CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDIC	CARE/MEDICAID C	ERTIFICATION A	ND TRANSMITTAL
DADTI	TO DE COMDLET		E CUDVEN A CENCI

ID: C7VC

	PART I	- TO BE COMP	LETED BY 1	THE STAT	TE SURVEY AGENCY	Facility ID: 31025
1. MEDICARE/MEDICAID PROVIDER N (L1) 245632 2.STATE VENDOR OR MEDICAID NO. (L2) 642487100	ΙΟ.	 NAME AND AI (L3) ST THERES (L4) 7555 BAILE (L5) WOODBUR 	SE OF WOODB EY ROAD		(L6) 55129	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 9. Grim Up to the constraint
5. EFFECTIVE DATE CHANGE OF OWN (L9)	IERSHIP	7. PROVIDER/SU 01 Hospital	IPPLIER CATEGO 05 HHA	RY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
 6. DATE OF SURVEY 11/6/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 	17 (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 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 06/30
11LTC PERIOD OF CERTIFICATION From (a) : To (b) : 12.Total Facility Beds	56 (L18)	Complian		5:	And/Or Approved Waivers Of T2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SN5. Life Safety Code	he Following Requirements: 6. Scope of Services Limit 7. Medical Director F) 8. Patient Room Size 9. Beds/Room
13.Total Certified Beds	56 (L17)		mpliance with Prog and/or Applied Wa		* Code: A	(L12)
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 56 (L37)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABI	E SHOW LTC CANC	ELLATION DATE):		
17. SURVEYOR SIGNATURE Sue Miller, HFE - NE II		Date : 11/17/	2017		18. STATE SURVEY AGENCY Alison Helm, Enford	cement Specialist 05/22/2018
РА	RT II - TO BI	ECOMPLETED	BY HCFA R	(L19) EGIONAI	L OFFICE OR SINGLE ST	(L20)
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part 2. Facility is not Eligible		20. COM	MPLIANCE WITH GHTS ACT:		21. 1. Statement of Fina	ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE	23. LTC AGREEM	IENT 2	4. LTC AGREEN	IENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 09/08/2016	BEGINNING	DATE	ENDING DAT	Έ	VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursen	0 INVOLUNTARY 05-Fail to Meet Health/Safety nent 06-Fail to Meet Agreement
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:	(L25)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	
(L27)	B. Rescind Su	spension Date:	(L44) (L45)			00-Adive
28. TERMINATION DATE:	29	D. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
	(L28)	06201		(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL D	ATE		
	(L32)	10/27/2017		(L33)	DETERMINATION APPI	ROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245632

November 17, 2017

Ms. Kay Emerson, Administrator St. Therese of Woodbury LLC 7555 Bailey Road Woodbury, MN 55129

Dear Ms. Emerson:

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 November 1, 2017 the above facility is recommended for:

56 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 skilled nursing facility beds. You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions related to this electronic notice.

Sincerely,

Anne Retension -

Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 anne.peterson@state.mn.us Telephone #: 651-201-4206 Fax #: 651-215-9697

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 17, 2017

Ms. Kay Emerson, Administrator St. Therese of Woodbury LLC 7555 Bailey Road Woodbury, MN 55129

RE: Project Number S5632001

Dear Ms. Emerson:

On October 4, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 22, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 6, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 27, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 22, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 1, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 22, 2017, effective November 1, 2017 and therefore remedies outlined in our letter to you dated October 4, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Anne Peterson_

Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 anne.peterson@state.mn.us Telephone #: 651-201-4206 Fax #: 651-215-9697

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically delivered

November 17, 2017

Ms. Kay Emerson, Administrator St. Therese of Woodbury LLC 7555 Bailey Road Woodbury, MN 55129

Re: Project Number S5632001

Dear Ms. Emerson:

On November 6, 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 November 6, 2017, with orders received by you on October 4, 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.

Please feel free to call me with any questions related to this electronic notice.

Sincerely,

Anne Retenson_

Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 anne.peterson@state.mn.us Telephone #: 651-201-4206 Fax #: 651-215-9697

DEPARTMENT OF HEALT	H AND HUMAN	SERVICES			CENTERS FOR ME	EDICARE & MEDICAID SERVICES
	MEDIC	CARE/MEDICA	AD CERTIFI	CATION A	AND TRANSMITTAL	ID: C7VC
	PART I	- TO BE COM	PLETED BY 1	ГНЕ STAT	TE SURVEY AGENCY	Facility ID: 31025
1. MEDICARE/MEDICAID PROVIDI (L1) 245632	ER NO.	3. NAME AND A (L3) ST THERE				4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID NO	0.	(L4) 7555 BAILI	EY ROAD			3. Termination 4. CHOW
(L2) 642487100		(L5) WOODBUI	RY, MN		(L6) 55129	5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF C	OWNERSHIP	7. PROVIDER/SU	UPPLIER CATEGO	ORY	<u>02</u> (L7)	
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 09/	22/2017 (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	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	06/30
11LTC PERIOD OF CERTIFICATION	N	10.THE FACILITY	Y IS CERTIFIED A	.S:		
From (a):		A. In Compli	iance With		And/Or Approved Waivers Of The	e Following Requirements:
To (b) :			Requirements		2. Technical Personnel	6. Scope of Services Limit
		Complia	nce Based On:		3. 24 Hour RN	7. Medical Director
12. Total Facility Beds	56 (L18)	1.	Acceptable POC		4. 7-Day RN (Rural SNF)	8. Patient Room Size
13.Total Certified Beds	56 (L17)	X B Not in C	ompliance with Pro	oram	5. Life Safety Code	9. Beds/Room
13. Total Continue Deus	30 (===)		s and/or Applied W		* Code: B *	(L12)
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
56						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM.	AKKS (IF APPLICABL	E SHOW LTC CANC	ELLATION DATI	E):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	APPROVAL Date:
Robyn Woolley, HFE-NE	11	10/2	6/2017	(L19)	Anne Peterson, Enforcer	ment Specialist 10/27/2017 (L20)
	PART II - TO BI	E COMPLETED) BY HCFA R	EGIONAI	C OFFICE OR SINGLE STA	ATE AGENCY
19. DETERMINATION OF ELIGIBIL	ITY		MPLIANCE WITH	I CIVIL	21. 1. Statement of Finan	cial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)
 Facility is Eligible to 	Participate	K	ioni 5 Act.		 Both of the Above 	· · · · · · · · · · · · · · · · · · ·
2. Facility is not Eligib						
	(L21)					
22. ORIGINAL DATE	23. LTC AGREEN	IENT	24. LTC AGREE	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DA	TE	VOLUNTARY 00	INVOLUNTARY
09/08/2016					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	nt 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(1.27)			(L44)			00-Active
(L27)	B. Rescind Sus	spension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS	
		06201				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539		2. DETERMINATION		DATE	D	
51. NO RECEIFT OF UNIS-1559	32	. DETERMINATION	OF AFFRUVAL I	JAIE	Posted 10/27/2017 Co.	
	(L32)			(L33)	DETERMINATION APPR	OVAL



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 4, 2017

Ms. Kay Emerson, Administrator St. Therese Of Woodbury LLC 7555 Bailey Road Woodbury, MN 55129

RE: Project Number S5632001

Dear Ms. Emerson:

On September 22, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the eletronically attached CMS-2567 whereby corrections are required.

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

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

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor Metro A Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900

Email: susanne.reuss@state.mn.us Phone: (651) 201-3793 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 1, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 1, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

St. Therese Of Woodbury LLC October 4, 2017 Page 4

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 22, 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

St. Therese Of Woodbury LLC October 4, 2017 Page 5

the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 22, 2018 (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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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. Therese Of Woodbury LLC October 4, 2017 Page 6

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 relating to this electronic notice.

Sincerely,

Anne Retenson_

Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 anne.peterson@state.mn.us Telephone #: 651-201-4206 Fax #: 651-215-9697

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245632	B. WING			09/	22/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST THER	ESE OF WOODBURY	LLC			555 BAILEY ROAD VOODBURY, MN 55129		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	FC	000			
	a standard survey w by the Minnesota D determine if your fa requirements of 42	through September 22, 2017, was completed at your facility epartment of Health to cility was in compliance with CFR Part 483, Subpart B, and ong Term Care Facilities.					
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 279 SS=D	on-site revisit of you validate that substa regulations has bee your verification. 483.20(d);483.21(b		F 2	279			11/1/17
	assessments comp months in the resid results of the asses	nust maintain all resident leted within the previous 15 ent's active record and use the sments to develop, review dent's comprehensive care					
		Care Plans t develop and implement a son-centered care plan for					
		DER/SUPPLIER REPRESENTATIVE'S SIGN					(X6) DATE
	ically Signed	VEN/OUFFLIER REFREGENTATIVE'S SIGN	NATURE		TITLE		10/13/2017

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.

PRINTED: 10/26/2017

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/26/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245632	B. WING	à		09/2	22/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST THEF	RESE OF WOODBURY	LLC			7555 BAILEY ROAD WOODBURY, MN 55129		
(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 279	each resident, cons set forth at §483.10 includes measurabl to meet a resident's and psychosocial m comprehensive ass care plan must des (i) The services that or maintain the resi physical, mental, ar required under §483. (ii) Any services that under §483.24, §48 provided due to the under §483.10, incli- treatment under §443 (iii) Any specialized rehabilitative service provide as a result recommendations. findings of the PAS, rationale in the resident (iv)In consultation w resident's represent (A) The resident's g desired outcomes. (B) The resident's p future discharge. Fa whether the resider community was ass	istent with the resident rights (c)(2) and §483.10(c)(3), that e objectives and timeframes a medical, nursing, and mental eeds that are identified in the ressment. The comprehensive cribe the following - t are to be furnished to attain dent's highest practicable ad psychosocial well-being as 3.24, §483.25 or §483.40; and t would otherwise be required 3.25 or §483.40 but are not 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. <i>v</i> ith the resident and the tative (s)- goals for admission and preference and potential for acilities must document at's desire to return to the sessed and any referrals to ies and/or other appropriate	F	279			

		AND HUMAN SERVICES & MEDICAID SERVICES			FO	ED: 10/26/2017 RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		245632	B. WING			09/22/2017
NAME OF PROVIDER OR SUPPLIER				ST	TREET ADDRESS, CITY, STATE, ZIP CODE	
				75	555 BAILEY ROAD	
ST THEF	RESE OF WOODBURY	LLC		W	OODBURY, MN 55129	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From pa	ge 2	F 2	279		
	plan, as appropriate requirements set for section. This REQUIREMEN by: Based on document facility failed to develop include intervention 3 residents reviewe who were identified falls. Findings include: Review of the Pre-A Information form, down was being admitted fracture, and was a sheet, dated 9/20/1 fracture of neck of the R209's undated pre- note at the top of the care plan must be i admission." The do designating whethe "Fall Risk" by check- underneath the box implement safety m more boxes to check measures were in p mat, or other safety next to "other" for s measures in place for checked a box to in was a fall risk, and	a in the comprehensive care e, in accordance with the rth in paragraph (c) of this NT is not met as evidenced at review and interview, the elop a preliminary care plan to s to reduce risk of falls for 2 of d (R193, R209) for accidents, at admission as at risk for Admission Assessment ated 9/12/17, revealed R209 on 9/12/17 with a right hip t risk for falls. R209's face 7, listed diagnoses including right femur, and dementia. eliminary care plan had a typed e form that this preliminary nitiated "within 24 hours of cument included a section for r or not the resident was a king either "Yes" or "No", and the swas written, "If yes, neasures." The form contained ck if any of the following safety place: sensor, grab bars, floor r measure. There was a line taff to clarify any other safety for R209. Staff had not dicate whether or not R209 did not document that any ere in place for R209.			This plan of correction is not an admission of guilt on behalf of the provider. This plan of correction is bein submitted because it is required by law. Residents 209 and 193 are no longer at the facility. Residents have a falls careplan initiated within 24 hours of admission; to be completed within 48 hours. The facility 's policy and procedure regarding falls careplan was reviewed a revised. A comprehensive careplan for was developed and implemented for sta to use for all new admissions. Nursing staff were inserviced on the expectation and requirements of the careplan on 10/11/2017 and will continue until all licensed staff are educated. A new system of careplan binders was developed. The falls careplan will be audited for completion by nursing administration, and/or a charge nurse, 48 hours after admission. 5 careplans/week X4 weeks 3 careplans/week X4 weeks, 1 careplan/week X4 weeks will be audited	t and rm aff ss

Facility ID: 31025

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		AND HUMAN SERVICES				FORM	10/26/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245632	B. WING			09/3	22/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ST THER	ESE OF WOODBURY	(LLC			555 BAILEY ROAD /OODBURY, MN 55129		
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	registered nurse (R twice since admissi after admission on 9/17/17. RN-B desc confused." During interview on assistant (NA)-D th and came to the fac During an interview administrator clarifi plan along with the was considered to R On 9/21/17, at 3:20 nursing said staff tr common area to ke kept the call light ne room, but that she of in writing. Review of the unda Preliminary, reveale statement: "A prelim resident's immediat for each resident w admission."	9/19/17, at 11:54 a.m. (N)-B said R209 had fallen ion. The first fall was one day 9/13/17, and the second on cribed the resident as "very 9/20/17, at 7:48 a.m. nursing ought R209 fell previously, cility for falls and dementia. 7 on 9/20/17, at 2:17 p.m. the ed that the preliminary care Pre-Admission Assessment be the preliminary care plan. 9 p.m. the assistant director of ied to keep R209 in the eep an eye on the resident, and ear the resident in R209's could not find fall interventions ted policy titled, Care Plans - ed the following policy ninary plan of care to meet the te needs shall be developed ithin twenty-four (24) hours of	F 2	279	falls careplans are developed and initiated. Issues identified through auditing and QA process will be ref to the QAPI Team for input/sugges	erred	
		progress notes, dated 9/8/17,					

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		245632	B. WING _		09/	22/2017
		′LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7555 BAILEY ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	WOODBURY, MN 55129 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 279 F 282 SS=D	is on sedatives which review of the Care I within 24 hours of a off box for fall risk a No safety measures On 9/20/17 at 1:04 nursing verified the that information sho initial care plan. 483.21 (b)(3)(ii) SEF PERSONS/PER CA (b)(3) Comprehens The services provide as outlined by the c must- (ii) Be provided by the care. This REQUIREMEN by: Based on observat review, the facility fa accordance with the care for 2 of 3 reside sample who require of 3 residents (R72 oral care and 1 of 3	had fallen in the past and she ch puts her at risk for fall." A Plan -Preliminary (initiated admission) had a yes/no check and neither was checked off. s were identified. p.m. the interim director of resident was a fall risk and buld have been added to the RVICES BY QUALIFIED ARE PLAN ive Care Plans led or arranged by the facility, omprehensive care plan,	F 27	9	tandards ent s nails ident #72 vlicy and HS, and	11/1/17
	Findings include: R59 was assessed	to require staff assistance id not receive assistance in		All residents requiring assistant oral care, nail care, and turning repositioning will be provided th services in accordance with fac standards.	and ese	

Facility ID: 31025

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED	
		245632	B. WING		09/'	22/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03//	09/22/2017	
ST THEF	ESE OF WOODBUR	Y LLC		7555 BAILEY ROAD WOODBURY, MN 55129			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 282	accordance with th Document review of (MDS) dated 1/28/ cognitively intact ar (CAA) indicated R5 activities of daily liv for R59 dated 1/1/1 resident's finger an weekly bath". Docu Skin Assessment fo weeks verified nail R59. During an observat R59 had fingernails finger tips greater t dirty with dark tan a accumulated under fingernails had brol When interviewed of expressed frustration long and staff had of fingernails. Further substance under the feeding self without fingernails for "mar R72 was assessed with nail care and of assistance in accord interventions. Document review of Set), dated 8/25/17 and the CAA indica	e plan of care interventions. of R59's Minimum Data Set 17, indicated R59 was nd the Care Area Assessment 59 required staff assistance for ring (ADLs). The plan of care 17, read, "Staff to trim d toe nails as needed following iment review of the Weekly or weekly baths the previous 6 care was not performed for tion on 9/19/17, at 9:11 a.m. is that extended beyond the han 1/4th inch and appeared and brown substance r each nail. Two of the 10 ken side, jagged edges. on 9/19/17, at 9:11 a.m. R59 on that the fingernails are too not offered to clean or trim the more, R59 indicated the he nails was from "food" and t soaking or cleaning the	F 28	2 The facility provided education of care, nail care, and turning and repositioning starting on 9/27/20 will continue until all are completed in the completed of the completed	017 and ted. completed s, 3/week veeks. 3 or d 1/week uring that is policy and lentified process		

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		AND HUMAN SERVICES			FORM	10/26/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245632	B. WING		09/2	22/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST THEF	RESE OF WOODBURY	(LLC		7555 BAILEY ROAD NOODBURY, MN 55129		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	hygiene BID (twice (bedtime). Dressing Resident needs ass grooming due to os Staff to trim Reside needed following w of the Weekly Skin the previous 6 weel performed for R72 During an observat R72 had fingernails fingertips greater th dirty with dark tan a accumulated under had a heavy film of upper teeth which F being offered assist R72 had own top te During an observat until 12:00 p.m., R7 oral care. R72 state myself because of th hands, it is just too expressed frustration nail care and espect oral care which the weeks. Document review of Care and Nail Care assure adequate hy measures".	age 6 a day) in the AM and at HS g/Personal hygiene/Bathing: sist with dressing and steoarthritis and carpal tunnel. m't finger and toe nails as eekly bath." Document review Assessment for weekly baths,, ks verified nail care was not ion on 9/19/17, at 9:58 a.m. that extended beyond the nan 1/4th inch and appeared and brown substances each nail. Furthermore, R72 tan yellow substance on the R72 indicated was from not tance to brush teeth every day. eeth but no bottom teeth. ion on 9/20/17, from 7:00 a.m. 72 was not offered nail care or ed, "I cannot take care of the carpal tunnel in both painful." Furthermore, R72 on that the staff do not offer cially expressed a desire for staff have not offered for of the facility policy titled, Oral e, dated 11/9/07, read, "To ygiene and grooming on 9/20/17, at 2:00 p.m. NA)-C verified oral care and een performed for R72.	F 282			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/26/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245632	B. WING			09/	22/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST THER	ESE OF WOODBURY	LLC			555 BAILEY ROAD VOODBURY, MN 55129		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 282	interim director of n facility expectation f nail care every wee necessary. Oral car day for all resident's R59 did not receive and 15 minutes. R59 was assessed with a stage 2 press cleft according to th Interventions includ reposition Q2H (eve (whenever necessa (mechanical lift) for ambulate. Document review o Repositioning, date- review the resident' special needs of the When interviewed of nursing assistant (N were working togeth had not been perfor into the wheel chair When interviewed of interim director of n expectation for reside breakdown would b according to the assistant.	on 9/21/17, at 12:21 p.m. the ursing (IDON) verified the for grooming would include k with bathing and whenever re would be expected twice a s. a position change for 4 hours as at risk for skin breakdown sure ulcer on the right gluteal he plan of care, dated 8/30/17. e assist of 1-2 staff to ery 2 hours) and prn may, total assist of 2 with Hoyer transfers, resident does not f the facility policy titled, d May 2013, directed to s care plan to evaluate for any e resident. on 9/20/17, at 2:30 p.m. NA)-A, NA-B & NA-C, who her,verified repositioning Q2H rmed for R72 since getting up at 10:13 a.m. on 9/21/17, at 12:21 p.m. the ursing verified the facility dents assessed with skin e to reposition every 2 hours sessment and the plan of		282			11/1/17
F 309 SS=D		PROVIDE CARE/SERVICES	F3	309			11/1/17

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		AND HUMAN SERVICES				FORM	10/26/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245632	B. WING	i		09/;	22/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ST THER	RESE OF WOODBURY	LLC			555 BAILEY ROAD VOODBURY, MN 55129		
(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 309	Continued From pa	ge 8	F:	309			
	applies to all care a residents. Each res facility must provide services to attain or practicable physica well-being, consiste comprehensive ass 483.25 Quality of care Quality of care is a applies to all treatm facility residents. Ba assessment of a re that residents recei accordance with pro- practice, the compre- care plan, and the re but not limited to the (k) Pain Management The facility must emprovided to residen consistent with pro- the comprehensive and the residents' generative (l) Dialysis. The face residents who requi- services, consistent of practice, the com- care plan, and the re preferences. This REQUIREMENt by:	undamental principle that and services provided to facility sident must receive and the e the necessary care and r maintain the highest l, mental, and psychosocial ent with the resident's sessment and plan of care. are fundamental principle that hent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of rehensive person-centered residents' choices, including e following:			Resident #98 is being weighed da	ily per	
		nt review and interview, the blete a physician order of daily			MD orders.	ly per	

