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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: D1B2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00494

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245028**

2.STATE VENDOR OR MEDICAID NO.
(L2) **299242600**

3. NAME AND ADDRESS OF FACILITY
(L3) **HIGHLAND CHATEAU HEALTH CARE CENTER**
(L4) **2319 WEST SEVENTH STREET**
(L5) **SAINT PAUL, MN** (L6) **55116**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2004**

6. DATE OF SURVEY **04/04/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **64** (L18)

13.Total Certified Beds **64** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor — 04/04/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 03/31/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/04/2017
(L33)

Posted 05/12/2017 Co.

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245028
May 5, 2017

Ms. Pat Voelker, Administrator
Highland Chateau Health Care Center
2319 West Seventh Street
Saint Paul, MN 55116

Dear Ms. Voelker:

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 the above facility is certified for or recommended for:

64 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 64 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 5, 2017

Ms. Pat Voelker, Administrator
Highland Chateau Health Care Center
2319 West Seventh Street
Saint Paul, MN 55116

RE: Project Number S5028027

Dear Ms. Voelker:

On March 7, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 16, 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 April 4, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 28, 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 February 16, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 28, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 16, 2017, effective March 28, 2017 and therefore remedies outlined in our letter to you dated March 7, 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245028 Y1	A. Building B. Wing Y2	4/4/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CHATEAU HEALTH CARE CENTER	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0205	Correction	ID Prefix F0279	Correction	ID Prefix F0280	Correction
Reg. # 483.15(d)(1)(i)-(iv)(2)	Completed	Reg. # 483.20(d);483.21(b)(1)	Completed	Reg. # 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)	Completed
LSC	03/28/2017	LSC	03/28/2017	LSC	03/28/2017
ID Prefix F0282	Correction	ID Prefix F0312	Correction	ID Prefix F0314	Correction
Reg. # 483.21(b)(3)(ii)	Completed	Reg. # 483.24(a)(2)	Completed	Reg. # 483.25(b)(1)	Completed
LSC	03/28/2017	LSC	03/28/2017	LSC	03/28/2017
ID Prefix F0315	Correction	ID Prefix F0323	Correction	ID Prefix F0329	Correction
Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.25(d)(1)(2)(n)(1)-(3)	Completed	Reg. # 483.45(d)(e)(1)-(2)	Completed
LSC	03/28/2017	LSC	03/28/2017	LSC	03/28/2017
ID Prefix F0334	Correction	ID Prefix F0353	Correction	ID Prefix F0356	Correction
Reg. # 483.80(d)(1)(2)	Completed	Reg. # 483.35(a)(1)-(4)	Completed	Reg. # 483.35(g)(1)-(4)	Completed
LSC	03/28/2017	LSC	03/28/2017	LSC	03/28/2017
ID Prefix F0412	Correction	ID Prefix F0431	Correction	ID Prefix F0441	Correction
Reg. # 483.55(b)(1)(2)(5)	Completed	Reg. # 483.45(b)(2)(3)(g)(h)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	03/28/2017	LSC	03/28/2017	LSC	03/28/2017

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 05/05/2017	SIGNATURE OF SURVEYOR 16022	DATE 04/04/207
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 2/16/2017

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245028 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/28/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CHATEAU HEALTH CARE CENTER	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0211	Correction Completed 03/28/2017	ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 03/28/2017	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 05/05/2017	SIGNATURE OF SURVEYOR 37010	DATE 03/28/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/14/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: D1B2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00494

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245028**

2.STATE VENDOR OR MEDICAID NO.
(L2) **299242600**

3. NAME AND ADDRESS OF FACILITY
(L3) **HIGHLAND CHATEAU HEALTH CARE CENTER**
(L4) **2319 WEST SEVENTH STREET**
(L5) **SAINT PAUL, MN** (L6) **55116**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2004**

6. DATE OF SURVEY **02/16/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **64** (L18)

13.Total Certified Beds **64** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Susan Miller, HFE NE II — 03/20/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 03/31/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted 04/04/2017 Co.

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 7, 2017

Ms. Heather Welter, Administrator
Highland Chateau Health Care Center
2319 West Seventh Street
Saint Paul, MN 55116

RE: Project Number S5028027

Dear Ms. Welter:

On February 16, 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. In addition, at the time of the February 16, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5028042.

