and she would be hagement duties for the whole agree with those estated the ADON only units, the TCU units she had and and the one 3N unit. The ON was leaving employment the week. The DON stated goterm care units on second ith their concerns and the help complete the resident DON stated she is going to with nurse manager of DON stated the consultant is	2 800			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	04/1	4/2017
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 800	noticed some staff explained R60 requand the use of a hon transportation to metro mobility. How wait 5-10 minutes the without you. FM-A day the floor is only had to be the second with the hoyer lift of with metro mobility staff have not been use a hoyer lift becomes of fast due to the stresidents who can't buring a meal observed that the properties of the stresidents was the requested ketchup able to get up on his the refrigerator. The their hamburger with no condiments residents was observed onto the elevator at Four residents satthem to eat. At 6:00 dining room and browneals.  On 4/11/17, at 9:20 State is here manabut usually there with mings I don't answer and the staff of the staff	issues in the facility. FM-A uired 2 nursing assistants (NA) over lift to transfer. R60 relied and from appointments using wever metro mobility will only then they will leave with or stated that on more then one a staffed with one NA so she and person to help transfer R60 or they would miss there ride. FM-A also stated that new a trained on how to properly ause they were put on the floor chortage. "I feel sorry for the tapeak for themselves."  Bervation on 4/10/17, at 5:55 are served a plain hamburger is. The only staff serving the nurse, however three residents is own and get a packet out of the other two residents finished thout getting ketchup. The did helping another resident and left the floor in the elevator. The table with no meal for 50 p.m. the two NAs entered the ought the four resident's their a.m. NA-N stated when the gement scheduled two NAs as only one NA. "If my phone are it because I know the copick up a shift and I will have	2 800			

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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		
		00740	B. WING		04/1	4/2017
	PROVIDER OR SUPPLIER	6200 XER	DRESS, CITY, S XES AVENUE D, MN 55423			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 800	only one NA when to get the work don stated the licensed answer call lights. It she was the only Nobeing trained in whe person training her get the training she On 4/12/17, at 10:1 staffing challenges timely cares on R33 attempted a staff to however, felt the sed us to having more Although, the facilit NAs on the second DON was made awal lack of care for R35 The DON stated the charge nurse duties she stated she had nurses to assist with are in the process of cannot do both role was "unable to talk Pass-Over Holiday, she had not been a measurements in the gotten to them yet.  On 4/12/17, at 9:14 to schedule rides, a coordinate care before residents. She furth usually pulled from per week to be a mubuilding depending	here should be two, "it's hard e on time." NA-O further nursing staff does not help to NA-O explained just last Friday A on the floor and NA-L was en management pulled the to another floor so she did not	2 800			

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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		
		00740	B. WING		04/1	4/2017
	PROVIDER OR SUPPLIER	6200 XER	DRESS, CITY, S XES AVENUI D, MN 5542:			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 800	explained she does medications to com responsibilities. HU usually short due to staffing coordinator are usually 25% su occurs. HUC-A stat and staff complaining Further, explained thaving enough time meet the needs of the DON and administrating staffing and had in last week. HUC-A shiring people and so orientation. HUC-A stay for approximate because the job is the staff of the stay for approximate the stay for approxi	get pulled away from passing aplete medical record C-A stated the facility is a call ins which are handled by or the night supervisor and accessful at filling a shift if that ed she had heard residents and of being short staffed. The NAs complained about not be to get cares done and to the residents. HUC-A felt the eator know about the short fact discussed with the DON attated the facility is working on ees new employees start in explained new employees ely a month and then leave too hard. HUC-A is unsure if ything additional to continued	2 800			
	occurred last week conversation with the staffing. NP-A information partner with her for department, NAs, a stated the facility has recent change of or cannot afford the interval of the second floor but an emergency. This there were two NAs	p.m. NP-A stated a situation which prompted her to have a ne DON and her concern for med the DON she would education for the nursing and proper notification. NP-A ad large staff turn over with the wnership and the employees surance so they left.  p.m. NA-A stated that she he third floor but today was second floor due to short staff. to be three NAs working on tone left at 10:00 a.m. due to s staff was not replaced and a for all of the residents on the stated that today she will have chart.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00740	B. WING		04/1	4/2017
	PROVIDER OR SUPPLIER	6200 XFR	DRESS, CITY, S <b>XES AVENUI</b>	TATE, ZIP CODE E SOUTH		
LDINA	ARE & REHAB OLIVI	RICHFIEL	D, MN 5542	3		
(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) COMPLETE DATE
2 800	Continued From page 35		2 800			
	a.m. she stated the so had a hard time facility had trouble v 4/12/17, RN-D cove 26 residents during was overwhelmed t were two residents supposed to get ou happen every day v staff.  R35's Minimum Da	RN)-D, on 4/12/17, at 10:48 re was not adequate staffing finishing work. She stated the with staff retention. On ered two medication carts and her shift. She stated that she that day. RN-D stated there on the second floor that were to fo bed daily but this did not when there was not enough that Set (MDS) dated 2/7/17, moderately cognitively				
	impaired.  On 4/11/17, at 8:17 a.m. writer heard R35 calling out "help me" from behind a closed door without staff in the area. Writer advised Health Unit Coordinator (HUC)-A R35 was calling out "help me" continuously from her room with door closed. HUC-A opened door revealing R35 in her bed laying partially on her right side with face contorted and still calling out "help me". When R35 saw HUC-A she stated "where were you? I have been calling for a half hour and I am scared. I thought you forgot I was here."  On 4/11/17, at 8:20 a.m. during an interview with HUC-A she stated when she walked in R35's room she was facing away from her call light button and could not reach it. HUC-A stated R35 said she had been calling for a long while and when no one came she was scared. The call light was hanging from a grab bar attached to R35's bed and she probably could not reach it.					

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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		
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
EDINA C	ADE 9 DELIAD CENT	6200 XER	XES AVENUE	E SOUTH		
EDINAC	ARE & REHAB CENT	RICHFIEL	D, MN 55423	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 800	Continued From page 36		2 800			
	scared because she where she was and could not reach the out. R35 further sta when she calls for totall light.  On 4/11/17, at 8:29					
	On 4/11/17, at 8:29 a.m. Nursing Assistant (NA)-A stated sometimes there is not enough staff working so it makes double work the rest of the staff. We are short today. It takes a long time to get all the residents up in the morning and dressed and there are only two of us on second floor today. I think we need more staff because we can't take care of the residents like we are supposed to. Call lights can take a long time to get to and residents stated they do not get their breakfast on time or they had to wait a long time to get on the bedpan.					
	stated the facility we created staffing lad. We did not factor addiem for nurses and staff on 3/31/17, an accounted for about nurses and NA's. We going to be able to before the sale of the On 4/12/17, at 10:3 stated they were not for the facility at this open NA shifts and two weeks. If an enfacility instituted madetermined the numprovide safe care to	0 a.m. the executive director as sold as of 3/6/17, and they ders per diem per patient day. cuity into it. There is a per d NA's. We quit using agency d they had previously t 20% of our staffing for de did not know we were not use pool staff until one week he facility.  0 a.m. the staffing coordinator able to fill the staffing needs is time. The facility had 40 de open nursing shifts the last apployee called in sick the undatory overtime if we had residents. We have had e and have had a lot of staff				

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STATEMENT OF DEFICAND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY
7442 1 2744 01 001442	.011011	BENTH ION HONDER.	A. BUILDING:			
		00740	B. WING		04/1	4/2017
NAME OF PROVIDER	OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDINA CARE & RI	FHAB CENT	FR	XES AVENU			
		RICHFIEL	D, MN 5542	3		
PREFIX (EAC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 800 Continu	Continued From page 37		2 800			
working staff the Sometin floor on on 2nd over the NA day were shall show up another indicate staffing complair regarding work more siden. On 4/12 frustration unable of for the responsive stay over been dimedical short stay over the staff or are not they have on 4/12 morning which is order to	double shifts adeced the night shifts adeced the night shift position out two NA are was a nurse staying the staffing the staffing shave comed and the staffing staff. There are was are the properties on the affect the restrictions of the r	fts. We have not been able to quately the last 2 weeks. Vas only one NA on the 3rd nift. We had a NA call in sick and evenings so we were short On 4/8/17, we could not fill 3 ns in the facility. On 4/7/17, we so night shift on TCU and A who did not call in sick or or their evening shift but I know ed even though it is not need as not. We have had any from NA's and nurses any shortage and having to not longer hours. A few any lained about staffing also. It is a lot of call in sick because work harder and longer. Some are a lot of call ins they are The staff left working are meone calls in sick because work harder and longer. Some are calling in a lot which makes a rest of the staff. If it is unsafe the facility mandates overtime his morning was mandated to at shift because it would have set the day nurse to give all the second floor. When we are sidents know and they don't may usually ask for. Call lights as quickly and residents state	2 800			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		00740	B. WING		04/1	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	Continued From page 38		2 800			
	to work short for the	e last few weeks				
	to work short for the last few weeks.  On 4/12/17, at 3:08 p.m. the executive director stated the facility was currently accepting admissions.					
	was a concern. Whe were told we were staffing after 3/31/1 time and kept three members. Our staff been a struggle and especially with the filling staffing holes having them wait loanswered but I thin now the director of worked as a charge second floor. I assis members. On 3/27/DON. I know the dathe charge nurse bijob is only DON and	s a.m. the DON stated staffing then the facility was sold we not allowed to use float pool 7. We started hiring at that the of the float pool staff fing over the last month has do we have had to work short, NA staff. The struggle with affected the residents by onger for call lights to be keep the cares got done. I am the nursing (DON) and have not be nurse but do supervise the gen specific tasks to other staff for the care only thing. My do I have never functioned as a seep being named DON.				
	stated the DON sta not worked as a nu The Daily Staffing S DON is in charge o the actual charge n shift. We do not ha audits on dining an which we put into a also handle any sta grievances that aris facility, help serve a We stopped doing	7: p.m. the executive director arted on 3/25/17, and she has arse manager after that day. Schedules were wrong and the fifthe building but the ADON is arrest of all 3 floors on the day are call light logs but we do d call lights every weekend a summary. While auditing we aff or resident concerns or se. We round throughout the a meal and monitor call lights. The audits on 3/6/17, but will ack up next weekend. My				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(3) DATE SURVEY COMPLETED	
		00740	B. WING		04/	14/2017
	PROVIDER OR SUPPLIER	6200 XER	DRESS, CITY, S XES AVENU D, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 800	call lights, and if this do staff education at On 4/3/17, at 12:22 stated the policy us previous owners possible. SUGGESTED MET director of nursing a systems to ensure a for all nursing units met. The director of educate all appropriate staffing adequate nursing sinursing or designed systems to ensure a evaluated on a regulis monitored to ensure the evaluated on a regulis monitoring resign monitoring resign monitoring resign further recommendations.	ven minute response time for is is not accomplished, we will and corrective action. p.m. the staffing coordinator ed for staffing was the olicy.  THOD OF CORRECTION: The and/or designee could develop adequate staffing is in place to ensure resident needs are in nursing or designee could itate staff on how to determine levels and how to ensure taff is in place. The director of e could develop monitoring nursing staffing needs are ular basis and that shiftly staff ure adequate to meet resident of nursing or designee could sults to the QA/QI committee	2 800			
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car- custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 830			5/25/17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00740	B. WING		04/1	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	FDINA CARE & REHAB CENTER			E SOUTH		
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	D, MN 5542	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
2 830	Continued From pa	ge 40	2 830			
	prefers to remain in bed.					
	by: Based on observatireview, the facility from management for 2 reviewed with pain.  Findings include: R35 was observed 12:30 p.m. to 3:19 assisted or offered pressure) for at leathe DON and NA-Ep.m. NA-F and NA-bed. When seated stated. "God almight over." NA-F lifted R stated, "Ow."	ent is not met as evidenced on, interview and document ailed to provide adequate pain of 4 residents (R35, R73)  continuously on 4/11/17, from o.m. R35 had not been to reposition/offload (remove st 2 hours, 49 minutes. NA-F, entered R35's room at 3:20 E assisted R35 to transfer to on the edge of the bed R35 hty! Help me! I'm leaning way 35's legs into bed and R35		Corrected		
	(LPN)-C and LPN-E right ankle dressing removed R35's right a sore on her great identified. LPN-C stremoved was dated LPN-C reported no ankle. R35 complait was removed. As L with normal saline I hurts!" LPN-B appli	p.m., licensed practical nurse 3 were observed to complete a 3 change for R35. LPN-C at sock and reported there was right toe, not previously stated the ankle dressing being 4/9/17 (two days prior). Allevyn was present on the ned of pain when the dressing PN-C cleansed the wound R35 screamed out, "That ed Santyl to entire wound bed with Allevyn, wrapped with e dressing.				