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	E SURVEY PLETED
				i		
		245632	B. WING		09/	22/2017
	PROVIDER OR SUPPLIER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 7555 BAILEY ROAD WOODBURY, MN 55129		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 309 F 312 SS=D	resident (R98) revi Findings include: Record review for order, dated 5/26/1 Thursdays, Saturd Report also contain 6/29/17, that read, breakfast" A We for R98 from 7/20/ weights recorded. When interviewed licensed practical r was the responsibi obtain and record t explained that she that the daily weigh record of R98, and nursing assistants they told her that th weights and record record, and they qu something wrong v software. The interim directo about the missing and she replied that malfunction of the the weight scales i 483.24(a)(2) ADL C DEPENDENT RES	ent receiving dialysis for 1 of 1 ewed for dialysis. R98 revealed a physicians's 17, for dialysis Tuesdays, ays. The Order Summary ned a physician's order, dated "Weight daily before sights and Vitals Summary form 17 to 9/21/17 at 1:47 p.m., nurse (LPN)-C stated that it lity of the nursing assistants to the daily weights. She has noticed in the recent past its were not all in the electronic when she reminded the to complete the daily weights ney were doing the daily ding them in the electronic uestioned if there was with the electronic record or of nursing was interviewed weights on 9/21/17 at 2 p.m. at she was not aware of any electronic record software or in the facility. CARE PROVIDED FOR SIDENTS ho is unable to carry out	F 309	A list of all residents in the facility daily weights was obtained and r These individuals are having the obtained daily per orders. Nursing staff were educated on of daily weights starting on 9/27/20 will be ongoing until completion. facility reviewed the system for of daily weights. Residents with daily weights will audited daily for 1 month. The DON is responsible for ensu- daily weights are obtained per M Issues identified through facility a and QA process will be referred to QAPI Team for input/suggestions	eviewed. ir weights obtaining 17 and The obtaining be uring that D orders. auditing to the	11/1/17

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TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
				IG			
		245632	B. WING _	STREET ADDRESS, CITY, STATE, ZIP C		22/2017	
	PROVIDER OR SUPPLIER	(LLC		7555 BAILEY ROAD WOODBURY, MN 55129	CODE		
(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 DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 312	services to maintain personal and oral h This REQUIREMEN by: Based on observar review, the facility f hygiene care for 2 of the sample who we personal cares. Findings include: R59 was assessed with nail care and of accordance with the During an observat R59 had fingernails finger tips greater t dirty with dark tan a accumulated under fingernails had brok When interviewed of expressed the finge had not offered to of Furthermore, R59 i the nails was from soaking or cleaning weeks." During an observat R59 continued to h two broken, jagged Document review of (MDS) dated 1/28/1	n good nutrition, grooming, and	F 31	 Residents number 59 and 5 care per the facility policy ar of care. All residents requiring assis care will are provided these accordance with facility star The facility provided educat care beginning on 9/27/201 ongoing until completion. Random nail care audits wil on 5 residents/week for 4 w for 4 weeks, and 1/week for The DON is responsible for nail care is provided to resid facility policy and standards Issues identified through fac and QA process will be refe QAPI Team for input/sugges 	nd standards tance with nail services in adards. ion on nail 7 and will be I be completed eeks, 3/week 4 weeks. ensuring that dents per of practice. cility auditing rred to the		

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	10/26/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245632	B. WING	<u></u>		09/:	22/2017
NAME OF I	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST THEF	RESE OF WOODBURY	(LLC			7555 BAILEY ROAD WOODBURY, MN 55129		
	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(¥5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	IX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 312	Continued From pa	age 11	 F:	312			
		ing (ADLs). The plan of care		0.2			
		7, read, "Staff to trim					
		d toe nails as needed following ument review of the Weekly					
	Skin Assessment for	or weekly baths the previous 6					
	weeks verified nail R59.	care was not performed for					
		to require staff assistance					
		oral care and did not receive					
	interventions.	rdance with the plan of care					
	R72 had fingernails	tion on 9/19/17, at 9:58 a.m. Is that extended beyond the nan 1/4th inch and appeared					
	dirty with dark tan a	and brown substances					
		r each nail. Furthermore, R72 tan yellow substance on the					
		R72 indicated was from not					
		tance to brush teeth every day. beth but no bottom teeth.					
	h/2 had own top te						
		tion on 9/20/17, from 7:00 a.m.					
		2 was not offered nail care or ed, "I cannot take care of					
	myself because of t	the carpal tunnel in both					
		painful." Furthermore, R72					
		on that the staff do not offer cially expressed a desire for					
		staff have not offered for					
		of R72's MDS dated 8/25/17, ent was cognitively intact and					
		staff assistance for ADL's. The					
		2 dated 3/20/17, read, "Oral					
		ide set up for oral hygiene BID AM and at HS (bedtime).					

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		AND HUMAN SERVICES			FORM	10/26/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DAT	E SURVEY PLETED
		245632	B. WING	 	09/	22/2017
NAME OF	PROVIDER OR SUPPLIER		•	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST THEF	RESE OF WOODBUR	(LLC		555 BAILEY ROAD VOODBURY, MN 55129		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312 F 314 SS=D	Dressing/Personal needs assist with d osteoarthritis and c Residen't finger and weekly bath." Docu Skin Assessment fo weeks verified nail R72 Document review of Care and Nail Care assure adequate hy measures." When interviewed of nursing assistant (N nail care had not be When interviewed of interim director of r expectation for group every week with ba necessary. Oral ca day for all residents 483.25(b)(1) TREA PREVENT/HEAL P (b) Skin Integrity - (1) Pressure ulcers comprehensive assist facility must ensure (i) A resident receiv professional standa pressure ulcers and ulcers unless the in	hygiene/Bathing: Resident ressing and grooming due to arpal tunnel. Staff to trim d toe nails as needed following ment review of the Weekly or weekly baths the previous 6 care was not performed for of the facility policy titled, Oral e, dated 11/9/07, read, "To ygiene and grooming on 9/20/17, at 2:00 p.m. NA)-C verified oral care and een performed for R72. on 9/21/17, at 12:21 p.m. the nursing verified the facility oming would include nail care thing and whenever re would be expected twice a s. TMENT/SVCS TO PRESSURE SORES	F 3			11/1/17

Facility ID: 31025

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PRINTED: 10/26/2017 FORM APPROVED

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/26/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245632	B. WING			09/:	22/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST THEF	RESE OF WOODBURY	LLC			555 BAILEY ROAD /OODBURY, MN 55129		
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 13	F	314			
	necessary treatmen professional standa healing, prevent inf from developing. This REQUIREMEN by: Based on observat review, the facility fi identified at risk for timely repositioning the sample identified Findings include: R59 did not receive for 4 hours and 15 During an observat R59 was sitting up bedroom. When interviewed of regarding the frequi indicated it was not chair without any st the afternoon. R59 buttocks but was un not experience pair Document review of (MDS), dated 1/28/ cognitively intact ar (CAA) indicated R5 ulcer. The document Predicting Pressure	ion on 9/19/17, at 3:00 p.m. in the wheel chair in the on 9/19/17, at 3:00 p.m. ency of position changes, R59 unusual to sit up in the wheel aff offers to change position in was aware of an open area on hable to feel pressure and did			Resident #59 is turned and reposit 2 hours per plan of care. Individuals requiring q 2 hour turnin repositioning were identified; they a repositioned per policy. Nursing staff were inserviced begin on 9/27/2017, and ongoing, regardit turning and repositioning dependen residents. 3 residents/week will be audited for repositioning for 4 weeks, 2 residents/week for 4 weeks, and 1/ for 4 weeks. The DON is responsible for ensurin residents are turned and reposition facility standards and standards of practice.	ng and are nning ing nt week week	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/26/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245632	B. WING	ì		09/2	22/2017
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST THEF	RESE OF WOODBURY	LLC			7555 BAILEY ROAD WOODBURY, MN 55129		
(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 314	 8/30/17, indicated F for skin breakdown on the right gluteal assist of 1-2 staff to hours) and prn (who of 2 with Hoyer for ta ambulate. Document review of 6/6/17, read resider hours three times d in wheelchair longe reposition every 2 fr Document review of Repositioning, date review the resident' special needs of the During continuous of 7:00 a.m. until 10:1 positioned partially no offers to change 10:13 a.m. R59 was the mechanical lift a chair. At 11:00 a.m accompany family v and go to lunch in a 1:17 p.m. R59 retur family members. At had not offered any getting out of bed a When interviewed of nursing assistant (N working together, ven not been offered or 	f the plan of care dated R59 was assessed as at risk with a stage 2 pressure ulcer cleft. Interventions included o reposition Q2H (every 2 enever necessary), total assist transfers, resident does not f the physician order, dated ht should be up in chair 1-2 aily. resident should not be up r than 2 hours at a time, nours while in bed. f the facility policy titled, d May 2013, directed to s care plan to evaluate for any e resident. bbservation on 9/20/17, from 3 a.m., R59 remained in bed on the right side. There were position while in bed. At s transferred from bed using and positioned in the wheel . R59 left the unit to who also resided at the facility, another area of the facility. At red to the bedroom with : 2:30 p.m. R59 verified staff position changes since	F	314			

Facility ID: 31025

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245632	B. WING			09/:	22/2017
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ST THER	RESE OF WOODBURY	LLC			55 BAILEY ROAD OODBURY, MN 55129		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 15	F 3	314			
F 323 SS=D	interim director of n facility expectation f skin breakdown wor hours according to to of care. If a residen report to the nurse a resident. 483.25(d)(1)(2)(n)(1 HAZARDS/SUPER' (d) Accidents. The facility must en (1) The resident env from accident hazar (2) Each resident re and assistance dev (n) - Bed Rails. The appropriate alternat bed rail. If a bed or must ensure correc maintenance of bed to the following elem (1) Assess the resident from bed rails prior (2) Review the risks the resident or resident informed consent per (3) Ensure that the fappropriate for the resident of the following (3) Ensure that the fappropriate for the following for the following for the following for the fappropriate for the following for the fappropriate fappropria	vironment remains as free rds as is possible; and eccives adequate supervision ices to prevent accidents. e facility must attempt to use tives prior to installing a side or side rail is used, the facility it installation, use, and d rails, including but not limited ments. dent for risk of entrapment to installation. s and benefits of bed rails with dent representative and obtain	F3	323			11/1/17

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PRINTED: 10/26/2017

			()(0) 10 11 -			. 0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED		
		245632	B. WING _			22/2017		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE			
ST THEF		(LLC	7555 BAILEY ROAD WOODBURY, MN 55129					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE		
F 323		lge 16	F 32	23				
	observations, the fa interventions to red residents (R209) re- identified upon adm fell twice in the faci Findings include: Review of the Pre-/ Information form, d was being admitted fracture, and was a sheet, dated 9/20/1 fracture of neck of R209's undated pre- note at the top of th care plan must be i admission." The do designating whether "Fall Risk" by check underneath the box implement safety m more boxes to check measures were in p mat, or other safety next to "other" for s measures with in safety next to "other" for s measures were checked a box to in was a fall risk, and safety measures w The Kardex Report	Admission Assessment ated 9/12/17, revealed R209 d on 9/12/17 with a right hip it risk for falls. R209's face 7, listed diagnoses including right femur, and dementia. eliminary care plan had a typed be form that this preliminary nitiated "within 24 hours of ocument included a section for er or not the resident was a king either "Yes" or "No," and kes was written, "If yes, neasures." The form contained ck if any of the following safety place: sensor, grab bars, floor y measure. There was a line taff to clarify any other safety for R209. Staff had not ndicate whether or not R209 did not document that any ere in place for R209.		Resident number 209 is norresident at the facility. The facility 's policy and proregarding falls interventions and revised where necessal interventions are identified of care for residents at risk for Licensed staff were inservice implementing falls intervent beginning on 10/11/2017 arongoing. The falls interventions will for a charge nurse, 48 h admission. 5 careplans/week X4 weeks were a careplan/week X4 weeks were a careplan/week X4 weeks were falls interventions are developed initiated. Issues identified to the QAPI Team for input/	ocedure a was reviewed ry. Falls on the plan of falls. eed on tions ad will be be audited for nistration, nours after ek X4 weeks, s, 1 ill be audited. ensure that oped and hrough facility Il be referred			

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		AND HUMAN SERVICES				FORM	10/26/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245632	B. WING			09/;	22/2017
NAME OF !	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST THEF	RESE OF WOODBURY	(LLC			555 BAILEY ROAD VOODBURY, MN 55129		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	that R209 needed a the resident's waist while walking or tra assistance of one s did not specifically if falling. During interview on registered nurse (R twice since admissi after admission on 9/17/17. RN-B desc confused." Review of a fall rep 12:25 a.m. R209 fe incident description in her wheelchair at hitting the left elbow interventions were Review of a fall rep R209 was found in in the resident's root said R209 was four floor, and explained bathroom, and fell the note dated 9/17/17 on call light use." N noted on this report In an an occupation services completed date 9/15/17, the of attending a care co summary described precautions, but the the precautions disc	a gait belt (a belt worn around for staff to assist with balance insferring), and limited staff person to walk. The report indicate R209 was at risk of 9/19/17, at 11:54 a.m. RN)-B said R209 had fallen ion. The first fall was one day 9/13/17, and the second on cribed the resident as "very port dated 9/13/17, revealed at ell in the common area. The in described R209 standing up nd falling down onto the floor, w and hip on the floor. No new noted in this report. Fort dated 9/17/17, revealed the doorway of the bathroom om. The incident description ind laying on the left side on the d was coming back from the backwards. The fall progress revealed R209 was "educated to other new interventions were	F 3	323			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY	
	ST GOTTILE TION	DENTRIGATION NONDER.		à	001		
-		245632	B. WING		09/	22/2017	
	PROVIDER OR SUPPLIER	YLLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7555 BAILEY ROAD WOODBURY, MN 55129			
(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) COMPLETIC DATE	
F 323	the call light to ask During observation door to R209's roo inches. Through th seen sitting on the time, RN-B was pa when asked by the alone in the room, RN-B knocked on just getting dresse RN-B asked R209 room helping the ro replied, "Give me f confirmed that then the resident. RN-B dressed, but clarifie went to find a nurs resident. At 7:37 a. entered R209's roo edge of the bed dre NA-D and the resid wear that day, and dressing. At 7:40 a help R209 put show resident to remain R209 already went replied, "Yes." At th up from the edge of NA-D said, "[R209]	for help with toileting. for help with toileting. a on 9/20/17, at 7:33 a.m. the m was open by a couple e opening, R209 could be edge of the bed. Around this assing in the common area e surveyor whether R209 was or with a nursing assistant. R209's door. R209 replied, "I'm d, give me ten more minutes." if there was anyone in the esident get ready, and R209 ive more minutes." RN-B re was nobody currently helping said R209 was trying to get ed that R209 needed help, and ing assistant to help the .m. nursing assistant (NA)-D om to help. R209 sat at the essed in a shirt and underwear. dent discussed what clothes to NA-D assisted the resident in n.m. NA-D explained needing to es on, and directed the seated. NA-D asked whether to the bathroom, and R209 his time, R209 began to stand of the bed without assistance.], no, [R209], sit down please!	F 323				
	dressed, but clarific went to find a nurs resident. At 7:37 a. entered R209's roc edge of the bed dro NA-D and the resid wear that day, and dressing. At 7:40 a help R209 put sho resident to remain R209 already went replied, "Yes." At th up from the edge of NA-D said, "[R209] Thank you." R209 while NA-D put sho helped transfer R2 bringing R209 to th and brush teeth. At	ed that R209 needed help, and ing assistant to help the .m. nursing assistant (NA)-D om to help. R209 sat at the essed in a shirt and underwear. dent discussed what clothes to NA-D assisted the resident in .m. NA-D explained needing to es on, and directed the seated. NA-D asked whether to the bathroom, and R209 his time, R209 began to stand of the bed without assistance.					

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		AND HUMAN SERVICES				FORM	10/26/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245632	B. WING			09/:	22/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST THEF	RESE OF WOODBURY	LLC			555 BAILEY ROAD VOODBURY, MN 55129		
(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 323	was already wearing entered the room to thought R209 must independently that in not supposed to wa that R209 had previ- facility for falls and in R209 was able to un depended on how un R209 had an urgen probably not use the During interview on family member (FM fallen previously, ar R209 getting up wit R209 would get up if the resident felt th wondered if the fact worried R209 would was nobody around During an interview RN-B said staff wer interventions after F how staff kept R208 R209 to use the call the resident's room During interview on asked if R209 had never NA-E didn't know for R209 was at risk fo walking. NA-E expla- always wanting to g down again, and vio NA-E had to keep a	g underwear when NA-D b help with cares, so NA-D have started getting ready morning. NA-D said R209 was alk unassisted, and thought ious falls, and came into the dementia. When asked if se a call light, NA-D thought it urgent the need, explaining if t need, the resident would e call light for help. 9/20/17, at 11:47 a.m. R209's I)-F explained that R209 had hd knew that staff did not want hout help. FM-F thought that and go to the bathroom alone he need to void. FM-F ility was short staffed, and d get up independently if there	F	323			

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		AND HUMAN SERVICES				FORM	10/26/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245632	B. WING			09/;	22/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST THER	ESE OF WOODBURY	LLC			555 BAILEY ROAD VOODBURY, MN 55129		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From pa	ige 20 non area, or R209 might try to	F:	323			
	transfer alone.	for area, or R209 might try to					
	assistant director of keep R209 in the co on the resident, and	9/21/17, at 3:20 p.m. the f nursing said staff tried to ommon area to keep an eye d kept the call light near the room, but that she could not is in writing.					
F 325	policy, dated 4/16, r assessed upon adm for falls. If deemed prevention/reductio implemented and for "It will be noted on t assignment sheets falls." The policy co reviewed by the inter- falls will be monitored taken to prevent rep recommended by th members and the re- will be documented fall event The res updated as needed appropriate." 483.25(g)(1)(3) MA	n program would be bllowed. The policy required, the [nursing assistant] any resident at high risk for ontinued, "All falls will be erdisciplinary team. Resident ed and appropriate actions peat occurrences as he interdisciplinary team ecommendations/interventions in the evaluation of the post sident's care plan will be to reflect interventions as	F	325			11/1/17
SS=D	both percutaneous percutaneous endo enteral fluids). Base	n and hydration. tric and gastrostomy tubes, endoscopic gastrostomy and scopic jejunostomy, and ed on a resident's sessment, the facility must					

Facility ID: 31025

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		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 10/26/2017 M APPROVED D. 0938-0391			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY			
		245632	B. WING			9/22/2017			
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE				
ST THERESE OF WOODBURY LLC				7555 BAILEY ROAD WOODBURY, MN 55129					
(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F 325	Continued From pa	ge 21	F	325					
	status, such as usu body weight range a the resident's clinica this is not possible indicate otherwise;	table parameters of nutritional al body weight or desirable and electrolyte balance, unless al condition demonstrates that or resident preferences apeutic diet when there is a							
	nutritional problem orders a therapeutic This REQUIREMEN by: Based on documen facility did not comp weights for a reside	and the health care provider c diet. NT is not met as evidenced nt review and interview, the plete a physician order of daily ent receiving dialysis and t loss for 1 of 1 resident (R98)			Resident #98 is being weighed daily per MD orders. A list of all residents in the facility requirin daily weights was obtained and reviewed These individuals are having their weight obtained daily per orders				
	order, dated 5/26/1 Thursdays, Saturda Report also contain 6/29/17, that read, ' breakfast" A Wei for R98 from 7/20/1 weights recorded. O listed as 164 lbs. ar When interviewed o licensed practical n the responsibility of obtain and record th explained that she h that the daily weigh record of R98, and	R98 revealed a physicians's 7, for dialysis Tuesdays, ays. The Order Summary ed a physician's order, dated 'Weight daily before ghts and Vitals Summary form 7 to 9/21/17 showed only 16 On 7/20/17 R98's weight was and 140 lbs. on 9/19/17. On 9/21/17 at 1:47 p.m., urse (LPN)-A stated that it was the nursing assistants to be daily weights. She has noticed in the recent past ts were not all in the electronic when she reminded the o complete the daily weights			Nursing staff were educated on obtaining MD/NP ordered daily weights starting on 9/27/2017 and will be ongoing until completion. The facility reviewed the system for obtaining daily weights. Residents with daily weight orders will be audited daily for 1 month. The DON is responsible for ensuring that daily weights are obtained per MD orders Issues identified through facility auditing and QA process will be referred to the QAPI Team for input/suggestions.				