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

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

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

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

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

Informal Dispute Resolution - 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
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (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 March 28, 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 March 28, 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 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 May 16, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal

regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 16, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. BUILDING _____ B. WING _____	C 02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CHATEAU HEALTH CARE CENTER	**2319 WEST SEVENTH STREET SAINT PAUL, MN 55116**

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F 000	INITIAL COMMENTS A recertification survey was conducted February 13, 14, 15, and 16, 2017. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint H5028042 was also completed at the time of the standard survey. The complaint was substantiated, with a deficiency issued at F329.	F 000		
F 205 SS=D	483.15(d)(1)(i)-(iv)(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR (d) Notice of bed-hold policy and return- (1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;	F 205		3/28/17

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

Electronically Signed | 03/17/2017

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F 205	Continued From page 1 (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (c)(5) of this section, permitting a resident to return; and (iv) The information specified in paragraph (c)(5) of this section. (2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (e)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R37) or legal representative had been informed of bed hold rights at the time of two hospitalizations. Findings include: During a family interview on 2/13/17, at 12:54 p.m. R37's family member (FM)-A, as power of attorney, mentioned the family had not been provided with information indicating R37's bed would be held on each occasion that R37 was hospitalized. Record review and an interview with registered nurse (RN)-H on 2/14/17, at 3:22 p.m. revealed R37 had been hospitalized from 9/12/16-9/15/16 and again from 11/6/16-11/10/16.	F 205	All Residents or representative will receive written notice of bed hold rights upon transfer from the facility. All Residents may have been affected, but none show any ill effects. Staff have been educated on the need to provide information on bed hold upon transfer from the facility. It is the responsibility of the Director of Nursing/designee to ensure compliance. Audits will be conducted weekly and reviewed at QAPI for three months to ensure adherence to this policy is followed.	

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F 205	Continued From page 2 Review of R37's medical record and interview with health information manager (HIM)-A on 2/14/17, at 3:55 p.m. revealed bed hold information had not been provided to R37 during the two different hospitalizations. HIM-A and licensed social worker (LSW)-A, stated that at the time of admission, residents and/or the resident's legal representative are provided with bed hold information and explained that the resident or family member signed the bed hold policy at the time of admission. The bed hold form was used and signed when an actual hospitalization happened. However, there was no evidence that R37 or legal representative had been provided bed hold information for each of the two hospitalizations for R37. On 2/14/17, at 3:55 p.m. HIM-A stated being unable to find the bed hold notices in R37's thinned chart or business file. HIM-A stated for the last 6 months the business manager had instructed staff to give her the bed hold notices, however explained that the business manager was no longer employed at the facility. HIM-A stated the new business manager had a call out to the former employee. On 2/15/17, at 8:51 a.m. HIM-A stated the missing bed hold notices had been discussed with the former business manager, who now worked at the corporate offices, and the bed hold notices were still not found. A review of the undated form titled Bed Hold Policy revealed the bed hold policy upon hospitalization/therapeutic leave was spelled out for private pay, Medicare, Medicaid and Veteran's Administration residents. The form had a signature area on the bottom, which when signed	F 205	Deficient practice to be corrected by 3/28/2017	

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F 205	Continued From page 3 indicated the resident/responsible party had acknowledged having received the policy.	F 205		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 279		3/28/17

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F 279	Continued From page 4 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop the care plan for 1 of 3 residents (R37) with dental needs. Findings include: R37 was originally admitted to the facility on 8/24/16, and readmitted after hospitalizations on 9/15 and 11/10/16. The care plan dated as being initiated on 12/6/16, indicated R37 required assistance with grooming and if R37 refused cares, to re-approach at a	F 279	Resident #37 care plan has been reviewed and updated to reflect his individuals needs related to refusals to wear dentures at times. All Residents may be affected, but none show any ill effect. All other residents were interviewed to determine if there are dental care needs. All residents care plans updated to reflect specific dental care needs.	

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F 279	Continued From page 5 later time. However, the care plan was not developed to indicate R37 at times refused to wear the lower denture due to concerns of it not fitting. On 2/13/17, at 5:09 p.m. R37 was observed to be edentulous and a set of dentures was noted to be soaking in a denture cup in R37's bathroom. On 2/14/17, at 3:35 p.m. R37 was observed wearing the upper denture, but not the lower, as the lower denture was in a denture cup in the bathroom. On 2/15/17, at 7:30 a.m. nursing assistant (NA)-A cleansed R37's dentures; and at 8:03 a.m. offered the dentures to R37 for placement. R37 stated "these are the only one's I want" and grabbed the lower denture, tried to put it in top of mouth and gagged. NA-A assisted R37 with removing the denture. R37 then took the correct denture, placed adhesive on the upper denture and placed the denture properly in mouth. At 8:08 a.m. R37 was asked about not wearing the lower denture. R37 stated had tried wearing the lower denture on and off for a month and it did not fit. R37 stated people said to give it a chance and that he is done giving it a chance. On 2/14/17, at 12:46 p.m. family member (FM)-A stated R37 told FM-A the dentures are uncomfortable; and FM-A stated R37 was told that the dentures could not be adjusted until they were worn more. FM-A stated R37 could be "difficult" and if R37 did not want to put the dentures in, then R37 would not be wearing the dentures. A 8/24/16, document titled Nursing Comprehensive Admission Data Collection and Assessment indicated R37 had full dentures, but	F 279	Nursing staff have been educated to ensure dental care needs are reflected on the plan of care. Audits to be done weekly with scheduled care conferences to determine if there are new or different dental care needs. The Director of Nursing/designee is responsible to ensure compliance. Audits will be reviewed at QAPI for 3 months to ensure adherence to the policy. Deficient practice to be corrected by 3/28/2017	