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION		(3) DATE SURVEY COMPLETED	
		00740	B. WING		04/1	4/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542				
(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) COMPLETE DATE	
2 830	On 4/12/17, continue conducted while R3 a.m. to 10:19 a.m. assisted to repositing a.m. the surveyor in concerns regarding and pain management too." The DON enter (3 hours, 16 minute assessment of the DON changed the inperi-care. The DON skin condition and lying directly onto the and stated she "hunt to turn to her right sher jaw and had fur turn to her left side heel, which she statissue injury measure reported the area who put the gripper soci foot, which was directly onto the gripper soci	age 41  Jours observations were  35 was lying in bed from 7:03  without being offered or  on or use the toilet. At 10:10  Informed the DON of serious  Journal R35's lack of timely services  Journal R35's room at 10:19 a.m.  Journal R35's room at 10:19 a.m.  Journal R35's left heel was  Journal R35 moaned in pain  Journal R35 moaned in pain  Journal R35 moaned in pain  Journal R35 moaned, tightened  Journal R35 moaned, tightened  Journal R35 moaned, the left  Journal R35 moaned the left  Journal R35 moaned, the left  Journal R35 moaned in pain  Journal R35 moaned, the left  Journal R35 moaned, the left  Journal R35 moaned in pain  Joura	2 830				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/	14/2017
	PROVIDER OR SUPPLIER  ARE & REHAB CENT	6200 XER	DRESS, CITY, S EXES AVENU D, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	R35's correspondin (CAA) dated 2/7/17 physical assistance due to pain. The CA chronic health issue incontinence or pair activity participation. R35's care plan dat episodes due to rhe left knee pain, shou R35's care plan dire monitor/document/r signs/symptoms of bearing. The care panticipate need for immediately to any monitor/record pain plan further directed effectiveness of pair through if ineffective nurse any signs/syr and "keep pain free.  During an interview p.m. she explained however, she did no incontinence brief of stated R35 request but was unable to be incontinence brief of denied being aware buttocks, but had no from her right ankle stated R35 frequenthe night.	g Care Area Assessment, identified R35 needed for ADLs and had limitations Af further identified R35 had es/conditions, such as a that resulted in reduced to that resulted in reduced to the ed 3/21/17, identified pain eumatoid arthritis, history of alder and generalized pain. Extend facility staff to report to MD PRN any pain after exercise or weight all further directed staff to pain relief, respond complaint of pain, and to characteristics. R35's care distaff to monitor for medication with follow e, monitor/record/report to inptoms of non-verbal pain,	2 830			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING			
		00740	B. WING		04/1	4/2017
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(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) COMPLETE DATE
2 830	Continued From page 43		2 830			
	(TMA)-D stated R3 responding to her rational for pain who usually not until 10:	5 yelled when staff was not equests for help. R35 received en she got up for the day, but 00 a.m. or 11:00 a.m.				
	says she is in pain" and was "cussing when getting dressed and putting her in the wheelchair." R35 complained of pain in her feet and legs. NA-A stated they are supposed to check on R35 every 15-20 minutes. NA-A confirmed staff were supposed to ensure R35's feet were off of the bed and she had a boot on, but NA-A was unsure which foot or when this intervention began.					
	On 4/13/17, at 11:05 a.m. NA-H stated she was aware R35 had wounds on her thighs, toe, ankle, and heel and that R35 had "a lot of pain" and would not let NA-H touch her right leg due to the pain. NA-H stated R35 was on a repositioning program of every two hours in bed, but did not have a wheelchair repositioning program. NA-H stated when R35 was in bed, she needed a pillow between her legs so her ankles did not touch.					
	An interview was conducted with LPN-A via telephone on 4/13/17, at 11:12 a.m. LPN-A explained he had been the only nurse on the floor on 4/10/17, and "it was busy and difficult to get things done." LPN-A stated R35 was often "in pain and every part of her body is sore."					
	experienced pain w was unsure whethe provided for R35 pr changes, but stated	o p.m. the DON stated R35 with dressing changes. She or pre-medication for pain was nior to care and dressing dishe felt it should be.				
	R35's progress not	es from 3/6/17, to 4/11/17,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	nge 44	2 830			
	identified on 3/6/17, R35's right inner malleolus was painful to touch and tender.  R35's physician orders included acetaminophen (Tylenol) 1000 milligrams (mg) by mouth twice daily for pain and once daily as needed (PRN).					
	Pain assessments dated 2/1/17 to 4/12/17, indicated an increase frequency and severity (1-10, with 10 being the most severe pain) of pain. In 2/17, R35 had pain two days rated at a 4 and 5. In 3/17, R35 had pain eight days rated at levels: 3, 6, and 8. Further, in March R35 required three doses of PRN acetaminophen. In 4/17, R35 had pain seven days rated at levels: 2, 4, and 5. Facility documentation for nursing assistants indicated R35 could be aggressive when in pain and exhibited agitation with pain.					
	Management and A indicated residents	nd procedure titled "Pain Assessment" dated 7/28/15, would receive the necessary activities of daily living.				
	p.m. he had been in requested his oxyco (combination opioid reliever for moderal explained he was e (10 being the worst shoulder and lower had requested pain and he had been to	surveyor on 4/11/17, at 1:24 in pain for the last hour and odone-acetaminophen dinarcotic and non-opioid pain te to severe pain). R73 experiencing 8 out of 10 pain a possible pain) in his right back. R73 reported when he in medication from the nurse, old he would have to wait to the narcotic box were				
	made his own decis	ted 11/30/16, indicated R73 sions and had chronic pain in nd back. R73's goal was to				

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		00740	B. WING		04/1	4/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	have pain controlled providing medication administindicated he was to oxycodone-acetam 1 tablet every four hablets for pain rate been administered 4/10/17, at 4:12 p.m.  On 4/11/17, at 1:30 misplaced the only narcotic box where kept. RN-A verified oxycodone-acetam RN-A had still not follooking for them. The what he planned to management RN-A enough that he can RN-A stated he had were missing. At 1: located, RN-A admoxycodone-acetam On 4/11/17, at 2:01 (ED) stated she wo care for residents' rin pain for over an liget their pain medic provide another for The ED was unsure set of keys and wor maintenance direct During an interview DON explained RN	d. Interventions included on as ordered, monitoring notify nursing. R73's stration record (MAR) for 4/17, receive inophen 5-325 milligrams (mg) nours for pain rated 1-6 or 2 d 6-10. The last time R73 had the medication was on an end.  p.m. RN-A explained he had set of keys that opened the R73's pain medication was I R73 had requested inophen over an hour ago, but bound the keys and was still the surveyor inquired as to do regarding R73's pain areplied, "I know [R73] well wait for his pain medication." If informed the DON the keys 37 p.m., after the keys were hinistered 2 tablets of inophen to R73.  p.m. the executive director uld have expected the staff to needs. "No resident should go nour and all residents should eation when they ask for it or an of pain relief if appropriate." In the facility had a second all check with the cor.	2 830			
	picked up his medic	cation cart keys by accident, missing. The DON stated she				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00740	B. WING		04/1	4/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	minutes, as she haminutes later that the DON verified the faset of keys to the namissing. The DON to wait over an hour Instead, the RN shopharmacist to obtain needed medication storage system) or acetaminophen. In RN-A should have when he noticed the The facility's 7/28/1 Assessment policy residents would recept perform activities of SUGGESTED MET The director of nurse develop policies an appropriate individual programs are in place could educate all amanagement system could develop moniongoing compliance the QA/QI committee recommendations.	s were only missing a few d received a text a few he keys had been located. The cility did not have a back up arcotic box if the keys went said R73 should not have had received his pain medication. Fould have called the nermission to take the from the Omnicell (medication provided R73 with addition, the DON verified contacted her immediately exercise were missing.  5, Pain Management and and procedure indicated evice necessary comfort to featily living.  THOD FOR CORRECTION: Sing (DON) or designee could deprocedures to ensure palized pain management and the correct propriate staff on the pain mes. The DON or designee control of the pain mes. The DON or designee and share those results with	2 830			
2 840	MN Rule 4658.0520 Proper Nursing Car		2 840			5/25/17
	Subp. 2. Criteria fo	or determining adequate and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FDINA CARE & REHAR CENTER			XES AVENU D, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 840	B. Clean skin odors. A bathing place resident's plan of care condition requires the must be given a condition of the	criteria for determining er care include:  and freedom from offensive an must be part of each are. A resident whose hat the resident remain in bed implete bath at least every e often as indicated. An at must be checked at least and must receive perineal care ode of incontinence.  I. Incontinent residents. Innesota Rules, part intinent resident must be to a specific time interval ent's care plan. The resident's must authorize in writing any two hours unless the resident, amily member or legally ator, guardian, or health care who is not competent, agrees onlysician involvement in erval, and this waiver is resident's care plan. ]  Thing must be provided the bed or clothing is soiled. The desident is and for the resident's extention must be given to the ation. Rubber, plastic, or other must be kept clean, be and not come in direct sident. Soiled linen and moved immediately from	2 840			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU			
(V4) ID	SLIMMA DV STA	TEMENT OF DEFICIENCIES	.D, MN 5542	PROVIDER'S PLAN OF CORRECTI		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 840	Continued From pa	ge 48	2 840			
	by: Based on observatireview the facility faservices were provireviewed (R35) who on staff for checkin Findings include: R35 was continuou 1:58 p.m. to 4:15 p. seated in a wheelch with her head lower and her eyes closed Prevalon boot (soft pressure relief) on remained in the sar nursing assistant (Noffer cares. At 3:50 same position where walked past the restremained in wheelch positioning or assist hours, 17 minutes.  The following day of observations were from 12:30 p.m. to wheelchair without reposition or toilet, dining room table, I leaned to the right servalon boot on the left with both or the left with both servalors.	ent is not met as evidenced on, interview, and document alled to ensure timely toileting ded for 1 of 1 residents of was completely dependent grand changing.  Sly observed on 4/10/17, from m. At 1:58 p.m. R35 was nair near the nurses' station red in a chin to chest position d. The resident was wearing a blue boot used to aid in her right foot. At 2:30 p.m. R35 me position; at 3:15 p.m. a NA) walked by R35 but did not p.m. R35 remained in the nathed director of nursing (DON) sident. At 4:15 p.m. R35 chair without a change in tance offered for at least 2 on 4/11/17, continuous conducted in the dining room 3:19 p.m. R35 was seated in a being offered or assisted to At 12:30 p.m. while at the ner eyes were closed and she side. R35 was wearing the ne right foot and a gripper sock of feet touching the floor. R35 position with no offers for		Corrected		

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED  04/14/2017		
		00740	B. WING				
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
EDINA C	ARE & REHAB CENT	6200 XER	XES AVENU	E SOUTH			
LDINA	ARE & REHAD CENT	RICHFIEL	D, MN 5542	3			
(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) COMPLETE DATE	
2 840	called out, "Is anyoned." No staff were R35 then yelled, "C consultant (NC)-Fe provided R35 a glas room. At 2:22 p.m. wanted to go sit by declined. NA-A offe NA-A locked R35's walked away. R35 y NA-A replied from the afternoon." R35 NA-A went to the retime and ask if she station. No cares we resident assisted we resident assisted we resident assisted we resident assisted which in the eyes closed, and le enrichment coordin wheelchair slightly fanother resident. As worker (LSW)-B er	ge 49  ne around? I'm ready to go to present in the dining room. an I have some water?" Nurse entered the dining room and as of water and then left the NA-A asked R35 if she the nursing station which was red water and was declined. right wheelchair brake and yelled out "What time is it?" he nursing station, "It's 2:25 in again asked the time, and sident to inform her of the wanted to sit by nurses' ere offered nor was the ith any cares. At 2:57 p.m. thering in the dining room for nained at the table in the er head to her head to chest, aning to the right side. Life ator (LEC)-A moved R35's forward to accommodate to 3:01 p.m. licensed social intered the dining room and left istance to R35. Housekeeper	2 840				
	responded, "Yes." Hable and left R35's p.m. R35's tray was were offered. At 3:1 of the dining room a	R35, "You done eating?" R35 dK-A walked away to another food in front of her. At 3:06 s removed, but no other cares 9 p.m. NA-F assisted R35 out and informed her she would continence brief. R35 had not					
	been assisted or of (remove pressure) minutes. NA-F, the DON and 3:20 p.m. NA-F and transfer to bed. Wh	fered to reposition/offload for at least 2 hours, 49  I NA-E entered R35's room at I NA-E assisted R35 to en seated on the edge of the od almighty! Help me! I'm					

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 840	leaning way over." I and R35 state, "Ow the Prevalon boot, and provided pericobrief as moderately the resident's skin or R35's skin condition open and excoriate ischial tuberosity (honon-blanchable. The reddened but blandwas blanchable, the sores and scabs whand the right medial treatment was done boot was observed confirmed was soiled drainage. NA-F and as the ones she hawith urine. R35's which saturated with a circum smelled strongly of cushion was wet with urine. R35's which is saturated with a Sani not know the last tirrepositioned. R35 rows assisted back of the NAs and the licensed practical nentered at 3:45 p.m. dressing change. Licensed practical nentered at side provided to the control of the c	NA-F lifted R35's legs into bed c." NA-F and NA-E removed changed the incontinent brief are. NA-F described R35's wet. The DON then assessed condition. The DON stated as: right upper buttock was d from moisture, the left ip) was boggy and e left bottom buttock was hed, right ischial tuberosity e right lower extremity had nich had Tegaderm dressings, I ankle pressure ulcer and at bedtime. R35's Prevalon on the bed which the DON ed with blood and wound I NA-E changed R35's pants, d been wearing were wet wet neelchair cushion was cular area of urine and urine. NA-F confirmed the th urine, and attempted to Wipe. NA-F reported she did me R35 had been changed or equested to get up again, and into her wheelchair.  The DON left the room, urse (LPN)-C and LPN-B is to complete a right ankle PN-C removed R35's right here was a sore on her great usly observed. The soiled and gauze that was saturated allow/blood-tinged drainage. The wound as "reddened with edges" and measured 5	2 840			

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00740	B. WING		04/4	4/2017
		00740			04/1	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		6200 XER	XES AVENU	E SOUTH		
EDINA C	ARE & REHAB CENT	ER RICHFIEL	D, MN 5542	3		
(V4) ID	SHIMMARV STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	)N	(X5)
(X4) ID PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
2 840	Continued From pa	ige 51	2 840			
	-					
		lous observations were				
		35 was lying in bed from 7:03				
		without being offered or				
		on or use the toilet. At 7:03				
		ng in bed with her eyes closed, right side. The room had a				
		R35 continued in the same				
		3 a.m. NC-F stopped at R35's				
		continued to walk past the				
	room. At 10:02 a.m. the surveyor attempted to					
	locate an available staff person to intervene. At					
		reyor informed the DON of the				
		ation of R35 without care. The				
	DON was unaware	why care had not provided				
		OON stated R35 sometimes				
	resisted care. The I	DON stated she felt staffing				
	challenges contribu	ite to timely care for R35. The				
		s room at 10:19 a.m. (3 hours,				
		mpleted an assessment of the				
		dition. The DON changed the				
		d provided peri-care. The				
		5's brief as saturated with dark				
		nelling urine. The DON did not				
		R35 was last changed or				
		OON expected staff to follow change and reposition R35				
	at least every two h					
	at least every two ii	ours.				
	R35's annual Minim	num Data Set (MDS) dated				
		35 had moderate cognitive				
		d diagnoses including				
		(known to contribute to pain),				
		ety. R35 required extensive				
		ivities of daily living (ADLs).				
		oileting program, however,				
		ntinent of bladder and bowel.				
	. ,					
		ig Care Area Assessment				
		, identified R35 needed				
	physical assistance	for ADLs and had limitations				