		AND HUMAN SERVICES				FORM	10/26/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
		245632	B. WING			09/2	22/2017
NAME OF I	PROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ST THEF	ESE OF WOODBURY	LLC			555 BAILEY ROAD /OODBURY, MN 55129		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325 F 329 SS=D	they told her that th weights and record record, and they qu something wrong w software. The interim director about the missing v and she replied tha malfunction of the e the weight scales in When interviewed of registered dietician on nutritional high r receiving dialysis. S resident has experi- months and had be supplement and ne meals. She explain- daily weights were no resident's record an nursing staff about 483.45(d) (e)(1)-(2) FROM UNNECESS 483.45(d) Unneces Each resident's dru unnecessary drugs drug when used	ey were doing the daily ing them in the electronic estioned if there was with the electronic record of nursing was interviewed weights on 9/21/17 at 2 p.m. t she was not aware of any electronic record software or in the facility. On 9/21/17 at 10:27 a.m., (RD)-A stated that R98 was isk monitoring related to She was also aware that the enced weight loss in recent en receiving a nutritional eded more assistance at ed that she noticed that the not consistently in the hd she had spoken with the inconsistency. DRUG REGIMEN IS FREE SARY DRUGS sary Drugs-General. g regimen must be free from . An unnecessary drug is any se (including duplicate drug uration; or		325			11/1/17

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURV COMPLETE		
		IDENTIFICATION NUMBER.	A. BUILDIN	G	GOMPLETE	COMPLETED	
		245632	B. WING _		09/22/20	17	
				STREET ADDRESS, CITY, STATE, ZIP CODE 7555 BAILEY ROAD			
		ATEMENT OF DEFICIENCIES		WOODBURY, MN 55129 PROVIDER'S PLAN OF CORRECT			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMP	(X5) PLETIO DATE	
F 329	Continued From pa	age 23	F 32	9			
	(4) Without adequate indications for its use; or						
		e of adverse consequences dose should be reduced or					
		ons of the reasons stated in through (5) of this section.					
		ropic Drugs. ehensive assessment of a y must ensure that					
	drugs are not given medication is nece	have not used psychotropic In these drugs unless the Issary to treat a specific Issed and documented in the					
	gradual dose reduce interventions, unlease an effort to discont	use psychotropic drugs receive ctions, and behavioral ss clinically contraindicated, in inue these drugs; NT is not met as evidenced					
	Based on docume facility failed to ens excessive medicat residents (R48) rev medications receiv acetaminophen (gr a 24 hour period, a non-pharmacologic	ent review and interview, the sure residents did not receive ion doses when 1 of 5 viewed for unnecessary red excessive doses of reater than 4,000 milligrams) in and failed to identify cal interventions for the use of for sleep for 1 of 5 residents		Resident number 48 s medicati regimen was reviewed for total m Acetaminophen potential per day MD/NP was updated and orders to ensure that if resident took all PRN doses, that she would not e grams of Acetaminophen. Resid has a sleep careplan with nonpharmacological interventions	ng of changed allowable exceed 4 ent #66		

Facility ID: 31025

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	RS FOR MEDICARE OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II T	IPLE CONSTRUCTION		<u>. 0938-039</u> E SURVEY	
		A. BUILDING			COMPLETED		
		245632	B. WING _			09/22/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
ST THEF	RESE OF WOODBUR	(LLC	7555 BAILEY ROAD WOODBURY, MN 55129				
(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 AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
F 329	admitted to the faci admission, provider medication orders f brand name: Tylend and as needed for According to the Ur Administration (FD/ can cause serious directed is used." T practice for adults i milligrams (mg) of a period. Review of the medi revealed R48 recei acetaminophen on admission to the fa -8/26/17: received -8/26/17: received -8/26/17: received -8/26/17: received -9/10/17: received -8/27/17: received -8/26/17: received -8/27/17: received -8/26/17: rece	ission record revealed R48 lity on 8/19/17. Since rs prescribed R48 various for acetaminophen (common ol), both at scheduled times pain. hited States Food and Drug A) website, "Acetaminophen liver damage if more than The current standard of s not to exceed 4,000 acetaminophen in a 24 hour ication administration record ved greater than 4,000 mg of the following days since cility: 4,950 mg 4,450 mg 4,600 mg 4,100 mg hophen orders since admission ing history of provider orders: ablet 500 mg: give 1000 mg by or pain. Started 8/24/17 at 18/24/17 at 2104. ablet 500 mg: give 1000 mg by day for pain. Started 8/26/17 at	F 32	29 reviewed for Acetaminophen a ensure they do not exceed 4 g Residents taking a medication have a sleep careplan with nonpharmacological intervention The nursing staff were inservice Acetaminophen dosing regula sleep careplans with nonpharm interventions beginning on 10/ and ongoing until completed. consultant pharmacist reviews medications regimens monthly Acetaminophen dosing, his/he will be sent to the DON for ordor Random new admission audits completed for Acetaminophen nonpharmacological interventi residents/week for 4 weeks, 2 residents/week for 4 weeks, a resident/week for 1 week. The DON is responsible for err the Pharmacist recommendati acted upon and that sleep care developed with inclusion of nonpharmacological interventi included. The Pharmacist will audit reports at QAPI with the areas of improvement. Result audits will be forwarded to the QAPI meeting for input/sugges	rams/day. for sleep ons. ced on tions and nacological 11/2017 The v to audit for r findings er changes. s will be dosing and ons: 3 nd 1 suring that ons are eplans are l review her Team for s of the facility s		

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CENTE		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU			FORM MB NO	: 10/26/2017 APPROVED . 0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,				IPLETED
		245632	B. WING	i		09/	22/2017
NAME OF I	PROVIDER OR SUPPLIER	·	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
ST THEF	ESE OF WOODBUR	(LLC			7555 BAILEY ROAD WOODBURY, MN 55129		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	mouth three times a Maximum (Max) Ad mg/24 hours. Starte Discontinued 8/29/ -Acetaminophen Ta mouth three times a Acetaminophen do Started 8/29/17 at 1406. -Acetaminophen Ta mouth four times a Acetaminophen do Started 8/19/17 at 1211. -Acetaminophen Ta mouth four times a Acetaminophen Ta mouth four times a Acetaminophen Ta mouth four times a Acetaminophen do Started 8/24/17 at 2104. -Hydrocodone-Acet Give 2 tablet by mo for pain. Max Aceta hours. Started 8/19 8/29/17 at 1236. -Hydrocodone-Acet Give 2 tablet by mo for pain. Max Aceta hours. Started 8/29 8/29/17 at 1630. -Hydrocodone-Acet Give 2 tablet by mo for pain. Max Aceta hours. Started 8/29 8/29/17 at 1630. -Hydrocodone-Acet Give 2 tablet by mo for pain. Max Aceta hours. Started 8/29 8/29/17 at 1630.	ablet 500 mg: Give 500 mg by a day for osteoarthritis. Setaminophen dose: 3000 ed 8/25/17 at 0800. 17 at 1237. ablet 500 mg: give 500 mg by a day for osteoarthritis. Max se: 3,000 mg/24 hours. 1800. Discontinued 9/21/17 at ablet 500 mg: Give 500 mg by day for osteoarthritis. Max se: 3,000 mg/24 hours. 1700. Discontinued 8/24/17 at ablet 500 mg: Give 500 mg by day for osteoarthritis. Max se: 3,000 mg/24 hours. 1700. Discontinued 8/24/17 at ablet 500 mg: Give 500 mg by day for osteoarthritis. Max se: 3,000 mg/24 hours. 1700. Discontinued 8/24/17 at taminophen Tablet 5-325 mg: buth every 6 hours as needed uninophen dose: 4,000 mg/24 /17 at 1530. Discontinued taminophen Tablet 5-325 mg: buth every 6 hours as needed uninophen dose: 4,000 mg/24 /17 at 1530. Discontinued	F	329			

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STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DAT	0938-039 E SURVEY PLETED
		245632	B. WING			09/	22/2017
NAME OF	PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	00/	
ST THEF		(LLC			7555 BAILEY ROAD WOODBURY, MN 55129		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 329	"as needed" orders the total acetamino potentially given per 4,000 mg: -8/20/17-8/23/17: P -8/24/17: Potential -8/26/17-8/28/17: P -8/29/17-9/4/17: Potential -8/29/17-9/20/17: Potential -8/29/17-9/20/17: Potential -9/5/17-9/20/17: Potent	48 had requested all available Listed below are dates when phen staff could have r provider order exceeded otential of 4,600 mg of 5,600 mg otential of 5,100 mg tential of 4,425 mg tential of 4,425 mg tential of 4,100 mg 9/21/17, at 1:08 p.m. N)-C reviewed the medication rd for September and verified 19/19/17, R48 received 4,100 en. RN-C confirmed the lers on those dates, and the medication as ordered eived greater than 4,000 total in one day. RN-C confirmed maximum acetaminophen dication orders, and was b should have no more than mg acetaminophen daily. with the provider, and 0.m. that R48's maximum daily to be 4,000 mg of 9/22/17, at 9:38 a.m. the lated the total acetaminophen 27/17, and confirmed R48 acetaminophen, based on the	F3	329	9		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245632	B. WING			09/;	22/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 555 BAILEY ROAD		
ST THER	ESE OF WOODBURY	LLC			VOODBURY, MN 55129		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From pa	ge 27	F 3	29			
	resident had a diag	ician orders indicated the nosis of insomnia, and was ne HCI 25 mg orally at ia.					
	7/6/17 indicated the dementia and psych	num data set (MDS) dated e resident had diagnoses of notic disorder. The MDS taking antipsychotic and dications.					
	completed on 9/20/ reflect any identification insomnia and did no	tronic current care plan was 17. The care plan did not ation of a problem with ot identify any Il interventions for insomnia.					
F 371 SS=E	nursing reviewed th insomnia was not in did not identify nong for insomnia. 483.60(i)(1)-(3) FOO	p.m. the interim director of e care plan and verified included in the care plan and oharmacological interventions OD PROCURE, /SERVE - SANITARY	F 3	71			11/1/17
		I from sources approved or tory by federal, state or local					
		food items obtained directly s, subject to applicable State gulations.					
		pes not prohibit or prevent produce grown in facility					

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PRINTED: 10/26/2017

		AND HUMAN SERVICES			FO	RM AF	0/26/2017 PPROVED 938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION (X3)		URVEY	
		245632	B. WING			09/22/2017		
NAME OF I	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ST THEP		(LLC			555 BAILEY ROAD VOODBURY, MN 55129			
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 371	safe growing and for (iii) This provision of from consuming for (i)(2) - Store, preparation accordance with preservice safety. (i)(3) Have a policy foods brought to revisitors to ensure standling, and cons This REQUIREMENT by: Based on observation review, the facility f food in a manner the failed to wash dishes for sanitization. This of 53 residents (rest Hawthorn units) in the survey. Findings include: During a dining observent the residents in the up room trays for reviows. FS-A wore a and off the head, and that was secured in head. The slipping the nape of the neo- of the kitchenette we	compliance with applicable ood-handling practices. does not preclude residents ods not procured by the facility. are, 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	DS-A is no longer with St. Therese of Woodbury. Staff wear hairnets covering their hair adequately, they wash their hands and utilize gloves per policy/standards, thermometers are disinfected properly between foods, chemical sanitzer is us in the dish machines and its tested da Dining staff were inserviced beginning 9/27/2017 and will be ongoing until completed on: hairnet usage, hand washing standards, glove use, disinfect thermometer probes, infection control basics, chemical testing for dish machines, and safe food handling to minimize risk of foodborne illnesses. 3 audits/week X4 weeks, 2 audits/week X4 weeks, 1 audit/week X4 weeks will to completed on hairnet compliance, hand washing, dish machine chemical testing	ing be		

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PRINTED: 10/26/2017 FORM APPROVED

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MELT	PLE CONSTRUCTION		<u>. 0938-039</u> E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:			· /	IPLETED	
		245632	B. WING		09/	22/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ST THEF		Y LLC		7555 BAILEY ROAD WOODBURY, MN 55129			
(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) COMPLETIC DATE	
F 371	set the plates in fro away from the face back into the kitcher two more plates of hygiene. After drop returned to the kitch plates of food, used silverware from the the kitchenette said RESTRAINTS MUS At 5:30 p.m. the dir entered the kitcher wearing gloves. Th hairnet that was fal asking, "Is it falling hairnet, The DSD r after tucking stray p hairnet. FS-A turne hands. At 5:51 FS- gloves on, and colle tables to be cleane kitchenette with the creamer packets w and then served up	age 29 . FS-A was not wearing gloves, ont of residents, swiped hair with bare fingers, and went enette to dish up and bring out food without performing hand ping off the plates, FS-A henette and prepped more d the microwave, and pulled e drawers. A sign on the door to d in all capital letters, "HAIR ST BE WORN IN THIS AREA!" hing services director (DSD) hette and asked FS-A about not e DSD told FS-A to fix the ling off. FS-A was heard off again?" After fixing the eminded FS-A to wash hands bieces of hair back in the d on the water and washed A entered the dining room with ected dirty cloth napkins from d. FS-A returned to the e gloves on, picked up some ith the same gloved hands, o more food on a plate without performing hand hygiene.	F 37	display="block-color: block-space;">1 glove use, and general infection issue. follow up. Results of the audits will be revie QAPI. The Dining Services Man responsible for compliance.	wed at		
	confirmed the hairr service, and explain DSD mentioned it. for glove use, FS-A services director to wear gloves if they food. Now there wa not sure if the rules changed. In a follow DSD, expected stat	9/18/17, at 5:55 p.m. FS-A net was sliding off during dining ned not realizing it until the When asked about the policy a said the previous dietary Id staff they did not have to did not have any contact with as a newer DSD, and FS-A was a about glove use had w-up interview at 6:04 p.m. the ff to wash and dry hands ves, and then change gloves					

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STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA	D. 0938-039 TE SURVEY MPLETED	
				NG			
	PROVIDER OR SUPPLIER	245632	B. WING	STREET ADDRESS, CITY, STATE, ZIP COD		/22/2017	
		(LLC		7555 BAILEY ROAD WOODBURY, MN 55129			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 371	surfaces. The DSD dry hands between all hair in a hairnet. Review of the Hand revealed the following when dining service hands: before serving During observation kitchen on 9/21/17, placed thawed, raw chilled drawer that said they were to be probe thermometer ensure they were to be probe thermometer ensure they were to be probe thermometer ensure they were be (F). Between check pieces of raw meat of the thermometer checking the temper again quickly wiped wet towel, then imm same probe thermo temperature of read salad cart, such as mayonnaise, onion ready to eat vegeta temperature of eac probe one time on about using the sam meat to the ready to the towel was soak solution. During interview on dining services dire was okay for the same	ace, hair, or other non-food expected staff to wash and glove changes, and to cover	F 3	71			

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		AND HUMAN SERVICES				FORM	10/26/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245632	B. WING	i		09/;	22/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST THEF	RESE OF WOODBURY	LLC			7555 BAILEY ROAD NOODBURY, MN 55129		
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	eat foods, but want representative from manufactured the M explained being tra the same thermom- ready to eat foods, Multi-Quat Sanitize The manufacturer r DSD over the phon Multi-Quat Sanitize food contact surface minute. At 11:41 a.r pull all the food off serving residents, a just in case there has the temperature pro- Review of a manufa about Multi-Quat Sa directions for use: " Sanitizer at proper surfaces of equipm sanitizing solution for one minute. Air dry. During the initial kitt p.m. the dietary ser the EC-44 Dishmac to clean. High temp dishes using hot wa During observation 9/21/17, at 11:56 a. the water temperatu the dishmachine has and explained after time throughout the	immediately used on ready to ed to call and ask the the company that Multi-Quat Sanitizer. C-A ined that it was okay to use eter on raw meat, and then as long as it was wiped with a r soaked towel. At 11:35 a.m. representative spoke to the e, and clarified that a r saturated towel disinfected es after approximately one m. the DSD told dining staff to the chilled salad cart before and replace it with fresh food, ad been contamination from obe. acturer information sheet anitizer revealed the following "Apply Oasis 146 Multi-Quat use solution. Expose all ent, ware or utensils to the or a period of not less than		371			

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 10/26/2017 APPROVED : 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245632	B. WING	ì		09/	22/2017
NAME OF	PROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ST THEF	RESE OF WOODBURY	(LLC			7555 BAILEY ROAD WOODBURY, MN 55129		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 371	first, and then the ri D-E said the previo dropped until the wi 140 degrees Fahre temperature dropped logged water temper Temperature Log, a showed temperatur required. On 9/13/1 temperatures dropp and 165 degrees F bottom of the Dishv required, "Wash ter [degrees F]" and "F 180 [degrees F]". Review of the EC-4 information sheet re specifications for hi Wash temperature: rinse: 180 degrees The DSD explained the temperature pro- manufacturer on 9/2 that they visit the fa machine. During an interview administrator clarifi machine in the kitch the Evergreen and Rosewood unit had administrator expla machine used a ter temperature up to 7 administrator descri-	inse temperature "goes next." bus night, temperatures rash temperature was around enheit (F), and the final rinse ed below 170 degrees F. D-E eratures on a Dishwasher and the September 2017 log res were frequently lower than 17, the wash and rinse ped as low as 135 degrees F r, respectively. Type on the washer Temperature Log mperature must reach 150 Rinse temperature must reach 44 Dish machine manufacturer evealed the following machine igh temperature sanitization: : 160 degrees F. Sanitizing	F	371			

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		AND HUMAN SERVICES				FORM	10/26/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245632	B. WING			09/:	22/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST THER	RESE OF WOODBURY	LLC			555 BAILEY ROAD OODBURY, MN 55129		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371 F 428 SS=D	before reaching the the booster was not to 180 degrees F, re that were too cool. I temperatures, the a had just implement used in the dish ma the dishes at lower Additionally, the fac comprehensive infe include consistent t of illnesses in the fa to foodborne illness illness, that could p contamination, pool dishwashing. See F 483.45(c)(1)(3)-(5) REPORT IRREGUI c) Drug Regimen R (1) The drug regime reviewed at least or pharmacist. (3) A psychotropic of brain activities asso and behavior. Thes limited to, drugs in t (i) Anti-psychotic; (ii) Anti-anxiety; and (iv) Hypnotic.	cooled more than 5 degrees e kitchen dish machine, then t able to boost the temperatures Because of the risk of low administrator said kitchen staff ed a chemical that day to be achine, which would sanitize water temperatures. clity had not implemented a ection control program to racking, trending, and analysis acility, including but not limited s, and other gastrointestinal otentially result from food r hand hygiene, and improper F441. DRUG REGIMEN REVIEW, LAR, ACT ON Neview en of each resident must be nce a month by a licensed drug is any drug that affects poiated with mental processes se drugs include, but are not the following categories:	F 3				11/1/17

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		AND HUMAN SERVICES			FORM	10/26/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	IPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245632	B. WING _		09/2	22/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST THEF	RESE OF WOODBURY	(LLC		7555 BAILEY ROAD WOODBURY, MN 55129		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 428	to the attending phy facility's medical dir and these reports n (i) Irregularities inclu- drug that meets the (d) of this section for (ii) Any irregularities during this review n separate, written re attending physician director and directo minimum, the resid and the irregularity (iii) The attending p resident's medical r irregularity has bee action has been tak be no change in the physician should do the resident's medical (5) The facility must and procedures for review that include, frames for the differ steps the pharmaci identifies an irregula- to protect the reside This REQUIREMEN by: Based on documen pharmacist failed to irregularities to the medical director, ar of 5 residents (R48	ysician and the rector and director of nursing, nust be acted upon. ude, but are not limited to, any e criteria set forth in paragraph or an unnecessary drug. Is noted by the pharmacist nust be documented on a port that is sent to the and the facility's medical or of nursing and lists, at a lent's name, the relevant drug, the pharmacist identified. whysician must document in the record that the identified n reviewed and what, if any, ken to address it. If there is to e medication, the attending bocument his or her rationale in cal record. It develop and maintain policies the monthly drug regimen but are not limited to, time rent steps in the process and st must take when he or she arity that requires urgent action			of The nanged lowable	

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TATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	0938-039 SURVEY PLETED
		245632	B. WING _			09/2	2/2017
	PROVIDER OR SUPPLIER	LLC		75	TREET ADDRESS, CITY, STATE, ZIP CODE 555 BAILEY ROAD OODBURY, MN 55129		
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 428	acetaminophen (gre a 24 hour period. Findings include: Review of the admi admitted to the facil admission, provider medication orders f brand name: Tylend and as needed for p According to the Ur Administration (FD/ can cause serious I directed is used." T practice for adults is milligrams (mg) of a period. Review of the Cons Communication to I the pharmacist revi- regimen on 9/7/17. excessive acetamir potential for excess the communication Review of the medii revealed R48 recein acetaminophen on pharmacist's visit of -8/24/17: received 2 -8/26/17: received 2 Review of acetamir revealed the followi	eater than 4,000 milligrams) in ssion record revealed R48 lity on 8/19/17. Since 's prescribed R48 various or acetaminophen (common ol), both at scheduled times oain. Nited States Food and Drug A) website, "Acetaminophen iver damage if more than he current standard of s not to exceed 4,000 acetaminophen in a 24 hour ultant Pharmacist Physician form revealed that ewed R48's medication The pharmacist did not note hophen doses given to R48, or ive acetaminophen doses on form. cation administration record //ed greater than 4,000 mg of the following days prior to the n 9/7/17: k,950 mg k,450 mg	F 42	28	grams of Acetaminophen. All resident s medication regimen been reviewed by the consultant pharmacist for Acetaminophen and to ensure they do not exceed 4 grams/day. The nursing staff were inserviced of Acetaminophen dosing regulations beginning on 10/11/2017 and ongo completed. The consultant pharma reviews medications regimens mor audit for Acetaminophen dosing, hi findings will be sent to the DON for changes. Random new admission audits will completed for Acetaminophen dosi residents/week for 4 weeks, 2 residents/week for 4 weeks, and 1 resident/week for 1 week. The consultant pharmacist is respon for completing a medication regime review monthly for each resident. Pharmacist will review her audit rep QAPI with the Team for areas of improvement. Results of the audits forwarded to the facility s QAPI m for input/suggestions.	ounts on ing until acist othly to s/her order be ng: 3 onsible en The ports at s will be	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 10/26/2017 APPROVED : 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED	
		245632	B. WING	i		09/	22/2017	
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
ST THEF	ESE OF WOODBURY	LLC			7555 BAILEY ROAD WOODBURY, MN 55129	9		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC 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 428	mouth at bedtime for 1900. Discontinued -Acetaminophen Ta mouth one time a d 2000. Discontinued -Hydrocodone-Acet Give one tablet by r for 7 days. started 8 9/4/17. -Acetaminophen Ta mouth three times a Maximum (Max) Ac mg/24 hours. Starte Discontinued 8/29/1 -Acetaminophen Ta mouth three times a Acetaminophen dos Started 8/29/17 at 1 1406. -Acetaminophen Ta mouth four times a Acetaminophen dos Started 8/19/17 at 1 211. -Acetaminophen dos Started 8/24/17 at 1 2104. -Hydrocodone-Acet Give 2 tablet by mo for pain. Max Aceta hours. Started 8/19 8/29/17 at 1236. -Hydrocodone-Acet Give 2 tablet by mo for pain. Max Aceta	br pain. Started 8/24/17 at 8/24/17 at 2104. blet 500 mg: give 1000 mg by ay for pain. Started 8/26/17 at 8/29/17 at 1237. aminophen Tablet 5-325 mg: nouth one time a day for pain 8/29/17 at 2100. Completed blet 500 mg: Give 500 mg by a day for osteoarthritis. betaminophen dose: 3000 ad 8/25/17 at 0800.	F	428				