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F 279	Continued From page 6 the dentures were not present at the time of the admission. A new Nursing Comprehensive Admission Data Collection and Assessment completed at the time of a readmission on 9/15/18, indicated R37's dentures were not present at the time of the readmission; and another Nursing Comprehensive Admission Data Collection and Assessment dated 11/10/16, completed at the time of another readmission, indicated R37 had full dentures which were present at the time of the admission. On 2/14/17, at 3:44 pm NA-B stated R37 did not like to wear the lower denture and R37 had stated the denture did not fit. On 2/15/17, at 10:28 a.m. registered nurse (RN)-A stated sometimes R37 would wear the dentures and sometimes not. On 2/16/17, at 8:55 a.m. RN-A stated R37 had stated at times, the lower denture did not fit.	F 279		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type,	F 280		3/28/17

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F 280	Continued From page 7 amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 280		

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F 280	Continued From page 8 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan for 2 of 4 residents (R37, R126) reviewed for urinary incontinence. Findings include: R37 was admitted to the facility on 8/24/16, and readmitted on 9/15/16. According to the readmission Minimum Data Set (MDS) dated 9/22/16, R37 was continent of urine. A quarterly MDS dated 11/27/16, indicated R37 was always incontinent of urine.	F 280	Resident #37 and Resident #126 urinary incontinence assessments and care plans have been reviewed and updated to reflect current assistance needs with toileting. All Residents may be affected, but none show any ill effect. All other resident who are dependent for urinary continence have had their urinary incontinence assessments reviewed and care plan updated to reflect necessary care and treatment.	

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F 280	Continued From page 9 A form titled Bowel and Bladder Functional Evaluation Tool-HDGR dated 12/12/16, indicated R37 was incontinent of bowel and bladder; and staff were to encourage and assist R37 with toileting every two hours and as needed. The care plan revised on 12/6/16, addressed R37's urinary incontinence and staff were to assist with toileting needs "as determined." However, the care plan was not revised after completion of the 12/12/16, urinary incontinence assessment, which directed staff to encourage and assist R37 with toileting every two hours and as needed. On 2/14/17, at 12:45 p.m. R37's family member-(A) stated R37 used incontinent products and went from being continent of urine when first admitted to the facility, to being incontinent. On 2/15/17, at 7:53 a.m. nursing assistant (NA)-A stated R37 never took self to the toilet as R37 was too unsteady. R126 was admitted to the facility on 1/31/17, with an indwelling Foley catheter. The care plan was revised on 2/6/17, indicating the catheter was removed and R126 was on a check and change program. However, the care plan was not revised to indicate the frequency of the check and change program, which had been identified in a Bowel and Bladder Functional Evaluation Tool-HDGR assessment dated 2/7/17. The 2/7/17, assessment verified the Foley catheter had been removed on 2/6/17, and indicated staff were to provide incontinence care every two hours and when necessary following each episode of incontinence.	F 280	Education provided to nursing staff on revision of care plans Audits of three resident per week will be conducted to ensure urinary incontinence care plan is in place. It is the responsibility of the Director of Nursing or designee to ensure compliance. Audits will be reviewed at QAPI for three months. Deficient practice to be corrected by 3/28/2017.	

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F 280	Continued From page 10 The facility's 11/1/16, revised policy titled Care Plans-Comprehensive indicated the care plan was to be reviewed and revised after each assessment. The facility's 11/16, revised policy titled Bowel and Bladder Management-HDGR indicated a resident who was incontinent of bladder was to receive the appropriate treatment and services to prevent urinary tract infection and "restore continence to the extent possible."	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement the care plan to ensure the necessary treatment and services were provided to minimize the development and promote healing of pressure ulcers for 1 of 2 residents (R126) identified with a pressure ulcer. Findings include: R126 was not repositioned on 2/15/17, from 10:12 a.m. to 1:50 p.m. a total of 3 hours and 38 minutes. An undated Initial Care plan directed	F 282	Resident #126 has been repositioned per plan of care. All Residents may be affected, but none show any ill effect. All other residents who are dependent for repositioning have had their care plan reviewed to ensure appropriate plan of care to minimize development and promote healing of pressure ulcers. Nursing staff educated on developing a	3/28/17