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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COR		(X5) COMPLETE DATE
2 840	coordination, poor land pain. The CAA chronic health issue incontinence or pai activity participation had urinary urgency toileting which conto CAA also identified upon rising, after mounds. R35 wore a her skin and provided R35's care plan day needed assist of two R35 was to be cheefor incontinence. The monitor for signs of offer/encourage the and/or after meals, night rounds. Furth to assist with perine change incontinent check brief for incontinence of the composition, as should be incontinence by denied being aware buttocks, but had not from her right ankles stated R35 frequent the night.	limited range of motion, poor balance, visual impairment, further identified R35 had es/conditions, such as in that resulted in reduced in The CAA identified that R35 y and needed assistance in ributed to incontinence. The that R35 was offered toileting leals, at bedtime, and on an incontinence brief to protect e dignity.  Ited 3/21/17, identified R35 to staff members for toileting. Exed at least every two hours he care plan directed staff to fincontinence decline and to extilet upon rising, before and at bedtime and during er, the care plan directed staff eal hygiene after toileting, briefs when soiled and to ntinence with rounding.  p.m. NA-F explained R35 did however, she did not decline incontinence brief changed or explain to the was unable to move herself, equested to use the toilet at ble to bear weight, therefore, rief was changed in bed. NA-F explained of pain during the tomplained of pain during the total pain and the protection of the pain and the pain an	2 840			
		a.m. trained medication aide				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/14/2017	
NAME OF	PROVIDER OR SUPPLIER		L	STATE, ZIP CODE	1 0 1	
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE DATE
2 840	Continued From pa	ge 53	2 840			
	staff was not responding to her requests for help. R35 received Tylenol for pain when she got up for the day, but not usually until 10:00 a.m. or 11:00 a.m.					
	was conducted with reported he had first following the right in pressure ulcers. MI the left suspected of break down on R35 impression the staff and at a minimum of to be off the bed, at repositioned out of two hours. It was all	ip.m. a telephone interview in the wound physician (MD)-A st seen R35 on 4/7/17 and was nedial ankle and right heel D-A was Dr. was unaware of deep tissue injury and skin 5's buttocks. It was MD-A's if was elevating R35's heels, would have expected the heels and the resident would be her wheelchair at least every lso expected staff would e relieving interventions for and buttocks.				
	NA-A stated on 4/13/17, at 8:17 a.m. staff was supposed to check on R35 every 15-20 minutes. Staff were supposed to ensure R35's feet were off of the bed and she had a boot on, but NA-A was unsure which foot or when this intervention began. NA-A was unaware if there had been changes to R35's care plan.					
	repositioned and ch brief at 7:00 a.m. N changed R35 at 5:0 "screamed in pain" R35 stayed in bed a was reapproached	66 a.m. NA-G stated she had hanged R35's wet incontinence A-G stated the night shift had 00 a.m. NA-G reported R35 when assisted to reposition. after incontinence care, and at 10:00 a.m. and 10:35 a.m. g, but said R35 had refused.				
	reported she had c	7, at 11:05 a.m. NA-H hanged R35's incontinence nd the resident had been				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/14/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	EDINA CARE & REHAB CENTER 6200 XEI RICHFIE			E SOUTH 3		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CON		(X5) COMPLETE DATE
2 840	incontinent of both unsure when R35 h time. NA-H stated F program of every to have a wheelchair is stated when R35 w between her legs so NA-H did not place heels or feet.  On 4/13/17, at 12:3 "care plan is a mes DON was in the proconfirmed there we interventions noted expected staff to re R35 at least every to the bathroom. R35 bladder and to offer was directed to offer ising, before and/oduring night rounds  SUGGESTED MET The director of nurse could develop systems assessed for and reassistance. The DO all appropriate staff develop monitoring compliance and sha QA/QI committee for the state of the staff develop monitoring compliance and sha QA/QI committee for the state of the state of the staff develop monitoring compliance and sha QA/QI committee for the state of the stat	bowel and bladder. NA-H was had been changed prior to that R35 was on a repositioning to hours in bed, but did not repositioning program. NA-H as in bed, she needed a pillow to her ankles did not touch. a pillow under the resident's a pillow under the policy and the policy and is not good" and the policy and pressure relieving on the care plan. The DON position, check and change two hours.  The care tracker directed staffincy and give suitable time in was frequently incontinent of a toileting with rounds. Staffier/encourage to use toilet upon or after meals at bedtime and	2 840			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/14/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FDINA CARE & REHAB CENTER			XES AVENU D, MN 5542			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the		2 900			5/25/17
	comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:					
	A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and					
	B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.					
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure assessment, monitoring and interventions were implemented in a timely manner for 1 of 1 resident (R35) reviewed with pressure ulcers. R35 suffered actual harm, deterioration of pressure ulcers and development of new pressure related breakdown.			Corrected		
	Findings include:  R35 was observed continuously on 4/10/17, from 1:58 p.m. to 4:15 p.m. At 1:58 p.m. R35 was seated in a wheelchair near the nurses' station with her head lowered in a chin to chest position with her eyes closed. The resident was wearing a Prevalon (soft blue boot used to aid in pressure					

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
71110 1 127111	OF CONTROL OFFICE	IBENTI IOMION NOINBER.	A. BUILDING:			LLILD
		00740	B. WING		04/1	4/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
<b>EDIMA 0</b>	ADE A DELLAD AENT	6200 XER	XES AVENU	E SOUTH		
EDINA C	ARE & REHAB CENT	RICHFIEL	D, MN 5542	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Continued From pa	age 56	2 900			
2 900	3:15 p.m., nursing a resident. At 3:50 p (DON) walked by the observed to offer reassistance through continuous observation. On 4/11/17, continuous observation. On 4/11/17, continuous observation. On 4/11/17, continuous observation. On 4/11/17, continuous observation. R35 was being offered or as: 12:30 p.m. R35 was being offered or as: 12:30 p.m. approximation. R35 remained in the repositioning until 2 "Is anyone around? Is anyone around? Is anyone around? Staff were present if yelled, "Can I have consultant (NC)-Fe provided R35 a gla At 2:22 p.m. NA-A sit by the nursing station as a resident also decline wheelchair brake a out "What time is it nursing station, "It's again asked the time resident to inform the asked her if she was sit to offered R35 a resident to inform the saked her if she was sit she was she was sit she w	hroughout the observation. At assistant (NA)-A walked by the .m., the director of nursing ne resident. No staff were epositioning or any other out the 2 hour and 17 minute	2 900			
	p.m. residents bega for an activity. R35	an gathering in the dining room remained at the table in the er head to her chin, eyes				
	closed, and she wa	is leaning to her right side. The nent coordinator (LEC)-A				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
		A. BUILDING:			
	00740	B. WING		04/14/2017	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDINA CARE & REHAB CEN	6200 XEF	XES AVENU	E SOUTH		
EDINA CARE & REHAD CEN	RICHFIEL	D, MN 5542	3		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY 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) COMPLETE DATE
accommodate and licensed social wo room and left with thousekeeper (HK) eating?" R35 responsive away to another tate of her. At 3:06 p.m. no other care was and 49 minutes after had started, NA-F room and informed her incontinence be on 4/11/17 at 3:20 NA-E, entered R35 NA-F and NA-E as When seated on the "God almighty! He NA-F lifted R35's le "Ow." NA-F and Na-F and Na-F and Na-F and Na-E changed the peri-care. NA-F de "moderately wet". NA-E changed R3 changed her slack been wearing were R35's wheelchair of circular area of uri urine. NA-F confirmurine, and attempt The DON then assecondition. The DO upper buttock- open moisture; left ischinon-blanchable; le blanches; right ischilower extremity-so Tegaderm dressing	elchair forward slightly to other resident. At 3:01 p.m. rker (LSW)- B entered the out offering assistance to R35. replayed the onded, "Yes." HK-A walked ble and left R35's food in front a R35's tray was removed, but offered. At 3:19 p.m., 2 hours fer the continuous observation assisted R35 out of the dining the resident.	2 900			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00740	B. WING		04/1	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FDINA C	ARE & REHAB CENT	6200 XER	XES AVENU	E SOUTH		
	ARE GIVENIAD CERT	RICHFIEL	D, MN 5542	3		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE DSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5 COMPL DAT	
2 900	Continued From page 58		2 900			
2 000	bedtime. R35's Prethe bed which the Eblood and wound doushion was noted in thick and the DO adequate." During the did not know the changed or repositive requested to get up into her wheelchair After the NAs and Epractical nurse (LPI 3:45 p.m. to complet change. LPN-C and hygiene and applied R35's right sock and the control of the change.	valon boot was observed on DON verified was soiled with rainage. R35's wheelchair to be only about one half inch N stated, "it does not feel the observation, NA-F reported the last time R35 had been oned. After the care, R35 again, and was assisted back to DON left the room, licensed N)-C and LPN-B entered at the aright ankle dressing the LPN-B performed hand digloves. LPN-C removed direported there was a sore				
	on her great right toe, not previously observed. LPN-C stated the ankle dressing to be removed was dated 4/9/17 (two days prior). The soiled dressing was Kerlix and gauze that was saturated with foul smelling yellow/blood-tinged drainage. LPN-C reported no Allevyn was present on the ankle. R35 complained of pain when the dressing					
	having "slough" (ye consists of fibrin, pormaterial) and said sometimes wound bed. LPN-C because her ankles LPN-C described to discoloration on the measured 5 centimes.	-C described the wound as llow fibrinous tissue that us, and proteinaceous she could not visualize the stated the ulcer "was acquired touch when she is in bed." he wound as "reddened with e edges" and stated the wound eters (cm) x 4 cm x 1.5 cm.				
	supplies on the bar wound with normal "That hurts!" LPN-E wound bed and edg	rrier on the floor and placed rier. As she cleansed the saline R35 screamed out, 3 applied Santyl to the entire ges, covered the wound with wrapped the entire area with the dressing.				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/14/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION SHOULD BE COMPLETE THE APPROPRIATE DATE	
2 900	Continued From page 59		2 900			
	conducted while R3 a.m. to 10:19 a.m. R35 was not offered repositioning or toiler resting in bed with I to her right side. The odor. At 9:53 a.m. I looked in and conting R35 remained in the a.m. at which time I locate an available 10:10 a.m. the surve continuous observation DON stated she was been provided for Fresisted care. The I challenges contribus surveyor informed to regarding R35 and DON entered R35's 16 minutes) and coresident's skin control R35's incontinence The DON described dark colored punge acknowledged she R35 had been charthen assessed the reported R35's left bed. R35 moaned in everywhere when a side. The DON state had superficial skin identified Stage I frot tightened her jaw and assisted to turn to here.	Louis observations were 35 was lying in bed from 7:03 Throughout the observation, d any assistance with eting. At 7:03 a.m. R35 was her eyes closed, slightly tilted he room had a strong urine NA-F stopped at R35's door, nued to walk past the room. The same position until at 10:02 the surveyor attempted to staff person to intervene. At veyor informed the DON of the ation of R35 without care. The as unaware why care had not R35 but stated R35 sometimes DON stated she felt staffing atte to timely care for R35. The the DON of serious concerns she responded, "Me too." The stroom at 10:19 a.m. (3 hours, ampleted an assessment of the dition. The DON changed brief and provided peri-care. It is a saturated with ent smelling urine. The DON was unaware of the last time need or repositioned. The DON resident's skin condition and heel was lying directly on the in pain and stated she "hurt assisted to turn to her right ted the left ischial tuberosity of loss over the previously om 4/11/17. R35 moaned, and had furrowed brows when her left side. The DON then eel, and stated there was a				

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suspected deep tissue injury measuring 1 cm x 1

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/14/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	cm x 1 cm. R35 reptouch. The DON puthe resident's left formattress without a place. The DON costatus of R35's left know the severity or eassessed it. The comprehensive assembleted or docurexcoriation on her buberosity, and left DON stated she wo issues to have been discovery. In additional expected staff to formatters with the comprehensive assembletes as the complete or docurexcoriation on her buberosity, and left DON stated she wo issues to have been discovery. In additional expected staff to formatters with the complete of the comple	ported the area was painful to at the gripper sock back onto bot, which was directly on the pressure relieving device in onfirmed she was aware of the heel last week, but did not of the wound and had not	2 900			
	R35's record indicated the resident had multiple co-morbidities including: chronic kidney disease, signs/symptoms of peripheral vascular disease, dementia with behavioral disturbances, depression, and anxiety per her diagnosis list on the undated admission record, and consistent with a physician progress note provided by the facility following the recertification survey exit 4/14/17. Progress notes and medication/treatment administration records dated 1/6/17 through 4/13/17, indicated R35 had a history of intermittently refusing treatments and cares which included skin care treatment, assessments, physician appointments, and nutritional supplements.  A nutritional progress note dated 2/5/17, identified R35 had a low hemoglobin (8.7), low normal body mass index (19.3), and low normal body weight at 119 pounds. The nutritional progress note from 2/5/17, further noted R35's intake to be					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/14/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CO		(X5) COMPLETE DATE
2 900	goals were identified maintain hydration, There was no further was at risk. The MI assessment tool are completed to determ R35's correspondin (CAA) dated 2/7/17 physical assistance due to: weakness, coordination, poor land pain. The CAA to be at risk for skir comprehensive assecontributing to the problems with shor resident had daily be assistance and can danger or disrupt caprinted 4/12/17, and current identified a interventions identified a interventions identified risk factor R35's care plan data	ing from 26-100%. Nutritional disast maintain stable weight, and no skin breakdown. For nutritional update.  In the Data Set (MDS) dated as had moderate cognitive diagnoses including: (known to contribute to pain), by. The MDS further indicated sive assistance with activities (s), had no pressure ulcers but DS indicated a formal and a clinical assessment were mine R35's pressure ulcer risk.  In the Care Area Assessment were mine R35's pressure ulcer risk.  In the Care Area Assessment were mine R35's pressure ulcer risk.  In the Care Area Assessment were mine R35's pressure ulcer risk.  In the Care Area Assessment were mine R35's pressure ulcer risk.  In the Care Area Assessment were mine R35's risk factors in the care plant of the care plan	2 900			