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		AND HUMAN SERVICES				FORM	10/26/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE	E SURVEY PLETED
		245632	B. WING	i		09/2	22/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST THEF		(LLC			7555 BAILEY ROAD WOODBURY, MN 55129		
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	-Hydrocodone-Acel Give 2 tablet by mo for pain. Max Aceta hours. Started 8/29 Calculating the tota the orders above re to receive greater th on many days if the scheduled, and if R "as needed" orders to the pharmacist's acetaminophen sta per provider order of -8/20/17-8/23/17: P -8/24/17: Potential -8/26/17-8/28/17: P -8/29/17-9/4/17: Pot -9/5/17-9/7/17: Pote Additionally, at the medication regimer conflicting maximum as can be seen in t listed a maximum of another listed 4,000 During interview on pharmacist review of medication limits w pharmacist review of acetaminophen. Th expectation was for give no more than of During interview on	taminophen Tablet 5-325 mg: buth every 6 hours as needed minophen dose: 4,000 mg/24 /17 at 1630. Il prescribed acetaminophen in evealed R48 had the potential han 4,000 mg acetaminophen e medication was given as 48 had requested all available . Listed below are dates prior visit on 9/7/17, when the total ff could have potentially given exceeded 4,000 mg: 'otential of 4,600 mg of 5,600 mg 'otential of 4,425 mg ential of 4,100 mg time of the pharmacist's in review on 9/7/17, there were m daily acetaminophen limits, he order list above. One order of 3,000 mg/24 hours, and 0 mg/24 hours. I 9/21/17, at 3:57 p.m. the ed visiting the facility once a edications, and said ere part of that review. The ed R48's record, and saw an mg daily limit for he pharmacist said the r staff to follow the order and	F	428	3		

Facility ID: 31025

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		AND HUMAN SERVICES			FORM	: 10/26/2017 APPROVED
CENTER	<u> IS FOR MEDICARE</u>	& MEDICAID SERVICES	1		<u>OMB NO</u>	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		245632	B. WING _		09/	22/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST THER	RESE OF WOODBURY	' LLC		7555 BAILEY ROAD WOODBURY, MN 55129		
(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)	LD BE	(X5) COMPLETION DATE
F 428	Continued From pa	ae 38	F 42	28		
	specific policy writte limits, but that they	en about daily acetaminophen were to follow the standard n 4,000 mg of acetaminophen	1 72			
F 441 SS=F	483.80(a)(1)(2)(4)(e PREVENT SPREAL	e)(f) INFECTION CONTROL, D, LINENS	F 44	41		11/1/17
	(a) Infection preven	tion and control program.				
		tablish an infection prevention n (IPCP) that must include, at owing elements:				
	investigating, and constraints of communicable dise volunteers, visitors, providing services us arrangement based conducted according	l upon the facility assessment ng to §483.70(e) and following tandards (facility assessment				
		ds, policies, and procedures hich must include, but are not				
	possible communic	eillance designed to identify able diseases or infections read to other persons in the				
		om possible incidents of ase or infections should be				
		ansmission-based precautions event spread of infections;				

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	-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245632	B. WING	-		0.0 /	
	PROVIDER OR SUPPLIER	243032	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	09/2	22/2017
					555 BAILEY ROAD		
ST THER	ESE OF WOODBURY	' LLC		W	OODBURY, MN 55129		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 39	F 4	41			
	(iv) When and how resident; including b	isolation should be used for a but not limited to:					
	depending upon the involved, and (B) A requirement th	uration of the isolation, e infectious agent or organism hat the isolation should be the sible for the resident under the					
	must prohibit emplo disease or infected	ces under which the facility byees with a communicable skin lesions from direct nts or their food, if direct t the disease; and					
		ne procedures to be followed direct resident contact.					
		cording incidents identified PCP and the corrective e facility.					
	. ,	nel must handle, store, port linens so as to prevent the					
	annual review of its program, as necess	The facility will conduct an IPCP and update their sary. NT is not met as evidenced					
	Based on interview facility failed to impl	v and document review, the lement a comprehensive			Resident #59 has a new catheter s in place.	ystem	
	tracking, trending a infections to preven	ogram to include consistent nd analysis of illnesses and at potential spread to others. ial to affect all 53 residents,			Residents with a catheter have the bag-system in place. Glucometers disinfected after each use. The fac	are	

Facility ID: 31025

PRINTED: 10/26/2017

STATEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED	
		245632	A. BUILDIN				
	PROVIDER OR SUPPLIER	243032	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		22/2017	
	RESE OF WOODBUR	(LLC		7555 BAILEY ROAD WOODBURY, MN 55129			
(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 APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 441	staff and visitors in failed to use infective dressing change for observed during a of the facility failed to prevent the spread glucose monitoring residents (R77, R9 observed, who require monitoring, and fail resident's (R59) uri and tubing. Findings include: During a random in approximately 1:00 reported there were control logs that we and trending of residents on 9/21/17 at 12:30 nursing (IDON) rep control monitoring I after March 2017. previous staff perso and was unable to the months of Janu names of residents and treatment were documentation, how completed. The IDO was collected from that going forward, from the pharmacy The surveillance low were admitted with were acquired at the	the facility. The facility also on control measures during a ir one of one resident (R7) dressing change. In addition, implement procedures to of infection during blood and hand hygiene for 6 of 6 0, R93, R202, R205, R210), uired blood glucose ed to properly sanitize 1 of 1 nary catheter drainage bag	F 44	1 has implemented an infection of prevention and control program includes the required elements identifying, implementing, monireporting of infections. Infection Control logs are kept policy and regulations. Staff have been re-educated be 9/27/2017 on handwashing, gludisinfecting, glove use, as well infection control basics/polices. control rounds/audits will be co 3X s/week by the Infection Co Preventionist, or her qualified de ensure infection control practice being adhered to in the facility. outcome of these audits will be monthly at the IC meeting for tr tracking. The implemented IC be reviewed monthly by the Teal Issues identified with IC practice including catheter cleaning, will reviewed by the QAPI Team quitheir input/suggestions. The In Control Preventionist is respon ensuring that the facility has a comprehensive IC program in p facility.	a that of toring, and per facility eginning on icometer as other Infection mpleted ntrol lesignee, to es are The reviewed ends and log will also am. es, be arterly for fection sible for		

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 10/26/2017 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245632	B. WING	ì		09/:	22/2017
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	·	
ST THEF	ESE OF WOODBURY	LLC			7555 BAILEY ROAD WOODBURY, MN 55129		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	lacked specific infer community based of confirmed that no fu infections had occu When asked when discussed at the face meeting, on 9/22/17 the administrator in to be discussed qua monthly review in th An infection control however not provide On 9/20/17 at 1:30	of the illness. Documentation ctions, organisims, whether or house acquired. The IDON urther monitoring of patient rred since March 2017. infection control was cility's quality assurance (QA) 7 at approximately 11:00 a.m., dicated infection control was arterly, but will be changed to ne future. policy was requested, ed.	F	441			
	a dressing change, was made. The reg the room, washed h nursing assistants w on the right side ex area. The old dress the area appeared sprayed a cleansing gauze square and c gauze onto a wrapp the cleansing spray square and cleanse buttocks. The area cm across the uppe used a pen from the the dressing. RN-A papers on top of an RN-A donned anoth washing hands or u	for an excoriated area, for R7 gistered nurse (RN)-A entered hands and applied gloves. Two were assisting with holding R7 posing the buttocks and sacral ing had been removed and excoriated and red. RN-A g spray onto a 4 x 4 inch cleansed the area, tossed the per paper and again sprayed ronto another 4 x 4 gauze ed the area of the excoriated was approximately 6 cm x 4 er half of both buttocks. RN-A e pocket of uniform and dated placed paper and dressing opened dressing envelope. her pair of gloves, without using alcohol solution, and a dressing over the					

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		AND HUMAN SERVICES				FORM	: 10/26/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		245632	B. WING	à		09/	22/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ST THEF	RESE OF WOODBURY	(LLC			7555 BAILEY ROAD WOODBURY, MN 55129		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	When finished, RN- dressing debris and RN-A removed glow sanitizer gel that wa the room. When in procedure, RN-A ac forgotten to wash h gloves. On 9/21/17 at 12:25 nursing was asked verified the register	age 42 the sacral and buttocks area. -A picked up the remaining d disposed of it in the trash. ves and then used hand as clipped to uniform. RN-A left terviewed regarding the cknowledged she had lands after removing the soiled 5 p.m. the Interim director of about glove changes and red nurse should have washed ng the area and before putting	F	441	1		
	blood glucose mon nurse (LPN)-B enter the container of glu the container on the washing/sanitizing I obtained R202's blo glucometer in with t gloves, left the roor hallway, retrieved a uniform pocket, and set the phone back then sanitized the g seconds with a wipe hands. During an observat LPN-B took the glua and set the contain	tion on 9/18/17, at 4:13 p.m. of itoring, licensed practical ered R202's bedroom carrying icometer supplies. LPN-B set e tray table and without hands donned a pair of gloves, bod, set the contaminated the clean supplies, removed m and while walking down the a ringing phone from the swered the phone, and then a the nurses station. LPN-B glucometer machine for 10 e. LPN-B did not wash/sanitize					

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		AND HUMAN SERVICES				FORM	10/26/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245632	B. WING		·····	09/22/2017	
NAME OF	PROVIDER OR SUPPLIER		-		TREET ADDRESS, CITY, STATE, ZIP CODE		
ST THEF	RESE OF WOODBURY	LLC			555 BAILEY ROAD VOODBURY, MN 55129		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	bathroom without w obtained blood from gloves and washed 6 seconds. LPN-B p glucometer into the sanitized the glucor the wipe for 15 second glucometer to the c During an observati LPN-B took the con- supplies to R205, s counter, retrieved th hygiene and donner glucose reading. LF glucometer in the co- not wash/sanitize has the med cart and sa wipe for 15 seconds into the container. L with alcohol gel. When interviewed of was not sure how m was to be sanitized aware of the time s During an observati trained medication a glucometer contain- bedroom, and set th TMA-A donned glow hands, obtained the sanitizing the gluco the container with th removed gloves and	btained gloves from the vashing/sanitizing hands and n R210. LPN-B removed hands with running water for but the contaminated container, left the room and meter at the med cart using onds, then returned the	F	441			

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		AND HUMAN SERVICES			FORM	10/26/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY PLETED
		245632	B. WING		09/:	22/2017
NAME OF	PROVIDER OR SUPPLIER	•	ę	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ST THEF	RESE OF WOODBURY	(LLC		7555 BAILEY ROAD WOODBURY, MN 55129		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	TMA-A took the glu into R93, set the glu table, donned glove obtained blood from the machine, put it removed gloves any washing/sanitizing H During an observat TMA-A entered the glucometer contain sink washed the pa donned gloves take obtaining blood fror contaminated gluco took a pen out of th down the glucometer container and took cart. TMA-A docum computer using the the documentation. with alcohol gel. Th glucometer. When interviewed of TMA-A verified not in-between resident they were supposed in-between uses. T product was to be u and did not know the time for the sanitizin used and manufact Document review of Glucometer:Cleanin	age 44 ion on 9/20/17, at 7:15 a.m., icometer container supplies ucometer container on the tray es from the bathroom supply, in R93 and without sanitizing back in the container. d left the room without hands or glucometer. ion on 9/20/17, at 7:30 a.m. room of R90, set the er on the tray table and at the alms of hands for 7 seconds, en from uniform pocket, After in R90, TMA-A put the ometer back into the container, he uniform pocket and wrote er number, then removed es, retrieved the glucometer the supplies back to the med hented the blood sugar in the e computer mouse to navigate . Then, TMA-A sanitized hands here was no cleaning of the on 9/20/17, at 11:59 a.m. sanitizing the glucometer t use because did not know d to sanitize the machine MA-A did not know what used to sanitize the glucometer here was a required period of ng depending on the wipe turer recommendations. of the facility policy, titled; ng and Care, dated August cometers will be cleaned after	F 441			

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		AND HUMAN SERVICES				FORM	: 10/26/2017 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		245632	B. WING	à		09/	22/2017
NAME OF	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ST THEF	RESE OF WOODBURY	(LLC			7555 BAILEY ROAD WOODBURY, MN 55129		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	consistency in testi spread of infection cleaning procedure germicidal disposal manufacturer's guid Document review of dated January 5, 20 disinfecting bleach sodium hypochlorite saturation time on t to air dry. Document review of Handwashing, date to apply soap over and to rub hands vi 20 seconds. Furthe Hand Sanitizer (No washing. Use only a spread over comple back) and Rub unti Document review of glove use, dated Ju wash hands immed When interviewed of interim director of m are to wash hands gloves, and the glue with the bleach pro- manufacturer recor	d for properly. To ensure ng and results and prevent the and infectious diseases. The Disinfect meter with ble wipes and follow delines for dry time, of the facility Safety Data Sheet D15 indicated moistened wipes of 1:10 concentration of e (bleach). required a 2 minute the glucometer and then allow of the facility policy titled; ed March 9, 2016, directed staff the entire hands and wrists gorously together for at least ermore, the policy directed t a replacement for hand after washing hands) and ete surface of hands (front and I dry. of the policy titled; Disposable une 1, 2017, directed staff to diately after glove removal. on 9/20/17, at 12:30 p.m. the nursing (IDON) verified staff before and after removing cometers are to be disinfected duct for 2 minutes per	F	441			

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		AND HUMAN SERVICES			FORM	: 10/26/2017 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		245632	B. WING _		09/	/22/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST THEF	RESE OF WOODBURY	(LLC		7555 BAILEY ROAD WOODBURY, MN 55129		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	poured 4 ounces of tubing of R59's fole swished the vinega the bottom valve ar toilet. NA-B then ra- into the connection bag and emptied th the foley catheter b and there was no c Document review o Urinary Catheter Da Skills Competency bag with soapy wat clean tap water, c. S a solution of one pa d. Empty the bag, e available, put a cap alcohol on the conn and catheter bags t difficult to see into. When interviewed of IDON explained no- cleaned catheter bag with pouring undilut	age 46 to a foley catheter bag. NA-B f vinegar into the connection ey catheter bag. Then, NA-B r in the foley bag and released and drained the vinegar into the n running water from the sink tubing of the foley catheter hat into the toilet. NA-B hung ag on the shower hand rail ap on the end of the tubing. of an undated policy titled; aily Cares and Bag Change Checklist, read; a. Clean the er, b. Rinse the bag well with Soak the bag for 30 minutes in art vinegar to three parts water, e. Air dry the bag, f. If that has been disinfected with hecting tip, g. Replace tubes that are cracked, hardened, or on 9/20/17, at 12:30 p.m., the t being familair with how staff ags/tubing, was not familiar ted vinegar into the catheter heed to do some audits.	F 44	41		

Facility ID: 31025

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		E SURVEY
ND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G 01 - ST THERESE OF WOODURY		
		245632	B. WING			/21/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
ST THER	ESE OF WOODBUR	(LLC		7555 BAILEY ROAD WOODBURY, MN 55129		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE PROPRIATE	COMPLETI
K 000	INITIAL COMMEN	rs	K 00	0		
	FIRE SAFETY					
	ALLEGATION OF (DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.				
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATION HAS	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE S BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departm Fire Marshal Divisio St Theresa of Woo substantial complia participation in Mec Subpart 483.70(a), 2012 edition of Nat Association (NFPA) Code (LSC), Chapt	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, dbury was not found in ince with the requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection) Standard 101, Life Safety ter 19 Existing Health Care 12 edition of NFPA 99, Health e.				
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-	R THE FIRE SAFETY				
j.	Healthcare Fire Ins State Fire Marshal					

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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 10/17/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION 01 - ST THERESE OF WOODURY		E SURVEY IPLETED
		245632	B. WING			09	/21/2017
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST THER	ESE OF WOODBURY	LLC			555 BAILEY ROAD /OODBURY, MN 55129		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 1	K	000			
	445 Minnesota St., St. Paul, MN 55101						
	By email to:						
	Marian.Whitney@s	state.mn.us					
	and Angela.Kappenmar	n@state.mn.us					
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
	1. A description of v to correct the defici	vhat has been, or will be, done ency.					
	2. The actual, or pro	oposed, completion date.					
I		r title of the person ection and monitoring to ence of the deficiency.					
	a full basement tha survey. The origina was determined to The building is fully facility has a fire ala smoke detection in to the corridor that is department notifica in all resident room Each floor is separa barrier and one 2 ho	ated by one 1 hour smoke our fire barrier.					
	The facility has a ca census of 48 at the	apacity of 56 beds and a time of the survey.					