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F 282	Continued From page 11 staff to reposition R126 every two hours. At 10:12 a.m. R126 was assisted out of bed via a mechanical lift and three staff, and transferred into a wheelchair. At 12:42 p.m. R126 was served lunch in room by NA-C and at 1:25 p.m. the lunch tray was picked up. However, there was no attempt or offer to reposition R126 during either interaction. At 1:25 p.m. NA-C stated shift ended at 2:00 p.m. When informed R126 had not been repositioned since being transferred from the bed to the wheelchair, NA-C verified R126 had been up in the wheelchair since 10:12 a.m., which was after morning cares. NA-A verified R126 was on an every two hour repositioning schedule. At 1:50 p.m. R126 was transferred back to bed via the mechanical lift and two staff. An 11/16, revised policy titled Person-centered Plan of Care-Comprehensive indicated services were furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.	F 282	care plan to minimize risk of development and promoting healing of pressure ulcers. Audits will be conducted on three residents per week to ensure that proper plan of care is present for repositioning need. It is the responsibility of the Director of Nursing/designee to ensure compliance. Audits will be reviewed at QAPI for three months to ensure adherence to policy is being followed. Deficient practice to be corrected by 3/28/2017	
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R126) dependent on staff for urinary incontinence care, received the appropriate	F 312	Resident #126 has been provided assistance with incontinence care. All Residents may be affected, but none	3/28/17

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F 312	Continued From page 12 services to minimize urinary incontinence. Findings include: R126 was not provided with incontinence care every two hours on 2/15/17, from 9:51 a.m. to 1:50 p.m. a total of 3 hours and 59 minutes. On 2/15/17, at 9:30 a.m. R126 was observed during morning cares. At 9:37 a.m. R126's incontinent product was removed and noted to be wet and R126 was also incontinent of bowel. The condition of the pad was verified by nursing assistant (NA)-A who was providing incontinence care. At 9:51 a.m. NA-A had finished providing incontinence care for R126. At 10:12 a.m. R126 was assisted out of bed via a mechanical lift and three staff, and transferred into a wheelchair. At 12:42 p.m. R126 was served lunch in room by NA-C and at 1:25 p.m. the lunch tray was picked up. R126 remained up in the wheelchair without being checked for urinary or bowel incontinence. At 1:25 p.m. NA-C stated shift ended at 2:00 p.m. When informed R126 had not been checked for urinary incontinence NA-C verified the last time R126 had been checked for urinary incontinence was during morning cares. NA-A stated R126 was on an every two hour repositioning/check and change schedule. At 1:50 p.m. R126 was transferred back to bed via the mechanical lift and two staff. The incontinent pad was noted to be wet, and the condition of the pad was verified during incontinence care by NA-A. A Bowel and Bladder Functional Evaluation Tool-HDGR was completed for R126 on 2/7/17, and identified an indwelling Foley catheter had been removed on 2/6/17. The assessment	F 312	show any ill effect. Residents who have been identified as dependent on staff for urinary incontinence have been reviewed to ensure proper care plan in place to minimize urinary incontinence. Nursing staff have been educated on providing residents care per their care plan to minimize urinary incontinence. Audits conducted three times weekly to ensure that incontinent care plan is being provided. It is the responsibility of the Director of Nursing/designee to ensure compliance. Audits will be reviewed at QAPI for three months to ensure adherence to policy is being followed. Deficient practice to be corrected by 3/28/3017	

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F 312	Continued From page 13 indicated staff were to provide incontinence care every two hours and when necessary following each episode of incontinence. The facility's 11/16, revised policy titled Bowel and Bladder Management-HDGR indicated a resident who was incontinent of bladder was to receive the appropriate treatment and services to prevent urinary tract infection and "restore continence to the extent possible."	F 312		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R126) with facility identified pressure ulcers received the appropriate treatment and services to maximize healing and minimize the development of pressure ulcers.	F 314	Resident #126 care plan was reviewed and updated to reflect current care needed to promote healing of a pressure ulcer. All residents may be affected, but none	3/28/17

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F 314	Continued From page 14 Findings include: R126 was admitted to the facility on 1/31/17, and according to a 2/1/17, Admission Skin Assessment there were no pressure ulcers at the time of admission. A nurses noted dated 2/2/17, revealed R126 developed a 2 centimeter long open area in the crevice of the buttocks. A Pathway Health Services Comprehensive Evaluation of Skin Risk Factors form dated 2/3/17, indicated the resident was bedfast, incontinent of bowel; and was assisted by two staff and hoyer for transfers and bed mobility and off loading/repositioning. Undated initial care plan directed staff to reposition R126 every two hours and there was a wound on R126's coccyx. A Wound Care Specialist Initial Evaluation document dated 2/7/17, revealed the area in the crevice was a stage III pressure ulcer on the coccyx and now measured 1 x 0.4 x 0.1 cm. Page two of the wound care sheet revealed "Wound is occurring amidst background of fairly significant moisture associated dermatitis. For that reason will trial barrier cream for wound care as it appears to be the causative event." The note further indicated a surgical debridement was performed and the coccyx area then measured 3 x 0.4 x 0.1 cm. The wound specialist saw R126 again on 2/14/17, and the pressure ulcer on the coccyx was noted to measure 0.8 x 0.2 x 0.1 cm, having gotten smaller. However, a new area on the left buttock, which measured 1 x 0.6 x 0.1 cm had developed	F 314	show any ill effect. Resident who are at risk for developing pressure ulcers where reviewed to ensure care plan is reflective of services needed to promote healing or prevent pressure ulcers. Nursing staff has been educated on providing the necessary treatment and services to prevent pressure ulcers and promote healing. Audits to be completed three times weekly to ensure appropriate care and services are in place and care is being delivered to promote and or heal pressure ulcers. It is the responsibility of the Director of Nursing/designee to ensure compliance. Audits to be reviewed at QAPI for the months to ensure adherence to this policy is being followed Deficient practice to be corrected by 3/28/2017	