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  6200 XERXES AVENUE SOUTH				A. BOILDING.			
EDINA CARE & REHAB CENTER 6200 XERXES AVENUE SOUTH			00740	B. WING		04/1	4/2017
EDINA CARE & REHAB CENTER	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	EDINA C	ARE & REHAB CENT	FR				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)    X4) ID PROVIDER'S PLAN OF CORRECTION (X5)   COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	ILD BE	COMPLETE
cognitively impaired, assistance with ADLs, neurodermatitis, and had scratches/wounds on both lower extremities, left buttock, shoulder, and chest. R35's care plan directed facility staff to assist with repositioning frequently in bed in order to help R35 avoid laying on the open areas. The care plan directed staff to ensure that proper pressure reducing devices were in the wheelchair, and that R35 was positioned correctly when transferring to wheelchair. Further, the care plan directed staff to "assist with repositioning in bed to avoid laying on open areas frequently". The care plan did not address R35's suspected deep tissue to left heel, unstageable ulcer to right heel, right inner ankle press ulcer, or right great toe wound. The care plan did not include interventions defining how often R35 needed to be turned/repositioned, nor did the care plan include other pressure reducing/relieving interventions.  During an interview with NA-F on 4/11/17, at 3:20 p.m. she explained R35 did not like to lie down however, NA-F stated R35 did not like to lie down however, NA-F stated R35 did not like to lie down however in the proposition. NA-F verified R35 was unable to move herself. NA-F also stated that although R35 requested to use the toliet at times, she was unable to bear weight therefore, she required assistance to change her incontinence brief. NA-F stated fis she observed a new skin alteration, she would inform the nurse at that time. NA-F denide being aware of open areas on R35's buttocks, but stated she had noticed red/yellow drainage from her right ankle on the bed sheet. NA-F stated R35 frequently complained of pain during the night.  On 4/12/17, at 9:14 a.m. trained medication aide (TMA)-D said R35 yelled when staff did not	2 900	cognitively impaired neurodermatitis, and both lower extremit chest. R35's care passist with reposition to help R35 avoid lacare plan directed spressure reducing wheelchair, and that when transferring to plan directed staff the to avoid laying. The care plan did not deep tissue to left the heel, right inner and to to wound. The care interventions definite turned/reposition include other pressinterventions.  During an interview p.m. she explained however, NA-F staff to have her inconting to assist her reposition unable to move here although R35 requests was unable to required assistance brief. NA-F stated in alteration, she woutime. NA-F denied R35's buttocks, but red/yellow drainage bed sheet. NA-F stated in alteration of pain.  On 4/12/17, at 9:14	d, assistance with ADLs, and had scratches/wounds on ites, left buttock, shoulder, and plan directed facility staff to oning frequently in bed in order aying on the open areas. The staff to ensure that proper devices were in the at R35 was positioned correctly to wheelchair. Further, the care to "assist with repositioning in on open areas frequently". The address R35's suspected neel, unstageable ulcer to right keep ress ulcer, or right great re plan did not include ng how often R35 needed to ned, nor did the care plan urre reducing/relieving  The with NA-F on 4/11/17, at 3:20 R35 did not like to lie down the R35 did not decline offers the nece brief changed or offers the steet to use the toilet at times, bear weight therefore, she are to change her incontinence of she observed a new skin lid inform the nurse at that being aware of open areas on a stated she had noticed a from her right ankle on the lated R35 frequently during the night.  The a.m. trained medication aide	2 900			

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	<del></del>	COMP	LETED
		00740	B. WING		04/4	4/2047
		00740			04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU			
		RICHFIEL	.D, MN 5542	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Continued From pa	age 63	2 900			
2 000	respond to her requestated R35 received got up for the day, or 11:00 a.m.	uests for help. TMA-D also d Tylenol for pain when she but not usually until 10:00 a.m.				
	stated she was new with R35. NP-A star staff would contact skin alterations, but informed of any proshe'd begun seeing said if skin alteratio would institute orde would implement p	s p.m. nurse practitioner (NP)-A v to the facility and unfamiliar ted it was an expectation the the NP regarding any new t verified she had not been oblems with R35's skin since of the resident on 4/3/17. NP-A are to off load pressure and ressure relieving interventions. If developed, she would Mepilex dressing.				
		ew was attempted with the day oicemail message was 2:19 p.m.				
	was conducted with He reported he saw 4/7/17 and was followed and right heel pressunaware of the left and skin break down expected to be noting wounds. It was also changes would be ankle. MD-A reportulcer, and would have without appropriate MD-A's impression heels, and at a min the heels to be off the would be reposition.	is p.m. a telephone interview in the wound physician (MD)-A. w R35 for the first time on owing the right medial ankle sure ulcers. MD-A was suspected deep tissue injury on on R35's buttocks. MD-A fied of significant decline in a expected daily dressing performed on R35's right ed R35 had a Stage IV ankle ave increased in size/severity of dressing changes. It was the staff were elevating R35's imum would have expected the bed, and the resident at the staff was also expected staff.				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU			
0.0.15	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	D, MN 5542		ON	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 900	Continued From pa	ge 64	2 900			
	would implement pressure relieving interventions for R35's heels, ankle, and buttocks.					
	says she is in pain" getting dressed and wheelchair." R35 cand legs. NA-A statcheck on R35 ever supposed to ensure and she had a boot which foot or when	3/17, at 8:17 a.m. R35 "always and was "cussing when diputting her in the emplained of pain in her feet ded they are supposed to y 15-20 minutes. Staff was a R35's feet were off the bed on, but NA-A was unsure this intervention began. NA-A re had been changes to R35's				
	On 4/13/17, at 8:28 a.m. LPN-D reported she was aware R35 had sores on her legs and hip. R35 slept from 10:00 a.m. to 1:00 p.m. but it was still expected the NAs would check on the resident because of her skin issues. LPN-D believed the right hip area was due to pressure, and the other wounds were from scratching and picking at herself. LPN-D was unfamiliar with other wounds, as they had not been passed on during shift to shift reporting.					
	repositioned and ch brief at 7:00 a.m. N changed R35 at 5:0 "screamed in pain" R35 stayed in bed a was reapproached to offer repositionin NA-G was unsure i or whether any cha care plan in the las	6 a.m. NA-G stated she had hanged R35's wet incontinence A-G stated the night shift had 00 a.m. NA-G reported R35 when assisted to reposition. After incontinence care, and at 10:00 a.m. and 10:35 a.m. g, but said R35 had refused. If R35 had wounds on her feet, nges had been made to her t week.				
		hanged R35's incontinence				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/1	4/2017
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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	(X5) COMPLETE DATE
2 900	incontinent of both unsure when R35 h time. NA-H was aw thighs, toe, ankle, a pain" and would no due to the pain. NA repositioning prograbut did not have a variety program. NA-H starneeded a pillow bed did not touch. NA-H the resident's heels. An interview was contelephone on 4/13/1 he worked on 4/10/1 completing a dress stated when dressing he usually dated and times was "busy and done so. LPN-A explained was "in pain and difficult to get the R35 was "in pain and sore." LPN-A was unissues other than a ankle.  On 4/13/17, at 12:3 following pressure of the survey: suspright heel, right innew was first observed we evidence of monitor R35's left heel ulce reflected in the document of the document	nd the resident had been bowel and bladder. NA-H was had been changed prior to that are R35 had wounds on her and heel. R35 had "a lot of tet NA-H touch her right lega-H stated R35 was on a sam of every two hours in bed, wheelchair repositioning ted when R35 was in bed, she tween her legs so her ankles I did not place a pillow under	2 900			

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00740	B. WING		04/1	4/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
EDINA CA	ARE & REHAB CENT	FR	XES AVENU				
		RICHFIEL	D, MN 5542	3			
(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)	D BE	(X5) COMPLETE DATE	
2 900	Continued From pa	ge 66	2 900				
	DON confirmed the interventions noted survey entrance the thought of putting a bed. The DON expeand change R35 at DON expected nurse every shift and asse and to document fir expected a compre would be completed. This included a headocumentation of the measurements, with management form, order for R35's right calcium alginate, concerning to complete the conders prior to complete the conders pri	e process of updating it. The are were no pressure relieving on the care plan. Prior to the e DON said she had not different mattress on R35's ected staff to reposition, check least every two hours. The ses to monitor R35's skin ess once weekly on bath day, adings. In addition, it was hensive skin assessment d when a new area was found. In the location of wounds, wound he completion of a risk. The DON stated the current thankle was to apply Santyl, over with Allevyn and wrap with a tion was for nurses to read the pleting the dressing change. The process of the pleting the dressing change are right and left heel were to lied, but verified this the identified on the Treatment ford (TAR) or Medication ord (MAR). The DON did not reservice material showing staff education on wound training. The nurse to immediately the skin alteration was NP ultimately oversaw care for ed R35 experienced pain with She was unsure whether pain was provided for R35 essing changes, but the DON bould have been.					

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there was no notation regarding an update to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	physician. On 4/1/1 completed with docheel-pressure stage (inner) pressure- st skin areas. The foll documentation ider to right ankle was camount of yellowish site. Documentation provider had been progress note ident change was complebigger, had a white and was odorous, he documentation that updated.  Review of R35's we from 3/2/17, to 3/3/3/3/2/17, right inner adate by nurse manax 2.5 cm and class. Documentation ide on this date, depth slough, a moderate and pain associated.  Weekly wound doc 3/23/17, and 3/31/1 ankle measurement classified as a stageth depth was supermoderate serous dwith wound. Documented that indicated Professional and fanursing weekly wound wound.	7, a skin check was sumentation of: "Other right was unstagable, right ankle age II" and identified no new owing day on 4/2/17, attified that the dressing charge completed and had a large of drainage from the wound in lacked evidence that the notified. On 4/6/17, the diffied the right ankle dressing eted and the wound looked substance in the wound site in the physician had been easily wound documentation and the was identified on this ager with measurements of 2.0 fied as an unstagable. Intified that area was debrided is superficial, has 100% amount of serous drainage,	2 900			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		00740	B. WING		04/1	14/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDINA CARE & REHAB CENTER			XES AVENU D, MN 5542			
(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) COMPLETE DATE
2 900	evaluation docume revealed::  1) 3/2/17: unstageatissue) of the right, duration with meas not measurable defexudate and 100% necrotic tissue. The using surgical technand necrotic SQ (so at a depth of 0.1 cm pain associated with 3) 3/9/17: unstageat measurements of 2 depth with moderate thick adherent devi 10% granulation tisno change in wouncleansed and with stissue and necrotic fibers were removed pain associated with 4) 3/16/17: unstageate pressure wound with 10 departments were measurable with 10 wound progress depth with 11 wound progress depth with 11 wound progress depth with 12 wound progress depth wo	eekly wound care specialist ntation from 3/2/17 to 4/7/17  able (due to necrosis or dead medial ankle of at least 5 days urements of 2 cm x 2.5 cm x pth cm with light serous thick adherent devitalized e wound was cleansed and nique was devitalized tissue ubcutaneous) fat was removed in . There is no indication of the this condition.  able right medial ankle with 2 cm x 2 cm x not measurable the serous exudate and 90% talized necrotic tissue with sue. Documentation identified did progress. The wound was surgical technique devitalized muscle and surround fascial and. There is no indication of	2 900			
	cm x 1.3 cm x not r	measurable. Documentation ck adherent black necrotic				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/	14/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	RXES AVENUE			
0/4) ID	CHMMA DV CTA		_D, MN 55423		PECTION	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 69	2 900			
	ankle was documer cm x 3.5 cm x 0.2 c exudate, 85% grand	as ordered daily. Right medial need of measurements of 4.0 cm with light sero-sanguinous ulation tissue, 15% other visible. No indication of pain edition.				
	2.0 cm x 2.0 cm x r thick adherent black change in wound properties with maceration at part sero-sanguinous expranulation tissue a Documentation iden	lial heel with measurements of not measurable with 100% is necrotic tissue and no rogress. R35's right medial and at 4.0 cm x 4.0 cm x .02 cm periwound radius, moderate knudate, 15% other tissue, 85% and tendon observed. Intified there was no change in or was there an indication of the condition.				
	policy and procedur turned/positioned in care to prevent skir are unable to repos and repositioned evaccordance with the plan as determined Nurse is responsible	ed Repositioning and Turning re indicated: "Residents are accordance with the plan of a breakdown. Residents who ition themselves will be turned very one to two hours in heir needs, using a written care by licensed staff. The Charge e for incorporating the plan, heal on the care plan."				
	document indicated completed upon res for the first 4 weeks the score and the le Then, the risk facto interventions should on the care plan. The that when a residen	pecific Wound Care Program I a Braden Scale was to be sident's admission and weekly of admission to determine evel of risk for skin breakdown. In a potential cause(s) and be reviewed and addressed the document further indicated at is in bed or wheelchair they position at least every two				