Facility ID: 31025

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		& MEDICAID SERVICES			1	0938-039 E SURVEY	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - ST THERESE OF WOODURY		PLETED	
		245632	B. WING		09/	21/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ST THERESE OF WOODBURY LLC				7555 BAILEY ROAD WOODBURY, MN 55129			
(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) COMPLETIO DATE	
K 000		age 2 : 42 CFR, Subpart 483.70(a) is	K 00	D			
หววา	NOT MET. NFPA 101 Egress I	Doore	K 22	2		10/25/17	
K 222 SS=E	INFRA IUT EGIESS L	20013	N 22			10,20,11	
	equipped with a late use of a tool or key using one of the fol arrangements: CLINICAL NEEDS LOCKING Where special lock clinical security nee only one locking de each door and prov rapid removal of oc locks; keying of all all times; or other s to the staff at all tim 18.2.2.5.1, 18.2.2 SPECIAL NEEDS I Where special lock safety needs of the Clinical or Security being met. In additi electrical locks that upon loss of power protected by a supe system and the loc complete smoke de constantly monitore within the locked sp	2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 LOCKING ARRANGEMENTS ing arrangements for the patient are used, all of the Locking requirements are ion, the locks must be t fail safely so as to release to the device; the building is ervised automatic sprinkler ked space is protected by a etection system (or is ed at an attended location bace); and both the sprinkler erms are arranged to unlock the on. 2.2.5.2, TIA 12-4 S LOCKING					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/17/2017 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION 01 - ST THERESE OF WOODURY	(X3) DATE	E SURVEY PLETED
		245632	B. WING			09/2	21/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST THE	RESE OF WOODBUR	(LLC			555 BAILEY ROAD OODBURY, MN 55129		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	installed in accorda permitted on door a ordinary hazard con throughout by an al fire detection systel automatic sprinkler 18.2.2.2.4, 19.2.2.2 ACCESS-CONTRO ARRANGEMENTS Access-Controlled installed in accorda permitted. 18.2.2.2.4, 19.2.2.2 ELEVATOR LOBBY ARRANGEMENTS Elevator lobby exit accordance with 7. door assemblies in by an approved, su detection system a automatic sprinkler 18.2.2.2.4, 19.2.2.2 This STANDARD i Based on observa facility failed to ens exit door locking de Code, 2012 edition practice could caus affecting 18 of the sundetermined amo Findings include: At 11:30 am on 09/ the delayed egress first floor transitional	Played-egress locking systems ince with 7.2.1.6.1 shall be assemblies serving low and intents in buildings protected oproved, supervised automatic m or an approved, supervised system. 2.4 DLLED EGRESS LOCKING Egress Door assemblies ince with 7.2.1.6.2 shall be 2.4 Y EXIT ACCESS LOCKING access door locking in 2.1.6.3 shall be permitted on buildings protected throughout pervised automatic fire and an approved, supervised system. 2.4 s not met as evidenced by: tion and staff interview the ure the proper operation of evices. NFPA 101, Life Safety section 7.2.1.7. This deficient as the door not to open, 56 residents and an unt of staff and visitors. 21/2017 observations revealed feature on the exit door of the al wing was not operable. ition was confirmed by The			 Twin Cities Hardware was called they repaired the door on the Trans Care unit to be operable. Door was repaired 10/6/2017. Plant Operations Director is responsible for operable doors. 	sitional	et Page 4 of 8

				E CONSTRUCTION (X3) D	D. 0938-039 ATE SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			MPLETED
		245632	B. WING		9/21/2017
AME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
		LLC		555 BAILEY ROAD VOODBURY, MN 55129	
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
K 222	Continued From pa	ge 4	K 222		
	· · · · ·	and the Plant Operations			
K 293 SS=D	NFPA 101 Exit Sign	nage	K 293		10/25/17
	accordance with 7. also served by the 19.2.10.1 (Indicate N/A in one with less than 30 of travel is obvious.) This STANDARD i Based on observa facility failed to prop as required in The 2012 edition sectio condition could affe	signs are displayed in 10 with continuous illumination emergency lighting system. e-story existing occupancies ccupants where the line of exit s not met as evidenced by: tions and staff interview the perly identify two exterior doors Life Safety Code NFPA 101 n 7.10.8.3. This deficient ect the exiting of an unt of residents, staff and		 No Exit signs were placed on the 2 identified doors. The work was completed on 9/25/20' The Plant Operations Director is responsible for proper signage on the doors. 	7
	the 2nd floor dining closed patio were r This deficient cond	21/2017 observations revealed room doors leading to a not signed with "No Exit". ition was confirmed by The and the Plant Operations			
K 341 SS=D	Director. NFPA 101 Fire Alar Fire Alarm System A fire alarm system components approv	m System - Installation - Installation i is installed with systems and ved for the purpose in FPA 70, National Electric Code,	K 341		10/25/17

		AND HUMAN SERVICES				FORM	10/17/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 1 - ST THERESE OF WOODURY		E SURVEY PLETED
		245632	B: WING			09/;	21/2017
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ST THER		(LLC			55 BAILEY ROAD OODBURY, MN 55129		
	SUMMARY STA	TEMENT OF DEFICIENCIES	DI		PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETION DATE
K 341 K 353 SS=D	building. In areas n detection is installe unit. In new occupa at notification applia and supervising sta Fire alarm system v paths are monitored 18.3.4.1, 19.3.4.1, 9 This STANDARD i Based on observat facility failed to inst accordance with NH (2012) section 19.3 National Fire Alarm This deficient pract the alarm system to during a fire event v undetermined amo visitors. Findings include: At 10:37 am on 09/ revealed a smoke of HVAC diffuser on th in front of the coole This deficient cond Executive Director Director.	arning of fire in any part of the ot continuously occupied, d at each fire alarm control ancy, detection is also installed ance circuit power extenders, ation transmitting equipment. wiring or other transmission d for integrity. 9.6, 9.6.1.8 s not met as evidenced by: tions and staff interview the all the smoke detection in FPA 101 Life Safety Code 8.4.1, 9.6.1.3 and NFPA 72 Code (2010) section 17.7.4.1. ice could affect the ability of o sound in a timely manner which could affect an unt of residents, staff and	KS	341	 The smoke detector in the iden area was moved to be more than 3 inches from the HVAC diffuser. This was completed on 10/6/20 The Plant Operations Director is responsible for ensuring that smok detectors are not within 36 inches a diffuser. 	36 17. s æ	10/25/17
FORM CMS-28	567(02-99) Previous Versions	s Obsolete Event ID: C7VC2	21	Fac	ility ID: 31025 If continu	uation she	et Page 6 of 8

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	10/17/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION IG 01 - ST THERESE OF WOODURY		E SURVEY IPLETED
		245632	B. WING		09/	21/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST THEF	RESE OF WOODBURY	LLC		7555 BAILEY ROAD WOODBURY, MN 55129		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 353	Sprinkler System - Automatic sprinkler inspected, tested, a with NFPA 25, Stan Testing, and Mainta Protection Systems maintenance, inspe- maintained in a sec available. a) Date sprinkler s b) Who provided s c) Water system s Provide in REMARI any non-required of system. 9.7.5, 9.7.7, 9.7.8, a This STANDARD is Based on observat facility failed maint accordance with the (NFPA 101) and NF standard for testing systems. This defic sprinkler system no allow for the spread undetermined amon visitors. Findings include: At 10:35 am on 09/ revealed 2 sprinkler that appeared to be color in the frangible	Maintenance and Testing and standpipe systems are ind maintained in accordance dard for the Inspection, ining of Water-based Fire . Records of system design, action and testing are sure location and readily system last checked system test upply source KS information on coverage for r partial automatic sprinkler and NFPA 25 s not met as evidenced by: tion and staff interview, the ain the sprinkler system in a 2012 Life Safety Code FPA 25 section 5.2.1.1.2. The and maintenance of sprinkler ient condition could cause the of to function properly and d of fire. This could affect an unt of residents staff and	K 35	 The sprinkler heads in the co were replaced with functional heads. The work was completed on 10/6/2017. The Plant Operations Directo responsible for ensuring function sprinkler heads. 	ads. r i s	

If continuation sheet Page 7 of 8

		AND HUMAN SERVICES				1 APPROVI 0. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - ST THERESE OF WOODURY	(X3) DA CO	TE SURVEY MPLETED
		245632	B. WING		09	/21/2017
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
ST THER	ESE OF WOODBUR	Y LLC		555 BAILEY ROAD /OODBURY, MN 55129		
(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 APPR DEFICIENCY)	JLD BE	(X5) COMPLETI DATE
K 353	Continued From pa Executive Director Director.	age 7 and the Plant Operations	K 353			
				5		
	67(02-99) Previous Versions	s Obsolete Event ID: C7V	/01 5-	cility ID: 31025 If con	tinuation ch	eet Page 8



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 4, 2017

Ms. Kay Emerson, Administrator St. Therese Of Woodbury LLC 7555 Bailey Road Woodbury, MN 55129

Re: State Nursing Home Licensing Orders - Project Number S5632001

Dear Ms. Emerson:

The above facility was surveyed on September 18, 2017 through September 22, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are 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 or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

St. Therese Of Woodbury LLC October 4, 2017 Page 2 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 **Susanne Reuss, Unit Supervisor, at susanne.reuss@state.mn.us or (651) 201-3793**.

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

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

Please feel free to call me with any questions related to this electronic notice.

Sincerely,

Anne Retension -

Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 anne.peterson@state.mn.us Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

Minneso	ota Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		31025	B. WING		09/2	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST THEF	RESE OF WOODBURY	/ 1 I C	EY ROAD RY, MN 551	29		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments					
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The State delineated on the a	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				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 10/13/17

Electronically Signed

6899

If continuation sheet 1 of 52

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		31025	B. WING		09/	22/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ST THEF	RESE OF WOODBUR	VIIC	ILEY ROAD URY, MN 5512	29		
(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	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	you electronically. is necessary for St enter the word "cor text. You must ther State licensure pro completion date, th	Alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rrected" in the box available for in indicate in the electronic cess, under the heading he date your orders will be electronically submitting to the nent of Health.				
	of this Department provider and the fo issued. Please ind correction that you	19, 20, 21, 22, 2017 surveyors 's staff visited the above llowing correction orders are licate in your electronic plan of have reviewed these orders, te when they will be completed				
	the State Licensing federal software. T	nent of Health is documenting correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled " I statute/rule out of c "Summary Stateme and replaces the " correction order. T findings which are after the statement evidence by." Follo	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute t, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMI "PROVIDER'S PLA APPLIES TO FEDI	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. NR ON EACH PAGE.				

C7VC11

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DATI COM	E SURVEY PLETED
		31025	B. WING		22/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
ST THEF	RESE OF WOODBURY	/IIC	LEY ROAD	129	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
2 000	Continued From pa	ge 2	2 000		
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.			
2 560	MN Rule 4658.0409 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560		11/1/17
	comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The c must include the inc required by Minnes	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, vchosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).			
	by: Based on documen facility failed to dev include intervention 3 residents reviewe	Subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on document review and interview, the acility failed to develop a preliminary care plan to include interventions to reduce risk of falls for 2 of B residents reviewed (R193, R209) for accidents, who were identified at admission as at risk for alls. The final statement of the statement	Resident number 209 is no longer a resident at the facility. The facility's policy and procedure regarding falls interventions was reviewed and revised where necessary. Falls interventions are identified on the plan of care for residents at risk for falls.		
	Information form, d was being admitted fracture, and was a sheet, dated 9/20/1 fracture of neck of R209's undated pre	Admission Assessment ated 9/12/17, revealed R209 on 9/12/17 with a right hip t risk for falls. R209's face 7, listed diagnoses including right femur, and dementia.		Licensed staff were inserviced on implementing falls interventions beginning on 10/11/2017 and will be ongoing. The falls interventions will be audited for completion by nursing administration, and/or a charge nurse, 48 hours after admission. 5 careplans/week X4 weeks, 3 careplans/week X4 weeks, 1	

C7VC11

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	
		31025	B. WING		09/2	2/2017
IAME OF F	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
ST THER	ESE OF WOODBUR	/ I I C	LEY ROAD URY, MN 55	129		
(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	TION SHOULD BE	(X5) COMPLET DATE
2 560	Continued From pa	-	2 560			
	admission." The do designating whether "Fall Risk" by check underneath the box implement safety m more boxes to check measures were in p mat, or other safety next to "other" for s measures in place checked a box to in was a fall risk, and safety measures we During interview on registered nurse (R twice since admissi after admission on 9/17/17. RN-B deso confused." During interview on assistant (NA)-D th and came to the fac	initiated "within 24 hours of boument included a section for er or not the resident was a king either "Yes" or "No", and kes was written, "If yes, neasures." The form contained ck if any of the following safety place: sensor, grab bars, floor y measure. There was a line staff to clarify any other safety for R209. Staff had not ndicate whether or not R209 did not document that any ere in place for R209. 9/19/17, at 11:54 a.m. RN)-B said R209 had fallen ion. The first fall was one day 9/13/17, and the second on cribed the resident as "very 9/20/17, at 7:48 a.m. nursing ought R209 fell previously, cility for falls and dementia. y on 9/20/17, at 2:17 p.m. the ed that the preliminary care		careplan/week X4 weeks The DON is responsible falls interventions are dev initiated. Issues identified auditing and QA process the QAPI Team for input/	to ensure that veloped and d through facility will be referred to	
	plan along with the was considered to l	Pre-Admission Assessment be the preliminary care plan.				
	nursing said staff tr common area to ke kept the call light ne	p.m. the assistant director of ied to keep R209 in the eep an eye on the resident, and ear the resident in R209's could not find fall interventions				
		ted policy titled, Care Plans - ed the following policy				

C7VC11

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		31025	B. WING		09/22/2017		
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		09/	09/22/2017	
	RESE OF WOODBUR	7555 BA	ILEY ROAD URY, MN 5512				
(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) COMPLET DATE	
2 560	Continued From pa	age 4	2 560				
	resident's immedia	ninary plan of care to meet the te needs shall be developed rithin twenty-four (24) hours of					
	diagnoses of histor rhabdomyolysis. R	d to the facility on 9/8/17 with y of falling and 193 had been admitted from a l after an unwitnessed fall at					
	indicated resident is on sedatives whi review of the Care within 24 hours of a	progress notes, dated 9/8/17, "had fallen in the past and she ich puts her at risk for fall." A Plan -Preliminary (initiated admission) had a yes/no check and neither was checked off. s were identified.					
	nursing verified the	p.m. the interim director of resident was a fall risk and ould have been added to the					
	The Director of Nur review policies/pro- to assure that prelin developed to include	THOD OF CORRECTION: rsing and/or designee could cedures, train staff and monito minary care plans are de interventions to reduce risk s that are admitted to the d at risk for falls.					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OATE SURVEY COMPLETED
		31025	B. WING		09/22/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE	
ST THER	ESE OF WOODBURY	LLC 7555 BAIL WOODBU	.EY ROAD RY, MN 55	129	
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
2 565	Continued From pa	ae 5	2 565		
2 565	•	5 Subp. 3 Comprehensive	2 565		11/1/17
		omprehensive plan of care personnel involved in the 			
	by: Based on observati review, the facility f accordance with the care for 2 of 3 resid sample who require of 3 residents (R72 oral care and 1 of 3 pressure ulcers who positioning. Findings include: R59 was assessed with nail care and d accordance with the Document review o (MDS) dated 1/28/1 cognitively intact ar (CAA) indicated R5	ent is not met as evidenced on, interview, and document ailed to provide services in e resident's written plan of lents (R59 & R72) in the ed assistance with nail care, 1) who required assistance with a residents (R59) reviewed for o required assistance with to require staff assistance with to require staff assistance in e plan of care interventions. f R59's Minimum Data Set 17, indicated R59 was nd the Care Area Assessment 9 required staff assistance for		Residents number 59 and 72 receive no care per the facility policy and standard of care. On 9/21/2017 all resident's nai were audited by the DON. Resident #7 receives oral care per facility policy and standards of care (in the AM, at HS, an PRN). Resident 59 is turned and repositioned per careplan. All residents requiring assistance with: oral care, nail care, and turning and repositioning will be provided these services in accordance with facility standards. The facility provided education on oral care, nail care, and turning and repositioning starting on 9/27/2017 and continue until all are completed. Random nail care audits will be completed.	s ils 2 i d ted
	for R59 dated 1/1/1 resident's finger an weekly bath". Docu Skin Assessment fo	ing (ADLs). The plan of care 7, read, "Staff to trim d toe nails as needed following ment review of the Weekly or weekly baths the previous 6 care was not performed for		on 5 residents/week for 4 weeks, 3/wee for 4 weeks, and 1/week for 4 weeks. 3 residents/week will be audited for repositioning for 4 weeks, 2 residents/week for 4 weeks, and 1/wee for 4 weeks. T	3

6899

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	
		31025	B. WING		09/2	2/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
ST THER		/ I I C	AILEY ROAD BURY, MN 55	129		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	ige 6	2 565			
	R59 had fingernails finger tips greater t dirty with dark tan a accumulated under fingernails had brok When interviewed o expressed frustration long and staff had n fingernails. Further substance under th	ion on 9/19/17, at 9:11 a.m. is that extended beyond the han 1/4th inch and appeared and brown substance reach nail. Two of the 10 ken side, jagged edges. on 9/19/17, at 9:11 a.m. R59 on that the fingernails are too not offered to clean or trim the more, R59 indicated the he nails was from "food" and t soaking or cleaning the ny weeks."		nail/oral care and repositi provided to residents per standards of practice. Iss through facility auditing an will be referred to the QA input/suggestions.	facility policy and sues identified nd QA process	
	with nail care and c	to require staff assistance oral care and did not receive dance with the plan of care				
	Set), dated 8/25/17 and the CAA indica The plan of care fo "Oral Care/Hygiene hygiene BID (twice (bedtime). Dressing Resident needs as grooming due to os Staff to trim Reside needed following w of the Weekly Skin	of R72's MDS (Minimum Data i, indicated cognitively intact ted staff assistance for ADLs r R72 dated 3/20/17, read, e Provide set up for oral a day) in the AM and at HS g/Personal hygiene/Bathing: sist with dressing and teoarthritis and carpal tunnel en't finger and toe nails as eekly bath." Document review Assessment for weekly baths ks verified nail care was not	V			
	R72 had fingernails fingertips greater th dirty with dark tan a	ion on 9/19/17, at 9:58 a.m. that extended beyond the nan 1/4th inch and appeared and brown substances reach nail. Furthermore, R72				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		LE CONSTRUCTION		E SURVEY PLETED
		31025	B. WING		09/	22/2017
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY,	STATE, ZIP CODE		
ST THEF	RESE OF WOODBUR	Y LLC	7555 BAILEY ROAD WOODBURY, MN 55	129		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F .SC IDENTIFYING INFORMAT	FULL PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 7	2 565			
	upper teeth which being offered assis	tan yellow substance R72 indicated was fron tance to brush teeth e eeth but no bottom tee	m not every day.			
	until 12:00 p.m., R oral care. R72 state myself because of hands, it is just too expressed frustrati nail care and espec	tion on 9/20/17, from 7 72 was not offered nai ed, "I cannot take care the carpal tunnel in bo painful." Furthermore on that the staff do no cially expressed a des staff have not offered	il care or e of oth e, R72 ot offer sire for			
	Care and Nail Care	of the facility policy title e, dated 11/9/07, read, ygiene and grooming				
	nursing assistant (I	on 9/20/17, at 2:00 p.r NA)-C verified oral car een performed for R7:	re and			
	interim director of r facility expectation nail care every wee	on 9/21/17, at 12:21 p nursing (IDON) verified for grooming would in ek with bathing and wh re would be expected s.	d the nclude nenever			
	R59 did not receive and 15 minutes.	e a position change fo	r 4 hours			
	with a stage 2 pres cleft according to the Interventions include reposition Q2H (ev	as at risk for skin bre sure ulcer on the right ne plan of care, dated de assist of 1-2 staff to ery 2 hours) and prn ary), total assist of 2 w	t gluteal 8/30/17. ว			

Minnesc	ta Department of He	alth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		31025	B. WING		09/	22/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ST THEF	ESE OF WOODBURY	/IIC	LEY ROAD JRY, MN 55 [.]	129		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 8	2 565			
	(mechanical lift) for ambulate.	transfers, resident does not				
	Repositioning, date	f the facility policy titled, d May 2013, directed to s care plan to evaluate for any e resident.				
	nursing assistant (N were working toget	on 9/20/17, at 2:30 p.m. NA)-A, NA-B & NA-C, who her,verified repositioning Q2H rmed for R72 since getting up at 10:13 a.m.				
	interim director of n expectation for resi breakdown would b	on 9/21/17, at 12:21 p.m. the ursing verified the facility dents assessed with skin e to reposition every 2 hours sessment and the plan of				
	The director of nurs review and revise p to ensuring the care resident is followed designee could dev and develop a mon	THOD OF CORRECTION: sing (DON) or designee could olicies and procedures related e plan for each individual . The director of nursing or relop a system to educate staff itoring system to ensure staff as directed by the written plan				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car) Subp. 1 Adequate and re; General	2 830			11/1/17
	Subpart 1. Care in	general. A resident must				
Minnesota D STATE FORI	epartment of Health M		6899 (C7VC11	If continua	tion sheet 9 of 52

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	
		31025	B. WING		09/2	2/2017
	ROVIDER OR SUPPLIER	7555 BAI	EY ROAD	STATE, ZIP CODE		
			RY, MN 55			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ige 9	2 830			
	custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	e and treatment, personal and supervision based on id 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 ain in bed or the resident bed.				
	by: Based on documen facility did not comp weights for a reside resident (R98) revie on document review the facility failed to reduce risk of falls reviewed for accide admission as at risk facility. Findings include: Record review for F order, dated 5/26/1 Thursdays, Saturda Report also contain 6/29/17, that read, breakfast" A Wei for R98 from 7/20/1 weights recorded.	ent is not met as evidenced at review and interview, the blete a physician order of daily ent receiving dialysis for 1 of 1 ewed for dialysis, and based w, interview, and observations, establish interventions to for 1 of 3 residents (R209) ents, who was identified upon k for falls, and fell twice in the R98 revealed a physicians's 7, for dialysis Tuesdays, ays. The Order Summary hed a physician's order, dated "Weight daily before ights and Vitals Summary form 17 to 9/21/17 showed only 16		Resident #98 is being weighed MD orders. A list of all residents in the facil daily weights was obtained and These individuals are having th obtained daily per orders. Nursing staff were educated or daily weights starting on 9/27/2 will be ongoing until completion facility reviewed the system for daily weights. Residents with daily weights weights. The DON is responsible for en- daily weights are obtained per Issues identified through facility and QA process will be referred QAPI Team for input/suggestio	ity requiring reviewed. eir weights obtaining 017 and the obtaining II be suring that MD orders. y auditing t to the	
		on 9/21/17 at 1:47 p.m., urse (LPN)-C stated that it				

STATE FORM

C7VC11

If continuation sheet 10 of 52

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		31025	B. WING		09/22/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
		7555 BA				
ST THEF	RESE OF WOODBUR	/ I I C	URY, MN 5512	9		
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO		COMPLE DATE
_				DEFICIENC	CY)	
2 830	Continued From pa	ige 10	2 830			
	-	ity of the nursing assistants to				
		he daily weights. She				
		has noticed in the recent past				
		ts were not all in the electronic				
		when she reminded the	-			
	nursing assistants t	to complete the daily weights				
		ey were doing the daily				
		ing them in the electronic				
		lestioned if there was				
		ith the electronic record				
	software.					
	The interim director	r of nursing was interviewed				
		veights on 9/21/17 at 2 p.m.				
		t she was not aware of any				
		electronic record software or				
	the weight scales ir	n the facility.				
	Deview of the Dre					
		Admission Assessment				
		ated 9/12/17, revealed R209 I on 9/12/17 with a right hip				
		t risk for falls. R209's face				
		7, listed diagnoses including				
		right femur, and dementia.				
		eliminary care plan had a type	d			
		e form that this preliminary				
		nitiated "within 24 hours of				
		cument included a section for				
	0 0	er or not the resident was a				
		king either "Yes" or "No," and kes was written, "If yes,				
		neasures." The form contained	4			
		ck if any of the following safety				
		place: sensor, grab bars, floor				
		measure. There was a line				
		taff to clarify any other safety				
	measures in place	for R209. Staff had not				
		dicate whether or not R209				1