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F 314	Continued From page 15	F 314		

and the wound care specialist indicated the area was caused by shearing.

On 2/15/17, morning cares for R126 were observed. There was a dry, non-draining scabbed area noted on the left buttock and an open area noted in the buttock crevice, on the coccyx. After completion of cares, at 10:12 a.m., R126 was transferred via mechanical lift and three staff from the bed to the wheelchair. R126 remained in room watching TV from 10:12 a.m. and at 12:42 p.m., was served lunch. At 1:25 p.m. nursing assistant (NA)-C picked up the lunch tray, placed it on a cart and took the cart to the kitchen.

NA-C returned to the unit at 2:00 p.m. and when interviewed at this time verified R126 had not been repositioned since after morning cares. NA-C stated R126 was to be an every two hour repositioning.

R126 was transferred back to bed, via a mechanical lift and two staff at 1:50 p.m.

After completion of incontinence care, R126's skin was observed at 2:10 p.m. and the areas noted on the wound specialist documentation were measured by registered nurse (RN)-B and observed by nurse practitioner (NP)-B. RN-B stated the area on the left buttock measured 1.2 x 1 cm and stated there was no depth to the area. RN-B verified there was no drainage from the area and the area was scabbed over and dry.

On 2/15/17, at 3:38 p.m. physical therapist (PT)-C stated she had worked with R126 after the transfer to the wheelchair. PT-C stated R126 did some leg exercises and some chair presses. However, PT-C stated she couldn't say R126 had

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F 314	Continued From page 16 cleared the wheelchair cushion to totally off- load. When asked about being able to off-load for at least a minute, PT-C stated R126 had low motivation and doubted R126 could clear the wheelchair cushion for that long. The facility's 11/16, revised policy titled Pressure Injury/Skin Integrity/Wound Management-HDGR indicated residents who were at risk or who had a loss of skin integrity were to receive the appropriate treatment/services which might include: repositioning or "off-loading" as per resident assessment and care plan.	F 314		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary	F 315		3/28/17

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F 315	Continued From page 17 and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 1 of 4 residents (R37) reviewed for urinary incontinence was provided with the necessary treatment and services to minimize urinary incontinence and improve bladder function. Findings include: On 2/15/17, from 7:49 a.m. to 10:38 a.m., a total of 2 hours and 49 minutes, R37 was not observed to be asked to use the toilet or checked for urinary incontinence. At 7:41 a.m. R37 was in bed and nursing assistant (NA)-A asked R37 about changing the incontinent pad, which NA-A stated was wet. R37 agreed and after pericare a new incontinent pad was placed. At 7:49 a.m. R37 requested of NA-A to use the toilet. NA-A assisted R37 to the toilet and R37 voided. Before being weighed, at 10:38 a.m., NA-A asked R37 about using the toilet, however R37 declined.	F 315	Resident #37 bowel and bladder care plan and assessment was reviewed and updated. All residents may be affected, but none show an ill effect. All residents at risk for incontinence were reviewed to ensure they are receiving the necessary treatment/services to prevent incontinence. Nursing staff has been educated on providing the appropriate care to reduce the risk for incontinence. Audits will be conducted three times weekly to ensure care is provided to those at risk for incontinence. It is the responsibility of the Director of Nursing/designee to ensure compliance. Audit to be reviewed at QAPI for three months to ensure adherence to policy is being followed.	

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F 315	Continued From page 18 A form titled Bowel and Bladder Functional Evaluation Tool-HDGR dated 12/12/16, identified R37 was incontinent of bowel and bladder; and staff were to encourage and assist R37 with toileting every two hours and as needed. Record review revealed R37 had a urology appointment on 1/20/17. According to the urology referral document the urologist placed R37 on the antibiotic Cipro 250 milligrams (mg) for 10 days. The referral form directed staff to contact the urologist after completion of the antibiotic if there was no improvement in R37's urinary incontinence. The referral summary also indicated that after the facility contacted the urologist with a progress report, the urologist would pursue, "anatomical evaluation with imaging and cysto." A review of nurses notes dated 1/20/17 to 1/31/17, revealed the only documentation regarding R37's urinary incontinence was referenced on 1/31/17, indicating R37 was incontinent of urine. There was no documentation to determine if R37's urinary incontinence had improved or if the urologist had been notified due to lack of urinary incontinence improvement. The Medication Administration Record dated 1/31/17, had a check mark in a box indicating the urologist had been updated, but there was no indication as to who had notified the urologist or what the conversation had entailed. The care plan revised on 1/31/17, indicated a three-day voiding data collection to evaluate voiding patterns was to be completed. On 2/15/17, at 10:18 a.m. the three-day voiding data was requested and at 11:58 a.m. was provided by registered nurse (RN)-B. Review of the data	F 315	Deficient practice to be corrected by 3/28/2017	