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STATEMENT OF DEFICIENCIES (X1) PRO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00740		B. WING		04/14/2017		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•		
EDINA C	EDINA CARE & REHAB CENTER 6200 XEI RICHFIE			E SOUTH 3			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE	
2 900	Continued From pa	ge 70	2 900				
	The care plan shall	ed on the resident's care plan. be evaluated and revised ent's response to treatment, es.					
	SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop systems to ensure adequate treatment/prevention of pressure ulcers, including but not limited to timely, comprehensive assessments and care plan development/revisions. The DON or designee could educate all appropriate staff on the systems. The DON or designee could develop monitoring systems to ensure ongoing compliance and review those results with the QA/QI committee for further recommendations.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days.						
21000	MN Rule 4658.0610 Requirements-Hygi	0 Subp. 4 Dietary Staff iene.	21000			5/25/17	
	wash their hands and their arms with soal washing facility before as often as is necessafter smoking, eating handling soiled equivalent.	Dietary staff must thoroughly nd the exposed portions of p and warm water in a hand ore starting work, during work ssary to keep them clean, and ng, drinking, using the toilet, or lipment or utensils. Dietary ir fingernails clean and					
	by: Based on observati	ent is not met as evidenced ion and interview, the facility nitary food was served to 3 of		Corrected			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU			
	OLIMANA DV. OTA		D, MN 5542		1011	0.5
(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 APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21000	Continued From pa	ge 71	21000			
	the 3N dining room	R55, R17) served a meal in . This had the potential to esidents in the 3N dining				
	Findings include:					
	observed sitting at t	p.m. 13 residents were tables in the 3N dining room. er resident walked in and sat				
	behind the steam ta meal tickets with glo up a bun, broke it in meat was picked up on the plate, and ta The cook pulled foil steam table, walked	ok was observed standing able touching the residents' oves on. The cook then picked a half and placed it on a plate, o with her gloved hand, placed ken out to the dining room. I off the pans of food on the dover to the garbage can and nds pushed down the cover of an cover.				
	gloved left hand, the and mashed potato her same gloved lebehind her and with touched her clothing. The cook picked uphand and picked uphand, used tongs to plate. With the glov hamburger around touched the bun for hands. The cook wassistants take the when the surveyor in the surveyor i	nolding a plate in the same e cook scooped ground rice es for R20. The cook placed ft hand on the yellow wet sign a the gloved right hand g and pulled up her slacks. It is a plate with the gloved left of a bun with the gloved right of place a hamburger on the ed left hand turned the on the plate for R55 and in R17 with the same gloved as going to have nursing plates out to the residents intervened. The Dietary informed of observation with				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED
	00740	B. WING		0.444	4/004=
NAME OF PROVIDER OR SUPPLIER	00740 STREET AD		STATE, ZIP CODE	04/1	4/2017
EDINA CARE & REHAB CENTE	6200 XER	XES AVENU	E SOUTH		
	RICHFIEL	D, MN 5542			
PREFIX (EACH DEFICIENCY	FEMENT 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) COMPLETE DATE
touching residents' figloved hands. DD in her gloves and put no cook to throw the thrialso stated the cook individual residents' residents touched the been a cook for almost was trained to wear gloves off after going.  Policy provided by the with Food and Use of indicated "Plastic glothandling food directly bacteria are not transhandlers' hands to the Bare hand contact with hands are considered can get contaminated contaminated surface to contaminated surface to the contaminated surface to for food handlers. The services could educate hand hygiene. The door designee could deen sure ongoing commendations.	the dirty garbage can cover food with the same dirty instructed the cook to take off new gloves on and instructed ree plates of food away. DD is should not be touching the meal tickets as staff and nem. Cook stated she had ost one month and a half, gloves and would take the g downstairs to the kitchen.  The facility Bare Hand Contact of Plastic Gloves dated 2010, oves will be worn when ally with hands to ensure that insferred from the food the food product being served. With food is prohibited. Gloved and a food contact surface that are is touched, the gloves must the director of nutritional ate all appropriate staff on director of nutritional services evelop a montiring system to inpliance and share those QI committee for further	21000			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	, , , ,	
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21015	Continued From page 73		21015			
21015	5 MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi		21015			5/25/17
	Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.					
	by: Based on observati	ent is not met as evidenced on and interview, the facility rigerators were sanitary in f 3 units observed.		Corrected		
	Findings include:					
	On 4/10/17, at 12:34 p.m. during a tour of dietary services with the DD, it was noted each floor had a refrigerator. The third floor refrigerator contained a bowl of oatmeal, not dated or sealed. There is a darker colored liquid spilled in the drawers and there were butter packs and milk creamer containers sitting in this liquid in the drawers. In the second floor refrigerator, there were two sealed containers of spaghetti on the shelf not dated or labeled. In the first floor refrigerator, the freezer had what looked like cherry pie on a plate not covered, sealed or dated. All three refrigerators had spilled food and were not clean. The DD stated that maintenance was responsible for the cleaning of these units.					
	(MD) stated he was department was res "check into it." He s maintenance super	a.m. the maintenance director not aware that his sponsible for this and he would stated he had been the visor for approximately one know who was responsible,				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` ´cow		(X3) DATE	SURVEY LETED
711101 12/111	OF CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			LLTLD
		00740	B. WING		04/1	4/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21015	5 Continued From page 74		21015			
	refrigerators were t and they had been	a.m. the DD stated the he housekeeping responsibility cleaned. The MD stated he og schedule and it was veyor				
	SUGGESTED METHOD OF CORRECTION: The director of dietary or designee could review and/or revise policies and procedures for ensuring sanitation of the kitchen on the nursing units. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan.					
	(21) Days.	CORRECTION: Twenty-one				
21375	MN Rule 4658.0800 Program	0 Subp. 1 Infection Control;	21375			5/25/17
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	by: Based on interview review, the facility f the spread of infect the blood glucose r the potential to affe	ent is not met as evidenced , observation and record ailed to prevent and control tion related to the cleansing of nonitoring machines. This had ct 5 of 5 residents on the hared the same glucometer.		Corrected		

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS. CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHIELD, MN 5423  [AVI]D PREFIX (SACHDERS) (SACHDERS)  RESULATORY OR LSC IDENTIFYING INFORMATION)  21375  Continued From page 75  Findings include:  On 4/10/17, at 6:35 p.m., licensed practical nurse (LPN)-A performed a glucometer check on R70. After leaving the room, LPN-A cleansed the glucometer with an alcohol wipe. At 7:21 p.m. LPN-A confirmed he cleaned the glucometer with an alcohol wipe. LPN-A stated he should have used saniwipes to clean the glucometer with an alcohol wipe. LPN-A identified the glucometer is used on multiple residents.  On 4/12/1, at 7 8:05 a.m. (RN)-D wiped off glucometer all ease of the glucometer with an element of the glucometer with an element of saniwipes. LPN-A identified the glucometer wrapped in wipe for at least two minutes.  On 4/13/17, at 9:40 a.m. registered nurse RN-C stated 5 residents currently used the glucometer that was cleansed with alcohol wipes. RR-C stated 5 residents currently used the glucometer that was cleansed with saniwipe and left glucometer that was cleansed with saniwipe and then wrap glucometer with saniwipe minutes.  The director of nursing (DON) stated on 4/12/17, at 3:18 p.m. that staff was expected to clean the glucometer in another saniwipe for 2 minutes.  The DON stated there were saniwipes available in the building on 4/10/17.  The facility's undated policy "Maintaining the Blood Glucose Meters" identified to clean and disinfect the meter, use pre-morstened wipe/towel	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
EDINA CARE & REHAB CENTER    CAGN   DEPICE   C			00740	B. WING		04/1	4/2017
CALL	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG    CANDIDATE   PREFIX TAG   PRECIDENCY MUST BE PRECEDED BY FULL PREGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   CROSS-REFERENCE TO THE APPROPRIATE   DATE	EDINA C	ARE & REHAB CENT	FR				
Findings include:  On 4/10/17, at 6:35 p.m., licensed practical nurse (LPN)-A performed a glucometer check on R70. After leaving the room, LPN-A cleansed the glucometer with an alcohol wipe. At 7:21 p.m. LPN-A confirmed he cleaned the glucometer with an alcohol wipe. LPN-A stated he should have used saniwipes to clean the glucometer but the facility was out of saniwipes. LPN-A identified the glucometer is used on multiple residents.  On 4/12/1, at 7 8:05 a.m. (RN)-D wiped off glucometer after using on resident with Saniwipe, then got a new Saniwipe and left glucometer wrapped in wipe for at least two minutes.  On 4/13/17, at 9:40 a.m. registered nurse RN-C stated 5 residents currently used the glucometer that was cleansed with alcohol wipes. RN-C stated proper cleansing of glucometers is to wipe off glucometer in saniwipe and then wrap glucometer in saniwipe and then wrap glucometer with saniwipe and then wrap glucometer with one saniwipe and then wrap the glucometer with one saniwipe saniwipe savailable in the building on 4/10/17.  The facility's undated policy "Maintaining the Blood Glucose Meters" identified to clean and disinfect the meter, use pre-moistened wipe/lowel	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUNDS) CROSS-REFERENCED TO THE APPROPRIES	JLD BE	COMPLETE
of 1 ml or 5-6% sodium hypochlorite solution (household bleach) and 9 ml water to achieve a 1:10 dilution final concentration of 0.5-0.6% sodium hypochlorite.  SUGGESTED METHOD OF CORRECTION:	21375	Findings include:  On 4/10/17, at 6:35 (LPN)-A performed After leaving the roglucometer with an LPN-A confirmed han alcohol wipe. Ll used saniwipes to a facility was out of s glucometer is used  On 4/12/1, at 7 8:09 glucometer after us then got a new Sanwrapped in wipe for the configuration of the conf	is p.m., licensed practical nurse a glucometer check on R70. om, LPN-A cleansed the alcohol wipe. At 7:21 p.m. e cleaned the glucometer with PN-A stated he should have clean the glucometer but the aniwipes. LPN-A identified the on multiple residents.  5 a.m. (RN)-D wiped off sing on resident with Saniwipe, niwipe and left glucometer r at least two minutes.  6 a.m. registered nurse RN-C currently used the glucometer with alcohol wipes. RN-C using of glucometers is to wipe saniwipe and then wrap wipe for two minutes.  8 sing (DON) stated on 4/12/17, aff was expected to clean the e saniwipe and then wrap the her saniwipe for 2 minutes. Here were saniwipes available /10/17.  1 ded policy "Maintaining the ters" identified to clean and use pre-moistened wipe/towel dium hypochlorite solution and 9 ml water to achieve a oncentration of 0.5-0.6% e.	21375			

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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		
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU			
(V4) ID	SHIMMADV STA	TEMENT OF DEFICIENCIES	D, MN 5542	PROVIDER'S PLAN OF CORRECTI		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 76	21375			
	review and revise p pertaining to glucon designee could edu these systems. The develop monitoring compliance and rev	sing (DON) or designee could olicies and procedures neter sanitization. The DON or leate all appropriate staff on a DON or designee could systems to ensure ongoing riew those results with the or further recommendations.				
	TIME PERIOD FOR (14) days.	R CORRECTION: Fourteen				
21426	MN St. Statute 144. Prevention And Cor	A.04 Subd. 3 Tuberculosis ntrol	21426			5/25/17
	maintain a comprehinfection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volume Health shall provide regarding implements.	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines distates Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of extechnical assistance intation of the guidelines.				
	This MN Requireme	ent is not met as evidenced				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00740	B. WING	B. WING		4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(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)	_D BE	(X5) COMPLETE DATE
21426	by: Based on interview facility failed to ens assessments were employees (E-A, E-(TST) administered employees (E-C an were reviewed. In a ensure TB risk assed of 5 residents (Radministered timely whose immunization.  Findings include:  Employees: 1) E-B was hired 3/file lacked evidence and TST administra 2) E-C was hired 3/revealed the first T3/22/17, however, tsecond test had be 3) E-A was hire 10/lacked evidence and TST administra 2) E-C was hired 3/revealed the first T3/22/17, however, tsecond test had be 3) E-A was hire 10/lacked evidence and TST administra 2) E-C was hired 3/revealed the first T3/22/17, however, tsecond test had be 3) E-A was hire 10/lacked evidence and completed annually Residents: 1) R110 was admitted immunization record assessment for risk active symptoms of 2) R89 was admitted immunization record assessment for risk active symptoms of 3) R74 was admitted record lacked evidence and 3/revealed the first T3/revealed the first T3/re	and document review, the ure tuberculosis (TB) risk completed for 2 of 5 -B) and tuberculin skin testing I as required for 2 of 5 -B) whose employee files addition, the facility failed to ressments were completed for I10, R89, R74, R109) and TST of for 1 of 5 residents (R109) in records were reviewed.  9/17, however, the employee's file ST was administered on here was no evidence a renadministered as required. 5/15, and the employee's file TB symptom screening was of I2/13/16. R110 ds lacked evidence an a factors and screening for ITB had been completed. In I2/13/16. R89's d lacked evidence an a factors and screening for ITB had been completed. In I2/13/16. R89's decompleted. I2/16/17. R74's immunization rence an assessment for risk regions of TB in I2/13/16. R89's decompleted. In I2/13/16. R89's decompleted. I2/16/17. R74's immunization rence an assessment for risk regions of TB	21426	Corrected		