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		31025	B. WING		09/	22/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ST THEF	RESE OF WOODBUR	VIIC	ILEY ROAD URY, MN 5512	29		
(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 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	was a fall risk, and safety measures w The Kardex Report assistants to know what type of assista Kardex Report, dat category for specia that R209 needed a the resident's waist while walking or tra assistance of one s did not specifically falling. During interview or registered nurse (F twice since admiss after admission on 9/17/17. RN-B dest confused." Review of a fall rep 12:25 a.m. R209 fe incident description in her wheelchair a hitting the left elbox	age 11 did not document that any ere in place for R209. t was a report for nursing how to care for residents, and ance they needed. R209's red 9/12/17, included a al interventions, which noted a gait belt (a belt worn around t for staff to assist with balance ensferring), and limited staff person to walk. The report indicate R209 was at risk of n 9/19/17, at 11:54 a.m. RN)-B said R209 had fallen ion. The first fall was one day 9/13/17, and the second on cribed the resident as "very port dated 9/13/17, revealed at ell in the common area. The n described R209 standing up nd falling down onto the floor, w and hip on the floor. No new noted in this report.	t			
	R209 was found in in the resident's roo said R209 was four floor, and explained bathroom, and fell note dated 9/17/17	oort dated 9/17/17, revealed the doorway of the bathroom om. The incident description nd laying on the left side on the d was coming back from the backwards. The fall progress revealed R209 was "educated lo other new interventions were t.	1			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		31025	B. WING		09/	22/2017
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ST THEF			ILEY ROAD URY, MN 5512	29		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ge 12	2 830			
	date 9/15/17, the or attending a care co summary described precautions, but the the precautions dis summary also note the call light to ask During observation door to R209's roor inches. Through the seen sitting on the time, RN-B was pas when asked by the alone in the room, or RN-B knocked on F just getting dressed RN-B asked R209 room helping the re replied, "Give me fi confirmed that ther the resident. RN-B dressed, but clarifie went to find a nursi resident. At 7:37 a. entered R209's roo edge of the bed dre NA-D and the resid wear that day, and dressing. At 7:40 a. help R209 put shoe resident to remain s R209 already went replied, "Yes." At th	I 9/18/17, regarding service ccupational therapist noted nference with family. The d educating R209 on hip e patient was unable to recall cussed after five minutes. The d R209 was unable to locate for help with toileting. on 9/20/17, at 7:33 a.m. the m was open by a couple e opening, R209 could be edge of the bed. Around this ssing in the common area surveyor whether R209 was or with a nursing assistant. R209's door. R209 replied, "I'm d, give me ten more minutes." if there was anyone in the esident get ready, and R209 ve more minutes." RN-B e was nobody currently helping said R209 was trying to get ad that R209 needed help, and ng assistant to help the m. nursing assistant (NA)-D m to help. R209 sat at the essed in a shirt and underwear ent discussed what clothes to NA-D assisted the resident in m. NA-D explained needing to as on, and directed the seated. NA-D asked whether to the bathroom, and R209 is time, R209 began to stand				
	NA-D said, "[R209] Thank you." R209 s while NA-D put sho	f the bed without assistance. , no, [R209], sit down please! sat down on the bed again es on the resident, then 09 to the wheel chair before				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		31025	B. WING		- 09/22/2017	
	ROVIDER OR SUPPLIER		.DDRESS, CITY, S ⁻		03/	
		7555 BA				
ST THER	ESE OF WOODBUR	VIIC	URY, MN 5512	29		
(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 AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 13	2 830			
	bringing R209 to th and brush teeth. At explained that R20 bathroom that more NA-D observed a b had to flush the toil was already wearing entered the room to thought R209 must independently that not supposed to wa that R209 had prev facility for falls and R209 was able to u depended on how of R209 had an urger probably not use th During interview on family member (FM fallen previously, at R209 getting up wit R209 getting up wit R209 would get up if the resident felt th wondered if the fac worried R209 would was nobody around During an interview RN-B said staff we interventions after I how staff kept R207 R209 to use the ca the resident's room	e bathroom sink to wash face is 7:48 a.m. NA-D said 9 had already taken self to the ning without help, because orief on the bathroom floor, and et. NA-D also observed R209 ig underwear when NA-D to help with cares, so NA-D thave started getting ready morning. NA-D said R209 was alk unassisted, and thought rious falls, and came into the dementia. When asked if use a call light, NA-D thought it urgent the need, explaining if at need, the resident would be call light for help. 19/20/17, at 11:47 a.m. R209's 4)-F explained that R209 had nd knew that staff did not want thout help. FM-F thought that and go to the bathroom alone he need to void. FM-F sillity was short staffed, and d get up independently if there				
	that R209 had neve NA-E didn't know for	er fallen during NÁ-E's shift, so or sure. NA-E was aware that or falls, and needed help				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		31025	B. WING		09/	22/2017
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
T THER	ESE OF WOODBUR	/ I I C	ILEY ROAD URY, MN 5512	29		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	always wanting to g down again, and via NA-E had to keep a to ensure the reside bed, or in the comm transfer alone. During interview on assistant director o keep R209 in the c on the resident, and resident in R209's of find fall intervention Review of the Fall I policy, dated 4/16, assessed upon adr for falls. If deemed prevention/reduction implemented and for "It will be noted on assignment sheets falls." The policy co reviewed by the inter falls will be monitor taken to prevent re recommended by the members and the r will be documented fall event The resident	ained that the resident was get up out of bed, then lay back ce versa. Because of this, an eye on the resident and try ent was comfortable either in non area, or R209 might try to 9/21/17, at 3:20 p.m. the f nursing said staff tried to ommon area to keep an eye d kept the call light near the room, but that she could not as in writing. Prevention/Reduction Program revealed all residents would be nission to determine the risk				
	The Director of Nur review and revise p	THOD OF CORRECTION: rsing and/or designee could policies/procedures, train staff ure that physician orders are				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED
		31025	B. WING	09/	22/2017
	PROVIDER OR SUPPLIER	7555 BAIL		STATE, ZIP CODE	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE
2 830	followed. The Direc could review and re monitor to assure ir implemented for res	ge 15 tor of Nursing and/or designee evise policies, train staff and interventions are identified and sidents at risk for falls. R CORRECTION: Twenty-one	2 830		
2 855	Proper Nursing Car Subp. 2. Criteria for proper care. The of adequate and prope E. Assistance as n keep the mouth, tee Measures must be lips This MN Requirement	or determining adequate and criteria for determining	2 855		11/1/17
	by: Based on observative review, the facility for hygiene care for 2 of the sample who we personal cares. Findings include: R59 was assessed with nail care and de accordance with the During an observate R59 had fingernails finger tips greater the dirty with dark tan a accumulated under the same same same same same same same sam	on, interview, and document ailed to provide personal of 3 residents (R59 & R72) in re dependent upon staff for to require staff assistance id not receive assistance in e plan of care interventions. ion on 9/19/17, at 9:11 a.m. that extended beyond the nan 1/4th inch and appeared and brown substance each nail. Two of the 10 ken side, jagged edges.		 Residents number 59 and 72 receive nail care per the facility policy and standards of care. All residents requiring assistance with nail care will are provided these services in accordance with facility standards. The facility provided education on nail care beginning on 9/27/2017 and will be ongoing until completion. Random nail care audits will be completed on 5 residents/week for 4 weeks, 3/week for 4 weeks, and 1/week for 4 weeks. The DON is responsible for ensuring that nail care is provided to residents per 	

C7VC11

If continuation sheet 16 of 52

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		31025	B. WING		09/2	2/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST THEF	RESE OF WOODBURY		LEY ROAD IRY, MN 55 ⁻	129		
(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)	JLD BE	(X5) COMPLET DATE
2 855	Continued From pa	ge 16	2 855			
	expressed the finge had not offered to of Furthermore, R59 i the nails was from	on 9/19/17, at 9:11 a.m. R59 ernails are too long and staff clean or trim the fingernails. ndicated the substance under "food" and feeding self without the fingernails for "many		facility policy and standards of pulsues identified through facility and QA process will be referred QAPI Team for input/suggestions	n facility auditing referred to the	
	R59 continued to ha	ion on 9/20/17, at 12:00 p.m. ave unclean fingernails and nails remained present.				
	(MDS) dated 1/28/1 cognitively intact an (CAA) indicated R5 activities of daily liv for R59 dated 1/1/1 resident's finger an weekly bath." Docu Skin Assessment for	of R59's Minimum Data Set 17, indicated R59 was not the Care Area Assessment 19 required staff assistance for ing (ADLs). The plan of care 7, read, "Staff to trim d toe nails as needed following ument review of the Weekly or weekly baths the previous 6 care was not performed for				
	with nail care and o	to require staff assistance oral care and did not receive dance with the plan of care				
	R72 had fingernails fingertips greater th dirty with dark tan a accumulated under had a heavy film of upper teeth which F being offered assis	ion on 9/19/17, at 9:58 a.m. a that extended beyond the han 1/4th inch and appeared and brown substances reach nail. Furthermore, R72 tan yellow substance on the R72 indicated was from not tance to brush teeth every day. beth but no bottom teeth.				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		31025	B. WING		09/	22/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ST THEF	RESE OF WOODBUR	VIIC	ILEY ROAD URY, MN 5512	29		
(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 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 855	Continued From pa	-	2 855			
	until 12:00 p.m. R7 oral care. R72 state myself because of hands, it is just too expressed frustrati nail care and espec	tion on 9/20/17, from 7:00 a.m. 2 was not offered nail care or ed, "I cannot take care of the carpal tunnel in both painful." Furthermore, R72 on that the staff do not offer cially expressed a desire for e staff have not offered for				
	indicated the reside the CAA indicated a plan of care for R7 Care/Hygiene Prov (twice a day) in the Dressing/Personal needs assist with c osteoarthritis and c Residen't finger an weekly bath." Docu Skin Assessment fi	of R72's MDS dated 8/25/17, ent was cognitively intact and staff assistance for ADL's. The 2 dated 3/20/17, read, "Oral ride set up for oral hygiene BID AM and at HS (bedtime). hygiene/Bathing: Resident dressing and grooming due to carpal tunnel. Staff to trim d toe nails as needed following ument review of the Weekly or weekly baths the previous 6 care was not performed for	1			
	Care and Nail Care	of the facility policy titled, Oral e, dated 11/9/07, read, "To ygiene and grooming				
	nursing assistant (I	on 9/20/17, at 2:00 p.m. NA)-C verified oral care and een performed for R72.				
	interim director of r expectation for gro every week with ba	on 9/21/17, at 12:21 p.m. the nursing verified the facility oming would include nail care athing and whenever re would be expected twice a				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		31025	B. WING		09/22/2017	
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	-	
T THEF		/ C	ILEY ROAD URY, MN 55 [°]	129		
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLE DATE
2 855	Continued From pa	ge 18	2 855			
	The Director of Nu review/revise polici	HOD OF CORRECTION: rsing and/or designee could es, train staff and monitor to recieve care in accordance e interventions.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 860	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 2 F. Adequate and re; Hands-Feet	2 860			11/1/17
	proper care. The c adequate and prop E. per care and att	or determining adequate and riteria for determining er care include: ention to hands and feet. nails must be kept clean and				
	by: Based on observat review, the facility f hygiene care for 2 d	ent is not met as evidenced ion, interview, and document ailed to provide personal of 3 residents (R59 & R72) in are dependent upon staff for		Residents number 59 and 72 rece care per the facility policy and sta of care.		
	personal cares. Findings include:			All residents requiring assistance care will are provided these servic accordance with facility standards	ces in	
	with nail care and c	to require staff assistance lid not receive assistance in e plan of care interventions.		The facility provided education on care beginning on 9/27/2017 and ongoing until completion.		
		ion on 9/19/17, at 9:11 a.m. that extended beyond the		Random nail care audits will be co on 5 residents/week for 4 weeks,		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		SURVEY
		31025	B. WING		09/2	2/2017
	PROVIDER OR SUPPLIER	7555 BAII		STATE, ZIP CODE		
ST THEF	RESE OF WOODBURY	VIIC	RY, MN 55	129		
(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 TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 860	Continued From pa	age 19	2 860			
	dirty with dark tan a accumulated under fingernails had brok When interviewed of expressed the finge had not offered to of Furthermore, R59 if the nails was from soaking or cleaning weeks." During an observat R59 continued to h two broken, jagged Document review of (MDS) dated 1/28/1 cognitively intact ar (CAA) indicated R5 activities of daily liv for R59 dated 1/1/1 resident's finger an weekly bath." Docu Skin Assessment for weeks verified nail R59.	han 1/4th inch and appeared and brown substance r each nail. Two of the 10 ken side, jagged edges. on 9/19/17, at 9:11 a.m. R59 ernails are too long and staff clean or trim the fingernails. indicated the substance under "food" and feeding self without g the fingernails for "many tion on 9/20/17, at 12:00 p.m. ave unclean fingernails and I nails remained present. of R59's Minimum Data Set 17, indicated R59 was not the Care Area Assessment 59 required staff assistance for ring (ADLs). The plan of care 17, read, "Staff to trim d toe nails as needed following ument review of the Weekly or weekly baths the previous 6 care was not performed for		for 4 weeks, and 1/week for The DON is responsible for nail care is provided to resis facility policy and standards Issues identified through far and QA process will be refe QAPI Team for input/sugge	r ensuring that idents per s of practice. icility auditing erred to the	
	with nail care and c assistance in accor interventions. During an observat R72 had fingernails fingertips greater th dirty with dark tan a	oral care and did not receive rdance with the plan of care tion on 9/19/17, at 9:58 a.m. is that extended beyond the nan 1/4th inch and appeared and brown substances r each nail. Furthermore, R72				

TATEMEN	ta Department of He TT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		31025	B. WING		09/22/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
T THER	ESE OF WOODBUR	VIIC	LEY ROAD URY, MN 5512	29		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 860	Continued From pa	age 20	2 860			
	being offered assis	R72 indicated was from not stance to brush teeth every day eeth but no bottom teeth.				
	until 12:00 p.m. R7 oral care. R72 state myself because of hands, it is just too expressed frustrati nail care and espec	tion on 9/20/17, from 7:00 a.m. '2 was not offered nail care or ed, "I cannot take care of the carpal tunnel in both painful." Furthermore, R72 on that the staff do not offer cially expressed a desire for e staff have not offered for				
	indicated the reside the CAA indicated a plan of care for R7 Care/Hygiene Prov (twice a day) in the Dressing/Personal needs assist with c osteoarthritis and c Residen't finger an weekly bath." Docu Skin Assessment for	of R72's MDS dated 8/25/17, ent was cognitively intact and staff assistance for ADL's. The 2 dated 3/20/17, read, "Oral ride set up for oral hygiene BID AM and at HS (bedtime). hygiene/Bathing: Resident dressing and grooming due to carpal tunnel. Staff to trim d toe nails as needed following ument review of the Weekly or weekly baths the previous 6 care was not performed for				
	Care and Nail Care	of the facility policy titled, Oral e, dated 11/9/07, read, "To ygiene and grooming				
	nursing assistant (I	on 9/20/17, at 2:00 p.m. NA)-C verified oral care and een performed for R72.				
		on 9/21/17, at 12:21 p.m. the nursing verified the facility				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED
		31025	B. WING	09/	22/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
ST THEF			LEY ROAD JRY, MN 551	29	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
2 860	expectation for groc every week with ba necessary. Oral ca day for all residents SUGGESTED MET The Director of Nur review/revise polici and monitor to assu provided to residen staff for personal ca	oming would include nail care thing and whenever re would be expected twice a s. THOD OF CORRECTION: rsing and/or desigee could es and procedures, train staff ure that personal hygiene is ts who are dependent upon	2 860		
2 905	Subp. 4. Positionin positioned in good of residents unable must be changed a including periods of been put to bed for has documented th hours during this tir	5 Subp. 4 Rehab - Positioning ag. Residents must be body alignment. The position to change their own position tt least every two hours, f time after the resident has the night, unless the physician hat repositioning every two me period is unnecessary or ordered a different interval.	2 905		11/1/17
	by: Based on observati review, the facility f identified at risk for timely repositioning	ent is not met as evidenced ion, interview, and document ailed to ensure a resident pressure ulcers received for 1 of 3 resident's (R59) in ed at risk for pressure ulcers.		Resident #59 is turned and repositioned q 2 hours per plan of care. Individuals requiring q 2 hour turning and repositioning were identified; they are repositioned per policy. 3 residents/week will be audited for	

STATE FORM

C7VC11

If continuation sheet 22 of 52

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		31025	B. WING		09/2	2/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
T THER		/IIC	ILEY ROAD URY, MN 55	129		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 905	Continued From pa	age 22	2 905			
	R59 did not receive an offer to position change for 4 hours and 15 minutes During an observation on 9/19/17, at 3:00 p.m. R59 was sitting up in the wheel chair in the bedroom.			repositioning for 4 weeks, residents/week for 4 week for 4 weeks.		
				The DON is responsible for residents are turned and r facility standards and stan	repositioned per	
	regarding the freque indicated it was not chair without any st the afternoon. R59	on 9/19/17, at 3:00 p.m. ency of position changes, R59 t unusual to sit up in the wheel taff offers to change position in was aware of an open area or nable to feel pressure and did n in the buttocks.	1	practice.		
	(MDS), dated 1/28/ cognitively intact an (CAA) indicated R5 ulcer. The docume Predicting Pressure	of R59's Minimum Data Set (17, indicated R59 was and the Care Area Assessment (39 had an existing pressure ant titled, Braden Scale for te Sore Risk, dated 7/22/17, trisk for pressure ulcers.				
	8/30/17, indicated F for skin breakdown on the right gluteal assist of 1-2 staff to hours) and prn (wh	of the plan of care dated R59 was assessed as at risk with a stage 2 pressure ulcer cleft. Interventions included o reposition Q2H (every 2 enever necessary), total assis- transfers, resident does not				
	6/6/17, read resider hours three times of	of the physician order, dated nt should be up in chair 1-2 laily. resident should not be up er than 2 hours at a time, nours while in bed.				
		of the facility policy titled, ed May 2013, directed to				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		31025	B. WING		09/22/2017	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		000/	
		7555 BAI	LEY ROAD			
DI IHEH	ESE OF WOODBUR	WOODB	JRY, MN 5512	29		
(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 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 905	Continued From pa	age 23	2 905			
	review the resident special needs of th	's care plan to evaluate for any e resident.				
	7:00 a.m. until 10:1 positioned partially no offers to change 10:13 a.m. R59 wa the mechanical lift chair. At 11:00 a.m accompany family and go to lunch in a 1:17 p.m. R59 retur family members. A had not offered any getting out of bed a When interviewed of nursing assistant (I working together, we not been offered or getting up into the of When interviewed of interim director of r facility expectation skin breakdown wo hours according to of care. If a resider	observation on 9/20/17, from 3 a.m., R59 remained in bed on the right side. There were e position while in bed. At s transferred from bed using and positioned in the wheel h. R59 left the unit to who also resided at the facility. At rned to the bedroom with t 2:30 p.m. R59 verified staff y position changes since at 10:13 a.m on 9/20/17, at 2:30 p.m. NA)-A, NA-B & NA-C who were erified repositioning Q2H had performed for R72 since wheel chair at 10:13 a.m. on 9/21/17, at 12:21 p.m. the hursing (IDON) verified the for residents assessed with puld be to reposition every 2 the assessment and the plan and to reapproach the				
	The Director of Nur assure that policies staff trained and m	THOD OF CORRECTION: rsing and/or designee could s/procedures are reviewed, onitored to assure that at risk for pressure ulcers				