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F 315	Continued From page 19 collection form revealed data was collected from 2/7 to 2/9/17, however, many sections of the form were blank with no data collection. When this was pointed out, RN-B stated "Correct" and explained not having time to analyze the data. The facility's 11/16, revised policy titled Bowel and Bladder Management-HDGR indicated a resident who was incontinent or bladder was to receive the appropriate treatment and services to prevent urinary tract infection and "restore continence to the extent possible." The policy also indicated the three-day bowel and bladder tracking tool was to be completed for incontinent residents with any significant change in incontinence and a person centered care plan was to be updated and revised to include the resident's bowel and bladder needs, goals and preferences.	F 315		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 323		3/28/17

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F 323	Continued From page 20 (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure water temperatures in resident bathrooms and/or bathing rooms were maintained at a comfortable range. This had the potential to affect 16 residents identified by the facility on 2/16/17, at 12:10 p.m. as having diagnoses that included Alzheimer's, dementia or other related diagnoses of the 57 residents who resided in the facility. Findings include: On 2/13/17, at 5:30 p.m. the water in the bathroom of room 111 was noted to feel overly warm to the touch by two different surveyors. At this time, water temperatures were tested with the executive director (ED) and two surveyors utilizing a thermometer provided and operated by the ED. Water temperatures were noted in the following areas on 2/13/17, to be greater than 120 degrees Fahrenheit (F). At 5:57 p.m. the water in room 104-west (W) registered 132° (degrees) (F) using a laser heat gun. The ED agreed the water felt hot to the	F 323	Immediately upon recognition of the issue on 2/13/2017 ED/DON alert staff to halt any showers/tub baths until further notice. All Residents maybe affected, but none show any ill effect. Water lines were bled by turning all hot water on in each resident bathroom and shower room to bleed out existing hot water from lines on 2/13/2017. Called placed to plumber to service water regulator by 2-14-2017, which was replaced evening of 2/14/2017. Written education given to maintenance on acceptable water temperatures and what to do when these are out of acceptable range. Updated Log form to include acceptable ranges and actions needed if the water temperatures are out of range. Audit of water temperatures will be done three times per week in alternating to	

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F 323	Continued From page 21 touch. At 6:01 p.m. water in room 111-W registered at 110° F using the laser thermometer. The ED, who was testing the water, touched the water and stated "That's hotter than 110, I know my temperatures." The ED stated he was going to get a different thermometer, which he personally used when testing water temperatures, and compared the two thermometers. When the water in room 111-W was retested using the ED's thermometer, the water temperature registered at 125° F. At 6:01 p.m. the water in room 105-W registered at 123.4° F with the ED's thermometer and 107° F with the laser thermometer. At 6:09 p.m. the water in room 112-E registered at 128.8° F. The ED stated "the gun needs calibrating" At 6:12 p.m. the water in room 114-E registered at 126.4° F with the ED's thermometer. The resident in the room stated the water temp felt fine. At this time the ED again stated the laser gun thermometer needed to be recalibrated. All water temps taken after this, were taken using the ED's thermometer. At 6:18 p.m. the water in room 240-E registered at 124.2° F. The resident in room 240-E stated had not used the bathroom, but the resident in 239-E did, as it was a shared bathroom. The resident in 239-E was not available for interview. At 6:20 p.m. the water in room 228-E registered at 127.5° F; at 6:22 p.m. the water in the 2 East shower registered at 126.7° F.	F 323	ensure appropriate temperatures are maintained. It is the responsibility of the Director of Environment Services/designee to ensure compliance. Audits to be reviewed at QAPI for three months to ensure adherence to policy is being followed. Deficient practice was corrected by 3/28/2017.	