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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	
		00740	B. WING		04/	14/2017
	PROVIDER OR SUPPLIER	FR 6200 XEF	DDRESS, CITY, ST RXES AVENUE LD, MN 55423	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21426	4) R109 was admitting immunization recording assessment for risk active symptoms of addition, TST was a post-admission.  On 4/13/17, at 12:2 (HUC)-D verified not available related to immunization recording immunization recording was at medit that all employees in for TB upon hire and employees were to completed; with the administered three also stated resident and annually therea residents were admand then one-step as	ted 3/23/17. R109's d lacked evidence an a factors and screening for administered 15 days  4 p.m. health unit coordinator b other documentation was employee and resident ds.  p.m. the DON provided the control plan, which indicated the turn risk. The DON stated was received symptom screening d annually thereafter. At hire have the two-step TST e second step being weeks after first. The DON ts were screened at admission after. Upon admission inistered the two-step TST annually. The DON confirmed residents had not been				
	and Control policy i long term care who a previous skin test Mantoux PPD [puri two-step skin test to within one month p admission as requi given at least one v weeks after the firs signs and symptom	, Tuberculosis Surveillance dentified "All residents new to do not have documentation ofshall have initial test of fied protein derivative] or rule out tuberculosis (TB) rior to or one week after redsecond test should be week and no more than three t test. Staff must be vigilant for its of TB in residents who are least, annually to assure				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Additionally, the pol "occupationally-exp tested at least annutest to all employee procedures and if re [millimeters], a secoleast one week and after first testemp an annual basis as a facility."  SUGGESTED MET The director of nurse could review policies could be provided a system could be imbrought to the quali	icy indicated osed persons should be uallyprovide a tuberculin skin s during pre-employment	21426			
21565	Medications Self Ad Subp. 4. Self-adm self-administer med resident assessmed care as required in 4658.0405 indicate is a written order from This MN Requirement by: Based on observation review, the facility for self-administered medical	inistration. A resident may dications if the comprehensive nt and comprehensive plan of parts 4658.0400 and this practice is safe and there om the attending physician.  The sent is not met as evidenced on, interview, and document ailed to ensure residents who nedications were assessed as r 1 of 1 (R53) resident who	21565	Corrected		5/25/17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00740	B. WING		04/14/2017	
NAME OF P	ROVIDER OR SUPPLIER			STATE, ZIP CODE	1 0-7/1	4/2017
	ARE & REHAB CENT	6200 XER	XES AVENU D, MN 5542	E SOUTH		
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	when licensed prace R53's evening med included an Ipratrop treatment. LPN-A loand reported there mask. Without re-sensuring R53 receileft the room. LPN-Ipratropium-Albuter R53's medication a On 4/10/17, at 7:21 should have set up R53 but did not becomedication left in him R53's physician or Ipratropium-Albuter milligrams/3 millilite times a day for chrodisease. R53's recresident had been a self-administration current care plan dicapable and chose nebulizer treatment. The director of nurs at 2:30 p.m. R53 with medications. Howeverified the staff has assessment that shipself-administering to 4/13/17, at 11:01 a.	ed on 4/10/17, at 5:08 p.m. tical nurse (LPN)- A brought in ications. The medications bium-Albuterol nebulizer mask was still medication left in the tarting the treatment and ved all of the medicine, LPN-A A then documented that the rol nebulizer was given on dministration record (MAR).  p.m. LPN-A stated that he the nebulizer treatment for cause the resident still had is nebulizer mask.  Iters included rol Solution 0.5-2.5(3) ers, 1 vial inhale orally four poinc obstructive pulmonary ord also lacked evidence the assessed for of medications, and R53's d not reflect the resident was to self-administer the cause (DON) stated on 4/12/17, was able to self-administer ver, at 3:18 p.m. the DON	21565			

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
		The Bollesino.				
	00740	B. WING		04/1	4/2017	
PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
FDINA CARE & REHAB CENTER						
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE	
Continued From pa	ige 81	21565				
the medication.						
Medication Policy a resident who reque medications will be resident is able to a SUGGESTED MET. The director of nurs develop systems to and resident safety opportunities. The educate all appropriate DON or design to ensure ongoing or results with the QA recommendations.	and Procedure directed "A sts to self-administer assessed to determine if safely self-medicate."  THOD OF CORRECTION: ses (DON) or designee could ensure regulatory compliance during self administration DON or desginee could riate staff on these systems. Hee could develop monitoring compliance and share those /QI committee for further					
	•	21610			5/25/17	
Subpart 1. Storage must store all drugs under proper temporal only authorized nur access to the keys.  This MN Requirem by: Based on observative review, the facility for carts were locked to	e of drugs. A nursing home in locked compartments erature controls, and permit sing personnel to have ent is not met as evidenced ion, interview and document ailed to ensure medication o minimize the risk of drug		Corrected			
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETTER CONTINUED TO PARTICIPATE AND THE MEDICAL STATE OF THE MEDICAL ST	ODT40  PROVIDER OR SUPPLIER  STREET AD  6200 XER RICHFIEL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 81 the medication.  The facility's undated Self-Administration Medication Policy and Procedure directed "A resident who requests to self-administer medications will be assessed to determine if resident is able to safely self-medicate."  SUGGESTED METHOD OF CORRECTION: The director of nurses (DON) or designee could develop systems to ensure regulatory compliance and resident safety during self administration opportunities. The DON or desginee could educate all appropriate staff on these systems. The DON or designee could develop monitoring to ensure ongoing compliance and share those results with the QA/QI committee for further recommendations.  TIME PERIOD FOR CORRECTION: Twenty One (21) days.  MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area; Storage  Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys.  This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medication carts were locked to minimize the risk of drug diversion for 1 of 7 carts.	PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STARE & REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  The facility's undated Self-Administration Medication Policy and Procedure directed "A resident who requests to self-administer medications will be assessed to determine if resident is able to safely self-medicate."  SUGGESTED METHOD OF CORRECTION: The director of nurses (DON) or designee could develop systems to ensure regulatory compliance and resident safety during self administration opportunities. The DON or designee could educate all appropriate staff on these systems. The DON or designee could develop monitoring to ensure ongoing compliance and share those results with the QA/QI committee for further recommendations.  TIME PERIOD FOR CORRECTION: Twenty One (21) days.  MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area; Storage  Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys.  This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medication carts were locked to minimize the risk of drug diversion for 1 of 7 carts.	PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  4. SUMMARY STATEMENT OF DEFICIENCIES  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 81  The facility's undated Self-Administration Medication Policy and Procedure directed "A resident who requests to self-administer medications will be assessed to determine if resident is able to safely self-medicate."  SUGGESTED METHOD OF CORRECTION: The director of nurses (DON) or designee could develop systems to ensure regulatory compliance and resident safety during self administration opportunities. The DON or designee could deducate all appropriate staff on these systems. The DON or designee could develop monitoring to ensure ongoing compliance and share those results with the QA/QI committee for further recommendations.  TIME PERIOD FOR CORRECTION: Twenty One (21) days.  MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area; Storage  Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys.  This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medication carts were locked to minimize the risk of drug diversion for 1 of 7 carts.	DENTIFICATION NUMBER:    00740   B. WING	

6899

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/4	4/0047	
		00740			04/1	4/2017	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21610	Continued From pa	ge 82	21610				
	On 4/12/17, at 7:41 cart was observed staff was observed unlocked medication the dining room are the unit nursing assured proceeded with the registered nurse (Rout of R60's room a unlocked medication the nurse working of immediately stated when she went into the facility policy are every time you leave	a.m. 3 North's medication in the hallway unlocked and no on the unit. R27 walked by the on cart and continued toward ea. A maintenance staff and sistants walked by the cart and ir normal routine. At 7:51 a.m. (N)-C was observed coming and walked over to the on cart. RN-C verified she was on the medication cart and she forgot to lock the cart (R60's room. RN-C explained and procedure is to lock the cart re it. RN-C verified while the residents and staff could take					
	stated her expectat	a.m. the director of nursing ion regarding medication carts be locked at all times when staff					
	observed wanderin reached the medica on the drawers white reached into the tra	roximately 9:30 a.m. R43 was g around 3 North. When R43 ation cart she attempted to pull ch were locked. She then she ash on the side of the cart, cup, looked at it placed it back					
	"Medication Storag	and procedure titled e" dated 8/1/15, indicated taining medication should be use.					
	director of nursing	THOD OF CORRECTION: The (DON) or designee could don't revise policies and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00740	B. WING		0.4/4	4/2047
		00740			04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(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 APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21610	procedures to ensu appropriately. The I educate all appropr procedures. The DO	re medications are stored DON or designee could iate staff on the policies and DN or designee could develop	21610			
	QA/QI committee.	to ensure ongoing are those results with the R CORRECTION: Twenty-one				
21685	MN Rule 4658.1415	5 Subp. 2 Plant eration, & Maintenance	21685			5/25/17
	including walls, floo systems, and equip continuous state of with regard to the h well-being of the re	plant. The physical plant, rs, ceilings, all furnishings, ment must be kept in a good repair and operation ealth, comfort, safety, and esidents according to a written e and repair program.				
	by: Based on observati failed to provide a fi environment. This a comfortable temper	on and interview, the facility unctional and comfortable affected one resident R5 with ratures and had the potential lents residing in the facility.		Corrected		
	Findings include:					
	director (MD) stated month ago and ther staff who worked fu	p.m. the maintenance I he became the director a was another maintenance Il time. MD stated staff notified ts either on his cell phone or n the computer.				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21685	Continued From page 84		21685			
	p.m. verified a sma door in room 202 h  MD took temperatured 68 degrees by by the bed. MD starcold in this room" a and closed window had not been comp why. MD stated star on one of the 70 deable to open that w to open the window window completely should now hold its think staff were away	mental tour on 4/12/17, at 2:00 ill circular gouge on the room e had not been aware of.  The of room 221 and laser gun to the window and 70.5 degrees ted, "I think I know why it is and went over to the window tight. MD stated the window oletely closed and that he knew off had come to him last week egrees days and wanted to be indow. MD stated it took a tool to MD stated now with the closed up tight the room is heat. MD stated he did not are of how to close the window affected the temperature in the				
	in room 221, MD veril laser gun was 66 d 72 degrees by the lawre turned on for MD stated closing the draft coming into the chilly in the room as window on the opposition of the window. MD sticky tape on the veril to help keep stated he did not know the residents wants	rified the temperature with a egrees under the window and bed. MD stated the boilers the night and off for the day. The window had eliminated the room. MD stated it still felt and took temperature of the osite of the room and it read grees and 64 degrees on each draft was felt on the right side verified what looked like old window. MD stated looks like raft block tape felt and could the draft out of the room. MD now what temperature range the but stated it should be what ed. MD stated he would fix the pand that should help warm up				

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	it of periodenous		(V2) MULTIPL	E CONSTRUCTION	(V2) DATE	CLIDVEV
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. DUILDING:			
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS CITY S	STATE, ZIP CODE		
TO WILL OF	TO VIBER OR GOLF EIER		XES AVENU			
EDINA C	EDINA CARE & REHAB CENTER RICHFIE					
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	)NI	(VE)
(X4) ID PREFIX	_	MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				<u> </u>		
21685	Continued From pa	ge 85	21685			
	the room. R5 was v	wheeling self down the hall to				
		stated to MD that her room				
	was still cold this m	orning. MD told R5 about her				
		v being drafty. R5 stated she				
		and had wondered if that				
		rafty but had not mentioned				
		O the last time he had helped				
	with her window in the room. MD stated he would put a covering on her roommate's window to cut					
	down the draft. (R5 had complained of being cold in her room on 4/12/17, at 9:50 a.m. to another					
	surveyor for the las	t few months and that staff				
		stated that NAs would come				
		to heat up the room by turning				
		out R5 would tell the NAs no,				
	as it just blew cold	air.)				
	On 4/12/17, at 2:00	p.m. in room 311, MD verified				
		of the closet was missing				
		cket exposed. MD also verified				
		e bottom of the closet door he				
		e of. MD verified cracked				
		g the bathroom floor wall in cracked splitting ceiling tile				
	_	ng the vent which MD stated				
		are of. MD stated it looked				
	like a mop handle h					
		rified the room door and the				
		e scratched up through the				
	middle and a large portion of the wall between the residents had missing paint. MD stated he had					
		he room needing paint but				
		the scratched doors. MD				
		ne door handle was scratching				
	the other door.					
		verified cabinets were sitting				
		by a plastered wall. MD				
		to put new cabinets, counter				
	and sink in. Mid sta	ted the old cabinets and sink				

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Minnesota Department of Health

Millinesc	ita Department of He	aith	1				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
		00740	B. WING		04/1	04/14/2017	
		00740			04/1	4/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
EDINIA O	ADE & DELIAD CENT	6200 XER	<b>XES AVENU</b>	E SOUTH			
EDINA CARE & REHAB CENTER RICHFIE			D, MN 5542	3			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)	
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE	
				DEFICIENCY)			
21685	Continued From pa	ae 86	21685				
	-						
		four weeks ago and that he					
		ne new counter put in next					
		e old cabinets and sink had					
		odate the dining room and					
		MD stated it had unfinished for					
		hoped he could find time to at					
	least get back to it i						
		erified a missing closet door					
		nser did not work. Small					
	trickles of soap would come out of dispenser with						
	continuous pressure put to it. MD stated he had						
		pap dispenser not working and					
		led new batteries which he					
		et. MD stated the closet door					
		er a month and they had not					
		it. MD stated the frame					
		before the new door could be					
	put on as it would le						
		mily Member (FM)-B came out					
		d MD the television in the					
		FM-B told MD the television					
		g over the weekend and she					
		d he had not been informed by					
		ould get a new television put in					
		verified the television did not					
		eplacing. MD stated it was a					
		erefore the facility needed to					
	replace it.	be elevator MD varified					
		he elevator MD verified					
		approximately half a foot and inches ripped in the hall to the					
		MD stated he had not heard of					
	any plans for the 35						
		e trying to triage the work and					
		ns over when residents					
		ted they had been busy					
		and trying to do things as they					
		tated they were called off to					
		had to prioritize the work. MD					
	stated ne nad a list	of things to get done. MD					

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OTATEMENT OF PERIORS AND		(VO) MULTIPL	E CONCEDUCTION	L(Va) DATE	CLIDVEV	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	C. SCHILLOHON	DEITH IO WICH HOWDER.	A. BUILDING:		30.1411	
		00740	B. WING		04/1	4/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	ORESS CITY S	STATE, ZIP CODE		
			XES AVENU			
FDINA CARE & REHAB CENTER			D, MN 5542			
	O. II. 41 A. F.) / O.T.A.					
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
21685	Continued From pa	ge 87	21685			
21000		_	2.000			
		ork requests for any of the				
	things looked at on					
		6 a.m. on first floor MD				
	•	he walls between rooms 109				
		noles and a gouged hole in the				
		room 107, and scratched				
		oom 100. MD stated hall walls				
	needed continual to					
	In room 221, MD verified four holes with blue					
	putty sticking out above the sanitizer dispenser on					
	the wall and stated	it had always been that way				
	and it did not look n					
		erified holes in the closet door,				
		e stain putty to repair. MD				
	added last week he	had to fill in for every				
		nim (laundry, housekeeping,				
		nce) as staff had been absent.				
		ied white chipped marks on				
		n the elevator stating they				
		nd that walls were a constant				
	touch up due to res					
		1 p.m. MD verified plastered				
		st floor at the entrance door				
		y door. MD stated wall touch				
	•	going from wheelchairs, and				
		to touch up. MD stated the				
		d a Preventative Maintenance				
		at one time but had been busy				
		D stated with new ownership				
		naintenance instead of the				
		enance the facility had. MD				
		director had recently left				
		ould now just keep two				
		a new ownership decision. MD				
		ed to put a plan in place for				
		enance. MD stated he did not				
	have any work orde					
		es verified. MD stated he was				
	not aware of any er	vironmental/maintenance				

Minnesota Department of Health

policies for the facility.