INNESOTA DEPARTMENT OF HE ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	
	31025	B. WING		09/22/2017	
ME OF PROVIDER OR SUPPLIER	7555 BAI	DRESS, CITY,	STATE, ZIP CODE		
REFIX (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 SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLE ⁻ DATE
2 905 Continued From pa	age 24	2 905			
TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
2 965 MN Rule 4658.060 -Nutritional Status	0 Subp. 2 Dietary Service	2 965			11/1/17
must ensure that a which supplies the determined by the assessment. Subs	onal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident stitutes of similar nutritive value residents who refuse food				
by: Based on documen facility did not com weights for a reside experiencing weigh reviewed for dialys Findings include: Record review for order, dated 5/26/1 Thursdays, Saturd Report also contain 6/29/17, that read,	ent is not met as evidenced nt review and interview, the plete a physician order of daily ent receiving dialysis and nt loss for 1 of 1 resident (R98) is. R98 revealed a physicians's 7, for dialysis Tuesdays, ays. The Order Summary ned a physician's order, dated "Weight daily before ights and Vitals Summary form		Resident #98 is being weighed d MD orders. A list of all residents in the facility daily weights was obtained and r These individuals are having the obtained daily per orders Nursing staff were educated on of MD/NP ordered daily weights st 9/27/2017 and will be ongoing ur completion. The facility reviewed system for obtaining daily weight	y requiring eviewed. ir weights obtaining arting on ntil d the	
for R98 from 7/20/ weights recorded.	17 to 9/21/17 showed only 16 On 7/20/17 R98's weight was nd 140 lbs. on 9/19/17.		Residents with daily weight order audited daily for 1 month. The DON is responsible for ensu		
When interviewed			daily weights are obtained per M		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED
		31025	B. WING		09/2	22/2017
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	•	
T THER			LEY ROAD JRY, MN 55	100		
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLE DATE
2 965	Continued From pa	age 25	2 965			
	the responsibility of obtain and record t explained that she that the daily weigh record of R98, and nursing assistants they told her that th weights and record record, and they qu something wrong w software.	turse (LPN)-A stated that it was if the nursing assistants to he daily weights. She has noticed in the recent past its were not all in the electronic when she reminded the to complete the daily weights hey were doing the daily ing them in the electronic uestioned if there was with the electronic record		Issues identified through fa and QA process will be refe QAPI Team for input/sugge	erred to the	
	about the missing wand she replied that	weights on 9/21/17 at 2 p.m. It she was not aware of any electronic record software or				
	registered dietician on nutritional high r receiving dialysis. resident has experi months and had be supplement and ne meals. She explain daily weights were	on 9/21/17 at 10:27 a.m., (RD)-A stated that R98 was isk monitoring related to She was also aware that the enced weight loss in recent een receiving a nutritional eeded more assistance at ed that she noticed that the not consistently in the nd she had spoken with the inconsistency.				
	The Director of Nur review policies/prod assure Physician o residents on dialysi supplies the caloric	THOD OF CORRECTION: rsing and/or designee could cedures, train staff, monitor to rders are followed and that is are offered a diet which and nutrient needs as comprehensive resident				

Minnesc	ta Department of He	alth			FORM A	PPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (>	X3) DATE S COMPL	
		31025	B. WING		09/22	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ST THEP	RESE OF WOODBURY		LEY ROAD IRY, MN 55 ⁻	129		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETE DATE
2 965	Continued From pa	ge 26	2 965			
	assessment.					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21000	MN Rule 4658.0610 Requirements-Hygi	0 Subp. 4 Dietary Staff iene.	21000			11/1/17
	wash their hands and their arms with soar washing facility befor as often as is necess after smoking, eating handling soiled equi	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 ipment or utensils. Dietary ir fingernails clean and				
	by: Based on observati review, facility Dieta serve food in a mar Findings include: During a dining obs p.m. 13 residents a room. Food server the residents in the up room trays for re rooms. FS-A wore a and off the head, ar that was secured in head. The slipping the nape of the nec of the kitchenette w	ent is not met as evidenced ion, interview, and document ary staff failed to prepare and nner that ensured food safety. eervation on 9/18/17, at 5:13 te in the Evergreen dining (FS)-A was observed serving dining room, and also dishing esidents who ate in their a hairnet that had slipped up nd loosely sat around long hair to a bun at the crown of the hairnet left exposed hairs at tk. At 5:19 p.m. FS-A came out <i>i</i> th a plate of food in each ing out of the front of the		DS-A is no longer with St. Therese of Woodbury. Staff wear hairnets covering their had adequately, they wash their hands a utilize gloves per policy/standards, thermometers are disinfected prope between foods, chemical sanitzer is in the dish machines and its' tested of Dining staff were inserviced beginnin 9/27/2017 and will be ongoing until completed on: hairnet usage, handwashing standards, glove use, disinfecting thermometer probes, inf control basics, chemical testing for of machines, and safe food handling to minimize risk of foodborne illnesses	tir Ind rly sused daily. ng fection dish	

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		31025	B. WING		09/2	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
		7555 BAIL	EY ROAD			
SIIRE	RESE OF WOODBURY	WOODBU	RY, MN 55	129		
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLET DATE
21000	Continued From pa	ge 27	21000			
	hairnet by the face. set the plates in fro away from the face back into the kitche two more plates of hygiene. After drop returned to the kitch plates of food, used silverware from the the kitchenette said RESTRAINTS MUS At 5:30 p.m. the dir entered the kitchen wearing gloves. The hairnet that was fall asking, "Is it falling hairnet, The DSD re after tucking stray p hairnet. FS-A turner hands. At 5:51 FS-/ gloves on, and colle tables to be cleaner kitchenette with the creamer packets w and then served up changing gloves or In an interview on 9 confirmed the hairn service, and explain DSD mentioned it. for glove use, FS-A services director to wear gloves if they food. Now there wa not sure if the rules changed. In a follow DSD, expected stat	FS-A was not wearing gloves, nt of residents, swiped hair with bare fingers, and went nette to dish up and bring out food without performing hand ping off the plates, FS-A nenette and prepped more a the microwave, and pulled drawers. A sign on the door to l in all capital letters, "HAIR ST BE WORN IN THIS AREA!" ing services director (DSD) ette and asked FS-A about not e DSD told FS-A to fix the sing off. FS-A was heard off again?" After fixing the eminded FS-A to wash hands bieces of hair back in the d on the water and washed A entered the dining room with ected dirty cloth napkins from d. FS-A returned to the gloves on, picked up some ith the same gloved hands, more food on a plate without performing hand hygiene. /18/17, at 5:55 p.m. FS-A et was sliding off during dining ned not realizing it until the When asked about the policy said the previous dietary d staff they did not have to did not have any contact with s a newer DSD, and FS-A was about glove use had v-up interview at 6:04 p.m. the f to wash and dry hands ves, and then change gloves		3 audits/week X4 weeks, 2 aud X4 weeks, 1 audit/week X4 wee completed on hairnet complian- handwashing, dish machine ch testing, glove use, and general control issue. follow up. Results of the audits will be rev QAPI. The Dining Services Ma responsible for this area.	eks will be ce, emical infection iewed at	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED	
		31025	B. WING	0	09/22/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST THEF	ESE OF WOODBUR		EY ROAD	29		
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE	
21000		ge 28 expected staff to wash and glove changes, and to cover	21000			
	revealed the followi when dining service	dwashing policy, dated 3/9/16, ng examples, among others, es staff were expected to wash ng food, after bussing dishes.				
	The Director of Nur review policies, trai that dietary staff co	THOD OF CORRECTION: sing and/or designee could n staff and monitor to assure over their hair and thoroughly food prep and serve food in a es food safety.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21015	MN Rule 4658.0610 Requirements- Sat	0 Subp. 7 Dietary Staff nitary conditi	21015		11/1/17	
	procedures and cor	conditions. Sanitary nditions must be maintained in e dietary department at all				
	by: Based on observati review, the facility f food in a manner th	ent is not met as evidenced on, interview, and document ailed to prepare and serve lat ensured food safety, and es at temperatures appropriate		DS-A is no longer with St. Therese of Woodbury. Staff wear hairnets covering their hair		
	for sanitization. This of 53 residents (res	s had the potential to affect 37 idents living on Evergreen and the facility at the time of		adequately, they wash their hands and utilize gloves per policy/standards, thermometers are disinfected properly		

C7VC11

If continuation sheet 29 of 52

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		31025	B. WING		09/22/2017	
AME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
T THEF		7 I I C	EY ROAD RY, MN 55	129		
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLE DATE
21015	Continued From pa	ge 29	21015			
	survey. Findings include:			between foods, chemical s in the dish machines and its Dining staff were inserviced	s' tested daily.	
	Findings include: During a dining observation on 9/18/17, at 5:13 p.m. 13 residents ate in the Evergreen dining room. Food server (FS)-A was observed serving the residents in the dining room, and also dishing up room trays for residents who ate in their rooms. FS-A wore a hairnet that had slipped up and off the head, and loosely sat around long hair that was secured into a bun at the crown of the head. The slipping hairnet left exposed hairs at the nape of the neck. At 5:19 p.m. FS-A came out of the kitchenette with a plate of food in each hand, and hair coming out of the front of the hairnet by the face. FS-A was not wearing gloves, set the plates in front of residents, swiped hair away from the face with bare fingers, and went back into the kitchenette to dish up and bring out two more plates of food without performing hand			 9/27/2017 and will be ongoin completed on: hairnet usa washing standards, glove up thermometer probes, infect basics, chemical testing for machines, and safe food harminimize risk of foodborne 3 audits/week X4 weeks, 2 X4 weeks, 1 audit/week X4 completed on hairnet comp washing, dish machine che glove use, and general inferiessues. Results of the audits will be QAPI. 	ing until ge, hand se, disinfecting ion control dish andling to illnesses. audits/week weeks will be liance, hand mical testing, ction control	
	returned to the kitcl plates of food, used silverware from the the kitchenette said RESTRAINTS MUS At 5:30 p.m. the dir entered the kitchen wearing gloves. Th hairnet that was fal asking, "Is it falling hairnet, The DSD r after tucking stray p hairnet. FS-A turne hands. At 5:51 FS- gloves on, and colle tables to be cleane	ping off the plates, FS-A nenette and prepped more d the microwave, and pulled drawers. A sign on the door to I in all capital letters, "HAIR ST BE WORN IN THIS AREA!" ning services director (DSD) ette and asked FS-A about not e DSD told FS-A to fix the ling off. FS-A was heard off again?" After fixing the eminded FS-A to wash hands bieces of hair back in the d on the water and washed A entered the dining room with ected dirty cloth napkins from d. FS-A returned to the gloves on, picked up some		The Dining Services Manageresponsible for this area.	jer is	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		31025	B. WING		- 09/22/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE	-	
		7555 B	AILEY ROAD			
SITHER	ESE OF WOODBUR	WOODI	BURY, MN 5512	29		
(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 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21015	Continued From pa	age 30	21015			
		o more food on a plate withou performing hand hygiene.	t			
	confirmed the hairr service, and explain DSD mentioned it. for glove use, FS-A services director to wear gloves if they food. Now there wa not sure if the rules changed. In a follow DSD, expected sta before wearing glow after touching the f	9/18/17, at 5:55 p.m. FS-A net was sliding off during dinin ned not realizing it until the When asked about the policy A said the previous dietary old staff they did not have to did not have any contact with as a newer DSD, and FS-A was about glove use had w-up interview at 6:04 p.m. th ff to wash and dry hands ves, and then change gloves ace, hair, or other non-food D expected staff to wash and glove changes, and to cover	as e			
	revealed the follow when dining service	dwashing policy, dated 3/9/16 ing examples, among others, es staff were expected to was ing food, after bussing dishes	h			
	kitchen on 9/21/17, placed thawed, raw chilled drawer that said they were to b probe thermometer ensure they were b (F). Between check pieces of raw meat of the thermometer checking the tempo again quickly wiped	of food preparation in the , at 11:10 a.m. Cook (C)-A v meat patties inside of a was underneath the grill. C-A ne cooked later. C-A inserted a r inside the raw meat patties t below 40 degrees Fahrenheit king temperatures of different t, C-A quickly wiped the probe r one time on a wet towel. After erature of the raw meat, C-A d the probe one time on the mediately proceeded to use the	a O Pr			
nesota D	same probe thermo	ometer to check the dy to eat foods on the chilled				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		31025	B. WING		09/	22/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
ST THEI	RESE OF WOODBURY	/ C	LEY ROAD JRY, MN 5512	9		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21015	salad cart, such as mayonnaise, onion, ready to eat vegeta temperature of each probe one time on t about using the sar meat to the ready to the towel was soak solution. During interview on dining services dire was okay for the sa used on raw meat, Sanitizer, and then eat foods, but want representative from manufactured the N explained being trai the same thermome ready to eat foods, Multi-Quat Sanitizer The manufacturer r DSD over the phon Multi-Quat Sanitizer food contact surfac minute. At 11:41 a.r pull all the food off the serving residents, a just in case there has the temperature pro- Review of a manufa about Multi-Quat Sa- directions for use: " Sanitizer at proper to surfaces of equipm	chicken salad, egg salad, tomato, and other fresh, bles. Between taking the h food item, C-A wiped the the wet towel. When asked ne thermometer from the raw o eat foods, C-A explained that ed in Multi-Quat Sanitizer 9/21/17, at 11:27 a.m., the ctor (DSD) was not sure if it me thermometer probe to be wiped with the Multi-Quat immediately used on ready to ed to call and ask the the company that Aulti-Quat Sanitizer. C-A ined that it was okay to use eter on raw meat, and then as long as it was wiped with a r soaked towel. At 11:35 a.m. epresentative spoke to the e, and clarified that a r saturated towel disinfected es after approximately one m. the DSD told dining staff to the chilled salad cart before and replace it with fresh food, ad been contamination from obe.	21015			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		31025	B. WING		09/22/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	TATE, ZIP CODE		
ST THEF	ESE OF WOODBUR	YIIC	AILEY ROAD BURY, MN 5512	29		
(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 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21015	Continued From pa	age 32	21015			
	p.m. the dietary set the EC-44 Dishman to clean. High temp dishes using hot wa During observation 9/21/17, at 11:56 at the water temperat the dishmachine ha and explained after time throughout the dropped. D-E said first, and then the r D-E said the previo dropped until the w 140 degrees Fahre temperature dropp logged water temp Temperature Log, a showed temperatur required. On 9/13/1 temperatures dropp and 165 degrees F bottom of the Dishw required, "Wash te [degrees F]" and "F 180 [degrees F]".	the machine manufacture washer Temperature solutions of the September 2017 log model to be a log to be a log to be a log to be a log to be atter, rather than chemicals. The dishwasher (D)-E said ad been like this for a while, the machine ran for a long ad ad been like this for a while, the machine ran for a long ad ad, the temperature drops inse temperature "goes next." The machine ran for a long aday, the temperatures the wash temperatures the wash temperatures the set temperature be as temperature was around mheit (F), and the final rinse ed below 170 degrees F. D-E eratures on a Dishwasher and the September 2017 log res were frequently lower than 17, the wash and rinse ped as low as 135 degrees F , respectively. Type on the washer Temperature Log mperature must reach 150 Rinse temperature must reach 14 Dish machine manufacture evealed the following machine	r			
	Wash temperature rinse: 180 degrees The DSD explained the temperature pro- manufacturer on 9/	igh temperature sanitization: : 160 degrees F. Sanitizing F. d being previously unaware of oblems, and called the '21/17 at 12:04 p.m. to reques acility and look at the dish				

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NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
ST THEF	RESE OF WOODBUR	VIIC	ILEY ROAD URY, MN 5512	29		
(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) COMPLET DATE
21015	Continued From pa	age 33	21015			
	administrator clarifi machine in the kitc the Evergreen and Rosewood unit had administrator expla machine used a ter temperature up to administrator descri- temperature in the degrees F to prever water temperature before reaching the the booster was no to 180 degrees F, r that were too cool. temperatures, the a had just implement used in the dish ma the dishes at lower Additionally, the fac comprehensive infe include consistent fo fillnesses in the fac to foodborne illness illness, that could p contamination, poor dishwashing.	v on 9/21/17, at 2:15 p.m. the ied that the EC-44 Dish hen washed all the dishes for Hawthorn units, but that the d its own dishwasher. The uned that the EC-44 Dish mperature booster to boost the 70 degrees higher. The ribed how the hot water facility was capped at 115 ont burns. Consequently, if the cooled more than 5 degrees e kitchen dish machine, then at able to boost the temperatures Because of the risk of low administrator said kitchen staff ted a chemical that day to be achine, which would sanitize water temperatures. cility had not implemented a ection control program to tracking, trending, and analysis acility, including but not limited s, and other gastrointestinal botentially result from food or hand hygiene, and improper				

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		31025	B. WING	09/	22/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
ST THEF			LEY ROAD JRY, MN 55	129	
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
21015	Continued From pa	age 34	21015		
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one			
21375	MN Rule 4658.080 Program	0 Subp. 1 Infection Control;	21375		11/1/17
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.			
	by: Based on interview facility failed to imp infection control pro- tracking, trending a infections to prever This had the potent staff and visitors in failed to use infection dressing change for observed during a of the facility failed to prevent the spread glucose monitoring residents (R77, R9 observed, who require monitoring, and fail resident's (R59) uri and tubing.	ent is not met as evidenced and document review, the lement a comprehensive ogram to include consistent and analysis of illnesses and at potential spread to others. tial to affect all 53 residents, the facility. The facility also on control measures during a or one of one resident (R7) dressing change. In addition, implement procedures to of infection during blood and hand hygiene for 6 of 6 0, R93, R202, R205, R210), uired blood glucose ed to properly sanitize 1 of 1 nary catheter drainage bag		Resident #59 has a new catheter system in place. Residents with a catheter have the new system. Glucometers are disinfected afte each use. The facility has implemented an infection control prevention and control program that includes the required elements of identifying, implementing, monitoring, and reporting of infections. Infection Control logs are kept per facility policy and regulations. Staff have been re-educated beginning on 9/27/2017 on handwashing, glucometer disinfecting, glove use, as well as other infection control basics/polices.	
	approximately 1:00	terview on 9/20/17 at p.m. the administrator e no up to date infection		completed 3X's/week by the Infection Control Preventionist, or her qualified designee, to ensure infection control practices are being adhered to in the facility. The outcome of these audits will	

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		31025	B. WING		09/22/2017	
	PROVIDER OR SUPPLIER	7555 BAI	DRESS, CITY, L EY ROAD J RY, MN 55 ID	STATE, ZIP CODE 129 PROVIDER'S PLAN OF CO	DRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLET DATE
21375	and trending of residents On 9/21/17 at 12:30 nursing (IDON) rep- control monitoring hafter March 2017. previous staff perso and was unable to the months of Janu names of residents and treatment were documentation, how completed. The IDO was collected from that going forward, from the pharmacy The surveillance low were admitted with were acquired at the identification of the of resolution dates lacked specific infe community based of confirmed that no fu- infections had occu. When asked when discussed at the far- meeting, on 9/22/17 the administrator in to be discussed qua- monthly review in the	build include ongoing tracking ident infections. D p.m. the interim director of orted the system for infection had not been kept up since The IDON had contacted the on for additional information obtain such information. For eary, February and March , room numbers, diagnoses e identified in the three month wever, there was no analysis ON was unaware of how data various units and indicated would include information as well as laboratory reports. gs did not identify if residents infections or if the infections e facility. There was no organism and no identification of the illness. Documentation ctions, organisims, whether or house acquired. The IDON urther monitoring of patient irred since March 2017. infection control was cility's quality assurance (QA) 7 at approximately 11:00 a.m., dicated infection control was arterly, but will be changed to ne future.	21375	be reviewed monthly at the trends and tracking. The ir log will also be reviewed m Team. Issues identified with IC pra including catheter cleaning reviewed by the QAPI Team their input/suggestions. The Infection Control Prever responsible for ensuring the has a comprehensive IC pr at the facility.	nplemented IC onthly by the actices, , will be n quarterly for entionist is at the facility	
inesota De ATE FORI	epartment of Health	p.m. a random observation of				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED 09/22/2017		
		31025	B. WING				
AME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
		7555 BAIL	EY ROAD RY, MN 5512				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE ⁻ DATE	
21375	Continued From pa	ige 36 for an excoriated area, for R7	21375				
	was made. The reg the room, washed h nursing assistants w on the right side ex area. The old dress the area appeared sprayed a cleansing gauze square and cleans gauze onto a wrapp the cleansing spray square and cleans buttocks. The area cm across the uppe used a pen from the the dressing. RN-A papers on top of ar RN-A donned anoth washing hands or u proceeded to press excoriated area on When finished, RN dressing debris and RN-A removed glow sanitizer gel that was the room. When in procedure, RN-A ac forgotten to wash h gloves. On 9/21/17 at 12:29 nursing was asked verified the register	gistered nurse (RN)-A entered hands and applied gloves. Two were assisting with holding R7 posing the buttocks and sacral sing had been removed and excoriated and red. RN-A g spray onto a 4 x 4 inch cleansed the area, tossed the ber paper and again sprayed y onto another 4 x 4 gauze ed the area of the excoriated was approximately 6 cm x 4 er half of both buttocks. RN-A e pocket of uniform and dated A placed paper and dressing n opened dressing envelope. her pair of gloves, without using alcohol solution, and a dressing over the the sacral and buttocks area. -A picked up the remaining d disposed of it in the trash. yes and then used hand as clipped to uniform. RN-A left terviewed regarding the cknowledged she had ands after removing the soiled 5 p.m. the Interim director of about glove changes and red nurse should have washed ng the area and before putting					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		31025	B. WING		09/	22/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		7555 BA	ILEY ROAD			
ST THEF	RESE OF WOODBUR	WOODB	URY, MN 5512	29		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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 HE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	ge 37	21375			
	blood glucose mon nurse (LPN)-B enter the container of glu the container on the washing/sanitizing obtained R202's blo glucometer in with gloves, left the roor hallway, retrieved a uniform pocket, and set the phone back then sanitized the g	ion on 9/18/17, at 4:13 p.m. of itoring, licensed practical ered R202's bedroom carrying cometer supplies. LPN-B set e tray table and without hands donned a pair of gloves bod, set the contaminated the clean supplies, removed in and while walking down the ringing phone from the swered the phone, and then at the nurses station. LPN-B glucometer machine for 10 e. LPN-B did not wash/sanitize	,			
	LPN-B took the glu and set the contain supplies on R210's bedroom. LPN-B of bathroom without w obtained blood from gloves and washed 6 seconds. LPN-B glucometer into the sanitized the glucor	ion on 9/18/17, at 4:36 p.m. cometer container to R210 er with the glucometer personal arm chair in the otained gloves from the vashing/sanitizing hands and n R210. LPN-B removed hands with running water for put the contaminated container, left the room and meter at the med cart using onds, then returned the container.				
	LPN-B took the cor supplies to R205, s counter, retrieved thy hygiene and donne glucose reading. LF glucometer in the c not wash/sanitize h the med cart and sa	ion on 9/18/17, at 4:29 p.m. ntainer with glucometer et the container on the he glucometer, no hand d gloves to obtain the blood PN-B set the contaminated ontainer, removed gloves, did ands, and proceeded back to anitized the glucometer with a s and put the glucometer back				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	E CONSTRUCTION		E SURVEY PLETED	
		31025	B. WING		09/	09/22/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
		7555 BA	ILEY ROAD				
SITHER	ESE OF WOODBUR	WOODB	URY, MN 5512	29			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21375	Continued From pa	ge 38	21375				
	into the container. I with alcohol gel.	PN-B then sanitized hands					
	was not sure how n was to be sanitized	on 9/18/17, at 4:45 p.m. LPN-E nany seconds the glucometer with the wipe and was not pent but stated, "For a while."	3				
	trained medication glucometer contain bedroom, and set t TMA-A donned glow hands, obtained the sanitizing the gluco the container with t removed gloves an	ion on 9/20/17, at 7:05 a.m. aide (TMA-A) took the er and supplies to R77's he container on the tray table. ves without washing/sanitizing blood test and without meter machine put it back in he clean supplies. TMA-A d left the room. TMA-A did not s or the glucometer machine.					
	TMA-A took the glu into R93, set the glu table, donned glove obtained blood from the machine, put it removed gloves an	ion on 9/20/17, at 7:15 a.m., cometer container supplies ucometer container on the tray es from the bathroom supply, n R93 and without sanitizing back in the container. d left the room without hands or glucometer.	,				
	TMA-A entered the glucometer contain sink washed the pa donned gloves take obtaining blood fror contaminated gluco took a pen out of th down the glucomet	ion on 9/20/17, at 7:30 a.m. room of R90, set the er on the tray table and at the lms of hands for 7 seconds, en from uniform pocket, After n R90, TMA-A put the ometer back into the container, he uniform pocket and wrote er number, then removed					
	container and took	es, retrieved the glucometer the supplies back to the med rented the blood sugar in the					