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F 323	Continued From page 22 At 6:25 p.m. the resident in room 221-CE stated the water heated up quickly, but liked hot water. When tested the water in the bathroom of 221-CE registered 125.3° F. At 6:31 p.m. the water in room 207-W registered at 118.5. When asked if the water temperature was still rising, the ED said it was still slowly rising, and that "I imagine that if we left it running it would continue to slowly rise." A review of water temperature logs from 1/17 and 2/17, revealed water temperatures ranged from temps 100° to 123° F. The log indicated water temperatures were taken once a day in different areas of the facility. At 7:34 p.m. the ED stated the maintenance staff had just determined there was a mixing valve problem. On 2/15/17, at 7:56 a.m. R37 was observed to turn on both the hot and cold water valves in the bathroom sink, while the nursing assistant was in the bedroom. When asked how the water temperature was he stated it was "warmer than average".	F 323		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or	F 329		3/28/17

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F 329	Continued From page 23 (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure appropriate monitoring for 2 of 6 residents (R103, R129) reviewed for unnecessary medications. Findings include:	F 329	Resident #103 behavior monitoring sheet was implemented as soon as recognized on 2/16/2017. Resident #129 has discharged from the facility.	

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F 329	Continued From page 24 Staff failed to monitor and document target behaviors for R103. R103 admitted to the facility on 9/25/16. Review of the undated Medical Data Sheet in R103's chart revealed diagnoses of Alzheimer's dementia, anxiety, and depression. R103's chart included current orders for Ativan and Paxil. The physician ordered 0.5 mg (milligrams) of Ativan to be given twice daily for agitation, and another 0.5 mg Ativan to be given as needed twice daily. The physician ordered 20 mg of Paxil daily for anxiety and depression. Review of R103's care plan, dated 10/7/16, revealed a focus on R103's use of antianxiety medications Ativan and Paxil, related to anxiety disorder. Interventions listed in the care plan required staff to monitor and record occurrences of target behavior symptoms, and document them per facility protocol. Review of the Unnecessary Drugs - Antipsychotic Drugs policy, last revised 4/09, revealed the following requirement: "All target behaviors must be quantitatively and objectively documented in the resident's medical record and/or on the medication administrative record, to monitor the effectiveness or the side effects of the antipsychotic." In an interview on 2/16/17, at 12:50 p.m., when asked where staff documented target behaviors, registered nurse (RN)-G said staff should document all behaviors on the Flow Record in the medication administrative record (MAR). RN-G continued that staff should always monitor behaviors, whether the medication was	F 329	All Residents may be affected, but none show any ill effect. All residents behavior monitoring sheets have been reviewed to ensure in place and appropriate target behaviors listed. All resident's MAR reviewed to ensure there are no medications that are3 not available from the pharmacy on their med list. Nursing staff educated on proper procedure for when medication is not available as prescribed. Audits of behavior monitoring sheets will be conducted two times weekly to ensure that they are in place with targeted behaviors. Audits of MAR will be completed two times per week to ensure all medications are available per MD orders. It is the responsibility of the Director of Nursing/designee to ensure compliance. Audits to be reviewed at QAPI for three months to ensure adherence to this policy is being followed. Deficient practice to be corrected by 3/28/2017	

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F 329	Continued From page 25 scheduled to be given at regular intervals, or to be given only as needed. RN-G looked through the MAR to find the Flow Records for February, saying "they have to be here." After looking through the records for R103's Flow Record, at 1:05 p.m. RN-G stated, "I can't find the February one." RN-G created a new Flow Sheet for Ativan and Paxil, to monitor and document target behaviors for the rest of February. Review of the Record of Medication Regimen Review revealed the pharmacist most recently reviewed R103's medication regimen on 2/14/17. The pharmacist wrote a short-hand comment for staff to monitor for the Ativan. In an interview on 2/16/17, at 4:28 p.m. the pharmacist confirmed visiting the facility on 2/14/17, and said she did not see evidence of staff monitoring target behaviors in February. The pharmacist confirmed noting on the Record of Medication Regimen Review that staff needed to monitor target behaviors for R103. R129 did not receive medications per physician orders. Review of R129's medical record indicated R129 was admitted to the facility on 1/6/16 with diagnosis including status post epilepsy surgery, intractable epilepsy, Cerebral Palsy with right spastic hemiparesis, mental retardation, depression, obsessive behavior and somnolence. R129's medications ordered on admit included: armodafinil (Nuvigil) 150 mg tab Take 1 tablet by mouth once daily. Review of R129's Medication Administration Record for January/February 2016 revealed an order for Nuvigil tab 150 mg. 1 tablet	F 329		

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F 329	Continued From page 26 orally daily. The medication was scheduled to be given in the AM. The medication administration record had nurses initials circled every day from 1/7/16 through 2/4/16. Six of the days had the letters NA written underneath the signatures, and the back side of the medication administration record had nothing written on it. Interview with the director of nursing (DON) on 2/15/17 at 12:51 p.m., indicated the facility did not have a policy regarding what the procedure was for when a medication was not available. DON indicated the expectation would be for the nurse to circle his or her initials and notify the physician of why the resident did not get the medication. DON explainednot being familiar with R129's case and would call the pharmacist to see if there was information regarding this and would also ask the staff. DON indicated if a resident's medication was not delivered by the pharmacy, the pharmacy should notify the facility. On 2/16/17 the DON verified there was no further information on why R129 did not receive the medications ordered by the physician, and the current staff did not recall the patient. The DON verified the physician was not notified in a timely manner of the resident not receiving the medication. Interview with registered nurse (RN)-A on 2/15/17 at 1:50 p.m., stated that if a resident's medication was not delivered by the pharmacy, she would call the pharmacy. If the medication still wasn't delivered she would contact the resident's physician. If the physician was not responsive to the request, she would contact the medical director. RN-A did not know if there was a policy for medications not being available.	F 329		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	F 334		3/28/17