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE COMP			SURVEY LETED
			A. BUILDING:			
		00740	B. WING		04/1	4/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
FDINA CARE & REHAB CENTER			XES AVENU D, MN 5542			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21685	Continued From page 88		21685			
	SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and implement policies and procedures and educate appropriate staff to ensure that the residents's environment was maintained in a safe, clean, functional, comfortable manner. The administrator or designee could educate all appropriate staff on the systems in place to ensure the environmental issues are identified and appropriately addressed. The administrator or designee could develop auditing systems to ensure ongoing compliance and share those results with the QA/QI committee for further recommendations.					
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-one				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			5/25/17
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide personal cares in a manner which promoted privacy and dignity for 2 of 4 residents (R1, R49) observed for activities of daily living (ADL's), and to provide a dignified dining experience for 1 of 13 residents (R49) served in the 3 north (3N) dining room.			Corrected		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	0-7/1	14/2017
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(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) COMPLETE DATE
21805	Findings include:  R1 was observed r 4/12/17, at 7:18 a.r R1 was lying in the room had two large an adjacent apartm peri care to R1 with shades or pulling R removed R1's gow retrieve clothing ite and lower private a may have entered from the outside.  R1's care plan date dementia, severely abilities with short a and required exten staff was directed t resident's needs ar agitation.  NA-L reported on 4 been a NA for seve providing privacy d sorry," then pulled explained the facilit to provide dignity b privacy curtain, and closed. NA-L verifie privacy for R1 to er  R1 was interviewed how she felt about cares. R1 replied, " how they do it ever	eceiving morning cares on m. by nursing assistant (NA)-L. bed closest to the door. The windows, one of which faced nent complex. NA-L provided nout shutting the window R1's privacy curtain. NA-L m walked across the room to ms for R1 leaving her upper reas exposed to anyone who the room or potentially view and long term memory loss, sive assistance to dress. The oranticipate and meet the moderal years. When asked about turing cares NA-L replied, "Oh the privacy curtain shut. NA-L ty's policy and procedure was youlling the shades and densuring the door was ed she should have provided asure she was not exposed.  If following the observation and not being covered during It doesn't bother me. This is yoday. What can I do?"  If on 4/12/17, at 1:46 p.m. the IED) stated he expected staff	21805			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00740	B. WING		04/1	4/2017
NAME OF PRO	OVIDER OR SUPPLIER			STATE, ZIP CODE		
EDINA CAR	RE & REHAB CENT	FR	XES AVENU D, MN 5542			
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
TRISE SEPSEPTION OF TRICES SEP	the facility's 1/12, For Respect & Dignity protestaff are responsible estaff are responsible ersonal privacy."  R49 was observed eated at a table in erved a plate of for atty and scrambled eggs with ancake and uncut angers.  R45 a.m. NA-P selped another resivas provided by NA-C cut R49's food or tensils.  The following morning the following morning estaff she was observed as ausage cut, but did acon. R49 replied ut and added map ouple of cuts into for alked away. Althoun it, it was not fully increased as the patty, and then and pulled off a piece acon and broke it at 8:34 a.m. NA-P selections.	nd privacy to all residents by and closing the door.  Policy on Resident Rights, policy and procedure noted le to maintain and enhance are and worth, by providing  on 4/11/17, at 8:34 a.m. while the 3N dining room. R49 was od with a pancake, a sausage dieggs. R49 ate bites of her ha spoon, but ate the uncut sausage patty with her  sat down at R49's table and dent to eat. No assistance and other to utilize  and on 4/12/17, at 8:25 a.m. sitting at the table in the dining late of food in front of R49, anted her french toast and do not offer to also cut her "yes." The french toast was le syrup. NA-K quickly made a R49's sausage patty and then ugh the patty had cut marks of cut through or into bite-sized up her fork and stabbed at picked it up with her fingers ce. She picked up a piece of	21805			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/1	4/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
21805	picked up the uncur NA-K asked if she was poured apple juice, some bites of scrar pieces dropped ont clothing. R49 picke egg and placed the the food and bevera R49's quarterly Minindicated R49 require eating, with R49 be activity. Staff provide of limbs or other not R49's current carepresident with meal spieces, and to provide required at mealtime. On 4/13/17, at 10:3 nursing (ADON) stated staff should her food cut up and plans because that how to provide care. The facility's 1/12, I responsible for carrithe residents self-estee of dignified care income suggested to main residents self-estee of dignified care income suggested.	rith a fork, and eventually a sausage with her fingers. Wanted anything more to eat, and walked away. R49 ate anbled eggs and some of the o the towel covering her d up the dropped pieces of m on her plate. R49 ate all of ages served at the meal.  The same of the month of the month of the served at the meal.  The same of the meal of the month of the served at the meal.  The same of the meal of the served at the meal of the served at the meal.  The same of the meal of the served at the meal.  The served at the served	21805				
	and prrocedures to	ensure resident rights are ents in the facility. The					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21805	administrator or des on resident rights a believe those rights administrator or des monitoring systems compliance and rep committee for further TIME PERIOD FOR (21) Days	signee could educate all staff nd what to do when they are violated. The signee could develop to ensure ongoing port those results to the QA/QI er recommendations.  R CORRECTION: Twenty-one	21805			5/25/17
	Subd. 3. Timing or reporter who has revulnerable adult is to or who has knowled has sustained a phyreasonably explains information to the condividual is a vulne the individual is a dreporter is not requimaltreatment of the to admission, unless (1) the individual was another facility and believe the vulnerable previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this sas described above (c) Nothing in this	f report. (a) A mandated cason to believe that a peing or has been maltreated, dge that a vulnerable adult sysical injury which is not ed shall immediately report the common entry point. If an rable adult solely because nitted to a facility, a mandated ired to report suspected individual that occurred prior s:  as admitted to the facility from the reporter has reason to be adult was maltreated in the nows or has reason to believe a vulnerable adult as defined to subdivision 21, clause (4). required to report under the ection may voluntarily report				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/1	4/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	EDINA CARE & REHAB CENTER 6200 XEF			E SOUTH 3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21980	knows or has reason been made to the condition (d) Nothing in this reporter from also reason to believe the factorial factorial for the condition of the condit	on to know that a report has common entry point. It is section shall preclude a reporting to a law enforcement reporter who knows or has not an error under section from 17, paragraph (c), clause make a report under this reporter or a facility, at any un investigation by a lead ne or should determine that was not neglect according to rection 626.5572, subdivision clause (5), the reporter or agency information explaining to the criteria under section 17, paragraph (c), clause not shall consider this naking an initial disposition of	21980	Corrected		
	Findings include:	uise on 3/19/17, on her left				
	knee measuring 4.3 cm wide according 3/29/17. The report	to an incident report dated indicated that on 3/19/17, NA)-B noted the bruise and				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(X4) ID PREFIX TAG	ID SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	reported it to registe she was not sure he when RN-A asked I However, R42 also "grabbed out" of he Witness/Observer SNA-B noted while a cares, she reported the way she was tre NA-B observed a b was reported to RN RN-A had done any also reported it to hinterviewed R42.  The facility was ask evidence the admir notified of the allegabeen notified three submitted at report NA-B was interview and stated that on the morning of 3/19 bruise on her left kn cares the night before abrupt. I reported it to NA-D.  During an interview a.m. RN-A stated hinformed of a bruise on 3/19/17, but the MDH until 3/2 our process regard	ered nurse (RN)-A. R42 stated by she sustained the bruise now it had happened. stated she did not like being	21980			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00740	B. WING		04/	14/2017	
NAME OF PROVIDER OR SUPPLIER  EDINA CARE & REHAB CENTE	6200 XER	DRESS, CITY, S XES AVENUI D, MN 5542:				
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
was not done. The fadocumentation as to notified.  During an interview of stated she was attact outside. It was young on me and hit my less people. I felt panicky attacked before. The people. I reported it  During an interview of Executive Director is was apprised of the occurred on 3/19/17 incident. He further is the facility is to call it should contact the Director incidents the MDH.  During an interview of Executive Director incidents like was not done.  During an interview of Executive Director incidents like was not done.  During an interview of Executive Director incidents like was not done.  During an interview of Executive Director incidents like was not done.  During an interview of Executive Director incidents like was not done.	Director and the MDH which acility could not provide the nurse on call being on 4/11/17, at 1:14 p.m. R42 cked sometime last winter ger girls and they climbed up gs. They were nasty young y as I had never been ere may have been three right away to RN-A.  on 4/13/17, at 12:02 p.m. stated he did not recall if he incident to R42 which young young you have been three right away to RN-A.  on 4/13/17, at 12:02 p.m. stated he did not recall if he incident to R42 which you he did remember the stated in this type of incident the nurse on call and they you, LSW and myself. We determine if it needs to d.  on 4/13/17, at 1:04 p.m. stated he could not confirm or notified of the incident 19/17, but the policy is to this within 24 hours and that on 4/12/17, at 9:25 a.m. any understanding that a NA R42's left knee on 3/19/19, in 3/22/17. The facility policy uise is noted the staff would ON to start an investigation	21980				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/1	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FDINA CARE & REHAB CENTER			XES AVENU D, MN 5542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		.D BE	(X5) COMPLETE DATE
21980	Continued From page 96 unknown origin or allegations of neglect or abuse		21980			
	to the facility administrator and state agency for 1 of 1 resident (R54) incident reports reviewed.					
	Findings include:					
	R54 reported she had been abused at the facility when interviewed on 4/11/17, at 8:36 a.m. R54 alleged her roommate, R74 began hitting her and being physically abusive. R54 immediately reported it to a nurse. R54 moved to a different room for the weekend and then R74 was moved to a different room the following Monday.					
	R54's medical diagnoses on the admission record included anxiety disorder, major depressive disorder, borderline personality disorder, bipolar disorder. R54's minimum data set (MDS) from 3/7/17, identified her to be cognitively intact. The care plan printed 4/12/17, and provided by the facility as current addressed R54 being a vulnerable adult including the following interventions: Remove from potentially abusive situations, observe for and implement interventions to minimize and prevent re-occurrence, remove individuals to rooms or private areas for persistent &/or inappropriate behaviors.					
	care center dated 3 had moved to room the weekend for he was verbal/physica for the concerns of	nented in progress note from 8/31/17, identified "Resident a 223 and will be staying over r safety. Resident's roommate I aggression toward her, and her safety, the RN on call to 223 temporary."				
	identified resident to	oort provided by the facility oresident abuse. The incident 7, and was reported to the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	(LSW)-A. R54 state corner, hit her and of the room to alert staff members as v R54 moved to anot Monday when private moved to a private noted.  On 4/13/17, at 10:4 (DON) stated regist know immediately a LSW-A was called the report filed due she was called immincident. The abuse state agency the net facility recently Nurses should the on-call nurse calls administrator, social and LSW-A will coll report abuse incides will typically be the	Inge 97  If 17, by licensed social worker and R74 backed her into a stried to punch her. R54 ran out the nurses. R74 tried to hit well. No injuries noted to R54, her room for the weekend, on ate room available R74 was room. No further incidences  If a.m. the director of nursing tered nurse (RN)-E let the her about this abuse incident and LSW-A was not able to get to internet issues, however nediately regarding this abuse incident was reported to the ext morning. The DON stated changed abuse reporting. Call on-call nurse and the everyone else like the DON, all worker, MD, etc. The DON laborate on if they should ant to the state agency. LSW-A one to submit abuse incidents as	21980			
	procedure for the fa 12/12, stated emplorabuse immediately building supervisor per protocol and wi making and will be agency in accordar also identified if the altercation was a w was to cause harm	ticipant protection policy and acility dated as last revised in byees must always report to the supervisor or the . The DON will be contacted Il involve LSW in decision reported to the state reporting ace to the state law. The policy e resident to resident illful act, the resident's intent or wanted to hurt the other nfliction of injury this				

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winnesc	ita Department of He	aith	_			
AND DUAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00740		B. WING		04/14/2017		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		6200 XFR	XES AVENU			
EDINA C	ARE & REHAB CENT	ER RICHFIEL	D, MN 5542	3		
(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 APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 98	21980			
		nen be reported, even if there illity must minimize and reoccurrence.				
	report alleged abus Supervisor or the B Executive Director/must be contacted reporter regarding a abuse/neglect. Immreported via voice r fax. Document date there is suspicion the reported to the State accordance with state substantiated, it will licensing board.  Based on interview failed to complete of	ntified employees must always e/neglect immediately to the uilding Supervisor. The or designated representative immediately by Supervisor or all allegations of nediate reporting may be nail, answering machine, or and time of notification. If nat abuse occurred, it will be e Reporting Agency in ate law. If the abuse is I be reported to the registry or and record review the facility triminal background checks on five employees (DA-A)				
	Findings include:					
	interview with huma 4/12/17, at 8:36 a.n (DA)-A, whose date have a completed bemployee file. DA-A worked in the facilit supervised or with a times. HR explaines the background corthat I will need to do was done". At 4/12/	employee records and an resource (HR) director on a cone employee/dietary aide of hire was 3/9/17, did not background check in the a was on the schedule and had by DA-A had not been another staff person at all of the "expectation is to have an audit to make sure this 17 11:01 a.m. HR reported removed from the schedule				

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pending her completed background check.