STATEMEN	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		31025	B. WING		09/	09/22/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ST THEF			ILEY ROAD URY, MN 5512	29			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21375	Continued From pa	ge 39	21375				
	the documentation.	computer mouse to navigate Then, TMA-A sanitized hands here was no cleaning of the	5				
	TMA-A verified not in-between residen they were suppose in-between uses. T product was to be u and did not know th time for the sanitizin	on 9/20/17, at 11:59 a.m. sanitizing the glucometer t use because did not know d to sanitize the machine MA-A did not know what used to sanitize the glucomete here was a required period of ng depending on the wipe curer recommendations.	r				
	Glucometer:Cleanin 2012, directed Gluc each use and cared consistency in testi spread of infection cleaning procedure	f the facility policy, titled; ng and Care, dated August cometers will be cleaned after d for properly. To ensure ng and results and prevent the and infectious diseases. The Disinfect meter with ole wipes and follow delines for dry time,	•				
	dated January 5, 20 disinfecting bleach sodium hypochlorite	f the facility Safety Data Shee 015 indicated moistened wipes of 1:10 concentration of e (bleach). required a 2 minute he glucometer and then allow					
	Handwashing, date to apply soap over and to rub hands vi 20 seconds. Furthe Hand Sanitizer (No washing. Use only	f the facility policy titled; d March 9, 2016, directed staf the entire hands and wrists gorously together for at least ermore, the policy directed t a replacement for hand after washing hands) and ete surface of hands (front and					

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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
ST THEF			LEY ROAD	29			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21375		-	21375				
	back) and Rub unti	l dry.					
	glove use, dated Ju	f the policy titled; Disposable ine 1, 2017, directed staff to liately after glove removal.					
	interim director of n are to wash hands gloves, and the glue	on 9/20/17, at 12:30 p.m. the jursing (IDON) verified staff before and after removing cometers are to be disinfected duct for 2 minutes per nmendations					
	a.m. Nursing assis bathroom, tending to poured 4 ounces of tubing of R59's fole swished the vinega the bottom valve ar toilet. NA-B then ra into the connection bag and emptied the the foley catheter b	bserved on 9/20/17, at 10:00 tant (NA)-B was in the R59's to a foley catheter bag. NA-B vinegar into the connection y catheter bag. Then, NA-B r in the foley bag and released ad drained the vinegar into the n running water from the sink tubing of the foley catheter at into the toilet. NA-B hung ag on the shower hand rail ap on the end of the tubing.					
	Document review o Urinary Catheter Da Skills Competency bag with soapy wat clean tap water, c. a a solution of one pa d. Empty the bag, e available, put a cap alcohol on the conr	f an undated policy titled; aily Cares and Bag Change Checklist, read; a. Clean the er, b. Rinse the bag well with Soak the bag for 30 minutes in art vinegar to three parts water, e. Air dry the bag, f. If that has been disinfected with becting tip, g. Replace tubes that are cracked, hardened, or					

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NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
ST THEF		/ I I C	LEY ROAD URY, MN 5512	29		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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) COMPLET DATE
21375		0	21375			
	IDON explained no cleaned catheter ba with pouring undilut	on 9/20/17, at 12:30 p.m., the t being familair with how staff ags/tubing, was not familiar ted vinegar into the catheter need to do some audits.				
	The Director of Nur review policies, trai an infection control established and ma	HOD OF CORRECTION: rsing and/or designee could n staff and monitor to assure program has been aintained to provide a safe and nt for residents, staff and				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21530	MN Rule 4658.131	0 A.B.C Drug Regimen Review	21530			11/1/17
	reviewed at least m currently licensed b This review must be Appendix N of the S Surveyor Procedure Requirements in Lo the Department of Health Care Finance This standard is in available through th system. It is not su B. The pharma irregularities to the and the attending p must be acted upon	en of each resident must be onthly by a pharmacist by the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, sing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan bject to frequent change. icist must report any director of nursing services hysician, and these reports n by the time of the next pooner, if indicated by the				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		31025	B. WING		09/22/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ST THEF	RESE OF WOODBUR		LEY ROAD	129		
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)		COMPLET DATE
21530	Continued From pa	ige 42	21530			
	upon" means the arreport and the sign of nursing services C. If the attend with the pharmacisi not provide adequa pharmacist believes being adversely aff refer the matter to t if the medical direct physician. If the me the attending physic justification for the physician does not must be referred fo assessment and as by part 4658.0070. the medical direct must refer the matter	urposes of this part, "acted cceptance or rejection of the ing or initialing by the director and the attending physician. ling physician does not concur t's recommendation, or does the justification, and the s the resident's quality of life is ected, the pharmacist must the medical director for review tor is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter or review to the quality ssurance committee required If the attending physician is or, the consulting pharmacist er directly to the quality ssurance committee.				
	by: Based on documer pharmacist failed to irregularities to the medical director, ar of 5 residents (R48 medications receive acetaminophen (gr a 24 hour period. Findings include: Review of the admi admitted to the faci	ent is not met as evidenced at review and interview, the b identify and report attending physician, facility and director of nursing, when 1) reviewed for unnecessary ed excessive doses of eater than 4,000 milligrams) in ission record revealed R48 lity on 8/19/17. Since rs prescribed R48 various		Resident number 48's medicat was reviewed for total mg of Acetaminophen potential per d MD/NP was updated and order to ensure that if resident took a PRN doses, that she would not grams of Acetaminophen. All resident's medication regim been reviewed by the consultat pharmacist for Acetaminophen ensure they do not exceed 4 gr	ay. The rs changed ill allowable rexceed 4 en has nt amounts to rams/day.	

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STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		31025	B. WING		09/2	2/2017
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY,	STATE, ZIP CODE		
ST THEF	ESE OF WOODBUR	/IIC	URY, MN 55	129		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21530	Continued From pa	age 43	21530			
	brand name: Tylend and as needed for p According to the Ur Administration (FD/ can cause serious directed is used." T practice for adults i milligrams (mg) of a period. Review of the Cons Communication to the pharmacist revi regimen on 9/7/17. excessive acetamin potential for excess the communication Review of the medi revealed R48 recei acetaminophen on pharmacist's visit o -8/24/17: received 4 -8/26/17: received 4 -8/26/17: received 4 -8/27/17: received 4 -8/27/17: received 4 Review of acetamin revealed the followi -Acetaminophen Ta mouth at bedtime for 1900. Discontinued -Acetaminophen Ta mouth one time a co 2000. Discontinued	ol), both at scheduled times pain. hited States Food and Drug A) website, "Acetaminophen liver damage if more than 'he current standard of s not to exceed 4,000 acetaminophen in a 24 hour sultant Pharmacist Physician form revealed that wed R48's medication The pharmacist did not note hophen doses given to R48, or sive acetaminophen doses on form. ication administration record ved greater than 4,000 mg of the following days prior to the n 9/7/17: 4,950 mg 4,450 mg 4,600 mg mophen orders since admission ing history of provider orders: ablet 500 mg: give 1000 mg by or pain. Started 8/24/17 at 8/24/17 at 2104. ablet 500 mg: give 1000 mg by lay for pain. Started 8/26/17 at		beginning on 10/11/2017 ar completed. The consultant reviews medications regime audit for Acetaminophen do findings will be sent to the f changes. Random new admission au completed for Acetaminoph residents/week for 4 weeks residents/week for 4 weeks resident/week for 1 week. The consultant pharmacist for completing a medication review monthly for each res Pharmacist will review her a QAPI with the Team for are improvement. Results of th forwarded to the facility's Q for input/suggestions.	t pharmacist ens monthly to osing, his/her DON for order dits will be nen dosing: 3 s, 2 s, and 1 is responsible n regimen sident. The audit reports at eas of ne audits will be	
	Give one tablet by a for 7 days. started 8 9/4/17.	mouth one time a day for pain 8/29/17 at 2100. Completed ablet 500 mg: Give 500 mg by				

STATE FORM

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		31025	B. WING		09/22/2017		
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
		7555 BAII	LEY ROAD				
SITHE	RESE OF WOODBUR	WOODBU	IRY, MN 5512	29			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21530	Continued From pa	age 44	21530				
	Maximum (Max) Ad mg/24 hours. Starte Discontinued 8/29/ -Acetaminophen Ta mouth three times Acetaminophen do Started 8/29/17 at 1406. -Acetaminophen Ta mouth four times a Acetaminophen do Started 8/19/17 at 1211. -Acetaminophen Ta mouth four times a Acetaminophen Ta mouth four times a Acetaminophen Ta mouth four times a Acetaminophen Ta mouth four times a Acetaminophen Aceta for pain. Max Aceta hours. Started 8/19 8/29/17 at 1236. -Hydrocodone-Acet Give 2 tablet by mo for pain. Max Aceta hours. Started 8/29 8/29/17 at 1630. -Hydrocodone-Acet Give 2 tablet by mo for pain. Max Aceta hours. Started 8/29 8/29/17 at 1630. -Hydrocodone-Aceta Give 2 tablet by mo for pain. Max Aceta hours. Started 8/29 8/29/17 at 1630.	17 at 1237. ablet 500 mg: give 500 mg by a day for osteoarthritis. Max se: 3,000 mg/24 hours. 1800. Discontinued 9/21/17 at ablet 500 mg: Give 500 mg by day for osteoarthritis. Max se: 3,000 mg/24 hours. 1700. Discontinued 8/24/17 at ablet 500 mg: Give 500 mg by day for osteoarthritis. Max se: 3,000 mg/24 hours. 1700. Discontinued 8/24/17 at taminophen Tablet 5-325 mg: buth every 6 hours as needed aminophen dose: 4,000 mg/24 1/17 at 1530. Discontinued taminophen Tablet 5-325 mg: buth every 6 hours as needed aminophen dose: 4,000 mg /24 1/17 at 1530. Discontinued					

	NT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		31025	B. WING		09/22/2017		
	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
		7555 BA	ILEY ROAD	,			
		WOODB	URY, MN 5512	29			
(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 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21530	Continued From pa	age 45	21530				
	acetaminophen sta per provider order of -8/20/17-8/23/17: F -8/24/17: Potential -8/26/17-8/28/17: F -8/29/17-9/4/17: Pot -9/5/17-9/7/17: Pot Additionally, at the medication regimen conflicting maximut as can be seen in t	Potential of 5,100 mg otential of 4,425 mg ential of 4,100 mg time of the pharmacist's n review on 9/7/17, there were m daily acetaminophen limits, he order list above. One order of 3,000 mg/24 hours, and					
	pharmacist confirm month to review me medication limits w pharmacist reviewe order with a 4,000 f acetaminophen. Th expectation was for give no more than During interview or administrator said t specific policy writte limits, but that they	ne pharmacist said the r staff to follow the order and					
	The administrator, consulting pharmad policies and proced	THOD OF CORRECTION: director of nursing (DON) and cist could review and revise dures for proper monitoring of Nursing staff could be					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY	
		31025	B. WING		09/22/2017		
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
ST THEF	ESE OF WOODBUR	/ 1 I C	AILEY ROAD BURY, MN 5512	29			
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE	
21530	Continued From pa	ge 46	21530				
	pharmacist's review with the pharmacist reviews on a regula	sary to the importance of the v. The DON or designee, alon c, could audit medication r basis to ensure compliance R CORRECTION: Twenty-one					
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary al	21535			11/1/17	
	must be free from u unnecessary drug i A. in excessive therapy; B. for excessive C. without adea D. in the prese which indicate the o discontinued. In addition to the d part 4658.1310, the with provisions in th Code of Federal Re 483.25 (1) found in Operations Manual Long-Term Care Fa Department of Hea Health Care Finand This standard is ind available through th	quate indications for its use; c nce of adverse consequences lose should be reduced or rug regimen review required i e nursing home must comply le Interpretive Guidelines for egulations, title 42, section Appendix P of the State , Guidance to Surveyors for icilities, published by the lth and Human Services, ing Administration, April 1992 corporated by reference. It is ne Minitex interlibrary loan te Law Library. It is not	n				
	by:	ent is not met as evidenced t review and interview, the		Resident number 48's med	ication regimen		

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		31025	B. WING		09/22/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ST THEF		VIIC	LEY ROAD IRY, MN 55	129		
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLET
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPF DEFICIENCY)	ROPRIATE	DATE
21535	Continued From pa	age 47	21535			
	facility failed to ensure residents did not receive excessive medication doses when 1 of 5 residents (R48) reviewed for unnecessary medications received excessive doses of acetaminophen (greater than 4,000 milligrams) in a 24 hour period, and failed to identify non-pharmacological interventions for the use of an antidepressant for sleep for 1 of 5 residents (R66) who was reviewed for unnecessary medication.			was reviewed for total mg of Acetaminophen potential per da MD/NP was updated and orders to ensure that if resident took all PRN doses, that she would not grams of Acetaminophen. Resid has a sleep careplan with nonpharmacological intervention identified.	changed allowable exceed 4 dent #66	
	admitted to the faci admission, provide medication orders to brand name: Tylend and as needed for According to the Un Administration (FD, can cause serious directed is used." T practice for adults i	nited States Food and Drug A) website, "Acetaminophen liver damage if more than The current standard of s not to exceed 4,000		All resident's medication has be reviewed for Acetaminophen am ensure they do not exceed 4 gra Residents taking a medication for have a sleep careplan with nonpharmacological intervention The nursing staff were inservice Acetaminophen dosing regulation sleep careplans with nonpharma interventions beginning on 10/11 ongoing until completed. The complexity pharmacist reviews medications monthly to audit for Acetaminop dosing, his/her findings will be s DON for order changes.	anounts to ams/day. or sleep d on ons and acological //2017 and onsultant regimens hen	
	period. Review of the medi revealed R48 recei acetaminophen on admission to the fa -8/24/17: received -8/26/17: received -8/27/17: received -9/10/17: received -9/19/17: received Review of acetamin	4,950 mg 4,450 mg 4,600 mg 4,100 mg		Random new admission audits of completed for Acetaminophen d nonpharmacological intervention residents/week for 4 weeks, 2 residents/week for 4 weeks, and resident/week for 1 week. The DON is responsible for ensi- the Pharmacist recommendation acted upon and that sleep carep developed with inclusion of nonpharmacological intervention included. The Pharmacist will r audit reports at QAPI with the Te	osing and ns: 3 I 1 uring that ns are plans are ns are eview her	

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
		31025	B. WING		09/	22/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
ST THEI	RESE OF WOODBUR	VIIC	ILEY ROAD URY, MN 55	129		
(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 ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
21535	Continued From pa	age 48	21535			
	-Acetaminophen Ta mouth at bedtime f 1900. Discontinued -Acetaminophen Ta mouth one time a d 2000. Discontinued -Hydrocodone-Ace Give one tablet by for 7 days. started 9/4/17. -Acetaminophen Ta mouth three times Maximum (Max) Ac mg/24 hours. Starte Discontinued 8/29/ -Acetaminophen Ta mouth three times Acetaminophen Ta mouth three times Acetaminophen Ta mouth three times Acetaminophen Ta mouth four times a Acetaminophen do Started 8/19/17 at 1211. -Acetaminophen Ta mouth four times a Acetaminophen Aceta Mours. Started 8/19 8/29/17 at 1236. -Hydrocodone-Aceta Give 2 tablet by mo for pain. Max Aceta	ablet 500 mg: give 1000 mg by or pain. Started 8/24/17 at ablet 500 mg: give 1000 mg by day for pain. Started 8/26/17 at 8/29/17 at 1237. taminophen Tablet 5-325 mg: mouth one time a day for pain 8/29/17 at 2100. Completed ablet 500 mg: Give 500 mg by a day for osteoarthritis. cetaminophen dose: 3000 ed 8/25/17 at 0800.		areas of improvement. Re audits will be forwarded to QAPI meeting for input/sus	the facility's	

STATE FORM

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		31025	B. WING		09/22/20 ⁻	
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST			
	RESE OF WOODBUR		AILEY ROAD			
	1	WOODI	BURY, MN 5512			
(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 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 49	21535			
	Give 2 tablet by mo	taminophen Tablet 5-325 mg: outh every 6 hours as needed aminophen dose: 4,000 mg/24 //17 at 1630.				
	the orders above re to receive greater t on many days if the scheduled, and if F "as needed" orders the total acetamino potentially given pe 4,000 mg: -8/20/17-8/23/17: F -8/24/17: Potential	Potential of 5,100 mg Intential of 4,425 mg	e			
	registered nurse (F administration reco that on 9/10/17 and mg of acetaminoph acetaminophen or verified that giving meant that R48 rec mg acetaminophen R48 had conflicting limits within the me asked whether R48 3,000 mg or 4,000 RN-C followed up v	A 9/21/17, at 1:08 p.m. RN)-C reviewed the medicatio rd for September and verified 9/19/17, R48 received 4,100 hen. RN-C confirmed the ders on those dates, and the medication as ordered evived greater than 4,000 tota in one day. RN-C confirmed maximum acetaminophen dication orders, and was a should have no more than mg acetaminophen daily. with the provider, and 0.m. that R48's maximum dail to be 4,000 mg of				
		9/22/17, at 9:38 a.m. the lated the total acetaminopher	ו			

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER		E CONSTRUCTION		E SURVEY PLETED		
		31025	B. WING		09/	22/2017		
NAME OF I	PROVIDER OR SUPPLIER	STR	EET ADDRESS, CITY, S	ADDRESS, CITY, STATE, ZIP CODE				
ST THEF	RESE OF WOODBUR	VIIC	5 BAILEY ROAD ODBURY, MN 551	29				
(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 AC CROSS-REFERENCED TO DEFICIEN(TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
21535	given by staff on 8/ received 4,600 mg medication adminis administrator said t specific policy writt limits, but that they	age 50 (27/17, and confirmed R48 acetaminophen, based or stration record. The the facility did not have a en about daily acetaminop were to follow the standa an 4,000 mg of acetamino	n the bhen rd					
	resident had a diag prescribed Trazodo bedtime for insomr The quarterly minin 7/6/17 indicated the dementia and psyc	num data set (MDS) date e resident had diagnoses chotic disorder. The MDS taking antipsychotic and	as d					
	completed on 9/20/ reflect any identific insomnia and did n	ctronic current care plan w /17. The care plan did not ation of a problem with not identify any al interventions for insomr						
	nursing reviewed th insomnia was not i	p.m. the interim director of he care plan and verified ncluded in the care plan a pharmacological intervent	nd					
	The Director of Nur review policies, phy	THOD OF CORRECTION rsing and/or designeed co ysician orders, train staff a residents do not receive	uld					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
			B. WING			
		31025	B. WING		09/	22/2017
ME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
T THER	ESE OF WOODBUR	VIIC	ILEY ROAD URY, MN 5512	29		
X4) ID REFIX 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 DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
21535	Continued From pa	age 51	21535			
	(greater than 4,000 period, and to iden	ion doses of acetaminophen) milligrams) in a 24 hour tify non-pharmacological e use of antidepressant used				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				