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STATEMENT OF DEFICIENCIES (X1)

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` 'co			TE SURVEY MPLETED	
,	IDENTIFICATION DELICATION DELICAT		A. BUILDING:				
		00740	B. WING		04/1	4/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21980	Continued From pa	ige 99	21980				
	Screening", revised employees would re upon the satisfacto screening.	aployment Background I 7/1/12, identified potential eceive job offers contingent ry completion of a background THOD OF CORRECTION:					
	The administrator a education to facility resident neglect to The administrator a monitoring systems	and/or designee could provide staff on reporting potential the state agency immediately. and/or designee could develop					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one					
22000		6.557 Subd. 14 (a)-(c) tment of Vulnerable Adults	22000			5/25/17	
	facility, except hom personal care atten establish and enfor prevention plan. The assessment of the environment, and it factors which may and a statement of to minimize the risk comply with any rul promulgated by the (b) Each facility, agency and person providers, shall dever prevention plan for	s population identifying encourage or permit abuse, specific measures to be taken to f abuse. The plan shall es governing the plan					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY DMPLETED	
		00740	B. WING		04/	14/2017
	PROVIDER OR SUPPLIER	6200 XER	DRESS, CITY, S XES AVENU D, MN 5542			
(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 SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
22000	The plan shall contassessment of: (1) abuse by other indivulnerable adults; (other vulnerable adspecific measures risk of abuse to tha adults. For the purterm "abuse" include (c) If the facility, and personal care a knows that the vuln violent crime or an toward others, the iplan must detail the minimize the risk the reasonably be expefacility and persons unsupervised. Undof a vulnerable adumisconduct or physuch information fro authority or through another facility, and	ain an individualized the person's susceptibility to viduals, including other 2) the person's risk of abusing ults; and (3) statements of the to be taken to minimize the t person and other vulnerable poses of this paragraph, the	22000			
	by: Based on interview facility failed to imp immediately report allegations of negle	and document review, the lement their policy to injuries of unknown origin or ect or abuse to the facility tate agency for 1 of 1 resident		Corrected		

Minnesc	<u>ita Department of He</u>	ealth				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00740	B. WING		04/1	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DDESS CITY S	STATE, ZIP CODE		
NAIVIL OI I	-NOVIDEN ON SUFFEIEN		XES AVENU			
EDINA C	ARE & REHAB CENT	FR	.D, MN 5542			
	OLIMA AA DV OTA					0.50
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	`	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
22000	Continued From pa	ge 101	22000			
	•					
	Findings include:					
	i ilidiliga ilicidde.					
	The facility's Policy	and Procedure for:				
		icipant Protection - selection				
	Reporting and Resp	oonse, revised 12/12, read:				
		ways report alleged				
		incidents, mistreatment,				
		ries of unknown origin, and				
		resident/client/participant				
		ely to the Supervisor or the				
		ntative must be contacted				
		pervisor or reporter regarding				
		use/neglect. Immediate				
		ported via voice mail,				
		e, or fax. Document date and				
		Director of Nursing will be				
		ocol and will involve Social				
		ee. If there is suspicion that				
		will be reported to the State n accordance with state law. If				
		intiated, it will be reported to				
		sing board. Documentation:				
		otified and the time the				
	notification occurre	d. Include social services or				
	designee in the not	ification.				
	Andrew 11.	1.1.10/00/47				
		lated 3/29/17, indicated on				
		sistant (NA)-B noted R42 had knee and reported it to				
		N)-A. Bruise measured 4.3				
		ng by 2.3 cm wide. When R42				
		e how it could have happened				
		not sure how it happened.				
		e did not like being grabbed				
		air. A Witness/Observer				
		19/17, NA-B noted while doing				
		R42, she related that she was				
	upset with previous	evening's treatment after				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
00740		B. WING		04/14/2017		
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU D, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
22000	supper. A bruise way which was reported unsure whether RN then reported incide consulted with R42  The facility could not director of nursing (Executive Director 3/22/17. The incide Minnesota Departm 3/22/17, by SS-A.  During an interview 10:00 a.m. NA-B st 3/19/17, R42 told his knee and was upset before and the NA's immediately to RN-During an interview 9:19 a.m. RN-A state being told about a buring an interview a.m. DON stated shight the incident of me on 3/19/17, by the MDH until 3/22/our process regard MDH. We should his the DON, Executive was not done. The documentation as to notified.	as noted on R42's left knee to RN-A but NA-B was l-A followed through. NA-B ent to his supervisor NA-D who	22000			
	stated she was atta outside. It was your	con 4/11/17, at 1:14 p.m. R42 acked sometime last winter ager girls and they climbed up ags. They were nasty young				

Minnesota Department of Health

STATE FORM B3HD11 If continuation sheet 103 of 107

NAME OF PROVIDER OR SUPPLIER  EDINA CARE & REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES  (CAN) ID PREFTX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (CAN) ID PREFTX TAG  CONTINUED FROM THE SUPPLIER  CONTINUED FROM THE SUPPLIER  (CAN) ID PREFTX TAG  CONTINUED FROM THE SUPPLIER  CROSS-REFERENCED TO THE APPROPRIATE  CROSS-REFERENCE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
SUMMARY STATEMENT OF DEFICIENCIES, MYEAR TAGE   SUMMARY STATEMENT OF DEFICIENCIES, MYEAR TAGE			00740	B. WING		04/1	4/2017
CALIDID   CALI	NAME OF	PROVIDER OR SUPPLIER					
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  22000  Continued From page 103 people. I felt panicky as I had never been attacked before. There may have been 3 people. I reported it right away to RN-A.  During an interview on 4/13/17, at 12:02 p.m. Executive Director stated he did not recall if he was apprised of the incident to R42 which occurred on 3/19/17, but he did remember the incident. He further stated in this type of incident the facility is to call the nurse on call and they should contact the DON, SS and myself. We then discuss it and determine if it needs to reported to the MDH.  During an interview on 4/13/17, at 1:04 p.m. Executive Director stated he could not confirm or deny if he had been notified of the incident involving R42 on 3/19/17, but the policy is to report incidents like this within 24 hours and that was not done.  During an interview on 4/12/17, at 9:25 a.m. SS-B stated it was my understanding that a NA reported a bruise to R42's left knee on 3/19/19, and I was notified on 3/22/17. The facility policy indicates that if a bruise is noted the staff would notify SS or DON to start an investigation and that did not happen in this instance.  Based on interview and document review and interview, the facility failed to implement their policy to immediately report injuries of unknown origin or allegations of neglect or abuse to the facility administrator and state agency for 1 of 1	EDINA C	ARE & REHAB CENT	FR				
people. I felt panicky as I had never been attacked before. There may have been 3 people. I reported it right away to RN-A.  During an interview on 4/13/17, at 12:02 p.m. Executive Director stated he did not recall if he was apprised of the incident to R42 which occurred on 3/19/17, but he did remember the incident. He further stated in this type of incident in the facility is to call the nurse on call and they should contact the DON, SS and myself. We then discuss it and determine if it needs to reported to the MDH.  During an interview on 4/13/17, at 1:04 p.m. Executive Director stated he could not confirm or deny if he had been notified of the incident involving R42 on 3/19/17, but the policy is to report incidents like this within 24 hours and that was not done.  During an interview on 4/12/17, at 9:25 a.m. SS-B stated it was my understanding that a NA reported a bruise to R42's left knee on 3/19/19, and I was notified on 3/22/17. The facility policy indicates that if a bruise is noted the staff would notify SS or DON to start an investigation and that did not happen in this instance.  Based on interview and document review and interview, the facility failed to implement their policy to immediately report injuries of unknown origin or allegations of neglect or abuse to the facility administrator and state agency for 1 of 1	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
Findings include:  The facility Resident/Client/Participant Protection policy and procedure dated as last revised in	22000	people. I felt panick attacked before. The I reported it right available. The I reported it right available in the pocuring an interview. Executive Director was apprised of the occurred on 3/19/1 incident. He further the facility is to call should contact the discuss it and deter the MDH.  During an interview Executive Director deny if he had beer involving R42 on 3/report incidents like was not done.  During an interview stated it was my un reported a bruise to and I was notified or indicates that if a binotify SS or DON to did not happen in the Based on interview interview, the facility policy to immediate origin or allegations facility administrator resident (R54) incider The facility Resider	ay as I had never been are may have been 3 people. The way to RN-A.  Ton 4/13/17, at 12:02 p.m. a stated he did not recall if he incident to R42 which are the incident to R42 which are the nurse on call and they DON, SS and myself. We then armine if it needs to reported to a con 4/13/17, at 1:04 p.m. a stated he could not confirm or an notified of the incident and they be this within 24 hours and that are on 4/12/17, at 9:25 a.m. SS-B and and the staff would be the staff would be start an investigation and that and document review and and document review and and the staff would be start an investigation and that and the staff would be start an investigation and that and the staff would be start an investigation and that and the staff would be start an investigation and that and the staff would be start an investigation and that and the staff would be start an investigation and that and the staff would be start an investigation and that and the staff would be start an investigation and that and the staff would be start an investigation and that and the staff would be start an investigation and that and the staff would be start an investigation and that and the staff would be start an investigation and that and the staff would be start an investigation and that and the staff would be start an investigation and that and the staff would be start an investigation and that and the staff would be start an investigation and that and the staff would be start an investigation and that and the staff would be start an investigation and that and the staff would be start an investigation and that and the staff would be start an investigation and the staff would be				

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		00740		B WING		0.4/4.4/2047	
EDINA CARE & REHAB CENTER  6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	04/1	4/2017
RICHFIELD, MN 55423  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			FR 6200 XER	XES AVENU	E SOUTH		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE		1	RICHFIEL	1			
DEFICIENCY)		(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	ILD BE	(X5) COMPLETE DATE
22000 Continued From page 104 22000	22000	Continued From pa	age 104	22000			
22000  Continued From page 104  12/12, stated employees must always report abuse immediately to the supervisor or the building supervisor. The DON will be contacted per protocol and will involve LSW in decision making and will be reported to the state reporting agency in accordance to the state law. The policy also identified if the resident to resident altercation was a wilful act, the resident's intent was to cause harm or wanted to hurt the other individual, a willful infliction of injury this altercation should then be reported, even if there is no injury. The policy further identified it was possible for a willful act to be committed by someone with dementia. The facility must minimize and monitor to prevent reoccurrence.  The policy also identified employees must always report alleged abuse/neglect immediately to the Supervisor or the Building Supervisor. The Executive Director/ or designated representative must be contacted immediately by Supervisor or reporter regarding all allegations of abuse/neglect. Immediate reporting may be reported via voice mail, answering machine, or fax. Document date and time of notification. If there is suspicion that abuse occurred, it will be reported to the State Reporting Agency in accordance with state law. If the abuse is substanilated, it will be reported to the registry or licensing board.  R54 reported she had been abused at the facility when interviewed on 4/11/17, at 8:36 a.m. R54 alleged her roommate, R74 began hitting her and being physically abusive. R54 immediately reported to the weekend and then R74 was moved to a different room for the weekend and then R74 was moved to a different room the following Monday.	22000	12/12, stated emploabuse immediately building supervisor per protocol and wi making and will be agency in accordar also identified if the altercation was a was to cause harm individual, a willful i altercation should t is no injury. The popossible for a willfu someone with demminimize and moni  The policy also idereport alleged abus Supervisor or the Executive Director/must be contacted reporter regarding abuse/neglect. Immediately in the state of the stat	oyees must always report to the supervisor or the The DON will be contacted ill involve LSW in decision reported to the state reporting nce to the state law. The policy resident to resident villful act, the resident's intent or wanted to hurt the other infliction of injury this then be reported, even if there olicy further identified it was all act to be committed by rentia. The facility must tor to prevent reoccurrence.  Intified employees must always see/neglect immediately to the Building Supervisor. The or designated representative immediately by Supervisor or all allegations of nediate reporting may be mail, answering machine, or e and time of notification. If hat abuse occurred, it will be the Reporting Agency in ate law. If the abuse is all be reported to the registry or and been abused at the facility on 4/11/17, at 8:36 a.m. R54 ate, R74 began hitting her and usive. R54 immediately se. R54 moved to a different and and then R74 was moved	22000			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/1	14/2017
	PROVIDER OR SUPPLIER	6200 XER	DRESS, CITY, S XES AVENU D, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
22000	disorder, borderline disorder. R54's min 3/7/17, identified he current care plan properties of plants of plants of plants of the cocurrence, remprivate areas for period behaviors.  The incident documber care center dated 3 had moved to room the weekend for he was verbal/physical for the concerns of agreed to place her an investigative repidentified resident to occurred on 3/31/13 state agency on 4/1 (LSW)-A. R54 state corner, hit her and to of the room to alert staff members as we R54 moved to another moved to a private noted.	sorder, major depressive personality disorder, bipolar imum data set (MDS) from to be cognitively intact. The rovided as current addressed able adult including the ons: Remove from potentially observe for and implement simize and prevent ove individuals to rooms or resistent &/or inappropriate  mented in progress note from /31/17, identified "Resident 223 and will be staying over r safety. Resident's roommate aggression toward her, and her safety, the RN on call to 223 temporary."  port provided by the facility or resident abuse. The incident 7, and was reported to the /17, by licensed social worker at R74 backed her into a stried to punch her. R54 ran out the nurses. R74 tried to hit well. No injuries noted to R54, her room for the weekend, on the room available R74 was room. No further incidences	22000			
	(DON) stated regist know immediately a LSW-A was called. the report filed due	8 a.m. the director of nursing tered nurse (RN)-E let the her about this abuse incident and LSW-A was not able to get to internet issues, however necliately regarding this abuse				

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00740	B. WING		04/1	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDINA C	ARE & REHAB CENT	FR	XES AVENU .D, MN 5542			
(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) COMPLETE DATE
22000	incident. The abuse state agency the net the facility recently Nurses should the con-call nurse calls administrator, social and LSW-A will coll report abuse incide will typically be the The DON stated the soon as possible.  SUGGESTED MET The administrator of systems to ensure a abuse/neglect are at The administrator of staff on those systems to ensure of staff on those systems and development of the systems with the QAM recommendations.	ge 106 e incident was reported to the ext morning. The DON stated changed abuse reporting. Call on-call nurse and the everyone else like the DON, all worker, MD, etc. The DON aborate on if they should not to the state agency. LSW-A one to submit abuse report. Eay report abuse incidents as a serious from the policies related to appropriately implemented. For designee could educate all ems. The administrator or relop monitoring systems to appliance and share those and committee for further as CORRECTION: Twenty-one	22000			

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