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F 334	Continued From page 27 (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal	F 334		

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F 334	Continued From page 28 immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R89) reviewed for immunizations was offered and provided the Prevnar 13 Vaccine. Findings include: The Center for Disease Control and Prevention (CDC) identified, "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses	F 334	Resident #89 has received the Prevnar 13 vaccine as previously requested. All residents may be affected, but none show any ill effect. All other resident's immunization records were reviewed to determine if resident received the Prevnar 13 vaccine. Residents who request Prevnar 13 have	

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F 334	Continued From page 29 of PPV23 [pneumococcal polysaccharide 23 Valent Vaccine] should receive a dose of PCV13. The dose of PCV13 should be given at least 1 year after receipt of the most recent PPV23 dose." R89's Consent for Immunizations form, signed by R89 on 10/18/1, identified R89 as giving consent to receive a Prevnar 13 immunization, however had no documented evidence the PCV13 had been offered or administered. R89's medical record was reviewed and lacked any evidence of R89 having been offered or provided the PCV-13 as recommended by the CDC. Review of R89's face sheet indicated R89 admitted to the facility on 7/15/16, and completed the consent on 10/18/16 On 2/16/17, at 11:10 a.m., the director of nursing (DON) verified R89 had given consent for the Prevnar 13 immunization, and had not received the immunization.	F 334	received the vaccine. Audits of staff offering Prevnar 13 will be done with each admission. The Director of Nursing/designee is responsible for compliance. Audits to be reviewed at QAPI for three months to ensure adherence to this policy is being followed. Deficient practice to be corrected by 3/28/2017	
F 353 SS=F	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 353		3/28/17

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F 353	Continued From page 30 at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure enough staff were available to meet the needs of residents residing in the facility. This affected 9 of 9	F 353	DON will monitor daily nursing staffing to ensure sufficient staff is provided. All Residents may be affected, but none	

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F 353	Continued From page 31 residents (R3, R96, R51, R81, R37, R126, R73, R130, R19) and had the potential to affect all 57 residents in the facility. Findings include: During stage one resident interviews, the following complaints were made regarding facility insufficient staffing: On 2/13/17, at 7:00 p.m. R3's room was observed with a smell of urine closer to the bed. R3's admission Minimum Data Set (MDS) dated 8/25/16, indicated R3 was cognitively intact. R3 stated "Since I have moved up here to second floor, it is almost impossible to get up at all", and indicated wanting to get up after lunch. It began about a month or two ago, if rooms were not completely full, they only staff the unit with one nurse and one nursing assistant. R3 was told "we are too busy, we can't help you" and R3 stated "I wanna get up too!" R3 indicated pushing the call button for assistance sometime after breakfast around 9:00 a.m. thinking staff should have time to assist with cares and explained that a nursing assistant came into the room and practically yelled, stating there were lots of other residents, not just you! R3 stated, answering "ok", and explained just wanting to get out of bed. R3 stated the director of nursing (DON) was told about it and the DON said it would be looked into but there had been no response. R3 further stated the physician did not want R3 to independently transfer, but to use a Hoyer lift with assist of two, and staff told R3 they don't have time. On 2/13/17, at 7:04 p.m. when asked if R96 felt there were enough staff available to provide care	F 353	show any ill effect. Education provided to staffing department on proper staffing levels; problem solving calling in; and hours reduction when needed. Interviews with residents will be done 5 days per week to ensure care needs are being met to their specifications. Audits of call lights will be done 3 days per week. It is the responsibility of the Director of Nursing/designee to ensure compliance. Audits will be completed and reviewed at QAPI for three months to ensure sufficient staff is provided. Deficient practice to be corrected by 3/28/2017	

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and assistance without waiting a long time stated "not nearly." R96's admission MDS dated 12/9/16, indicated R96 was cognitively intact. R96 stated there was one nursing assistant and one nurse working both east and west units. R96 further indicated staffing was the worst after 10:00 p.m. and busiest in the mornings and afternoons.

On 2/13/17, at 7:04 p.m. when asked about call light response, R51 stated nursing assistants should respond to the call light within 10 minutes. R51's quarterly MDS dated 12/22/16, indicated R51 was cognitively intact. R51 stated staff would come into the room, turn off the call light and leave, stating they would return or were busy. Sometimes it took one-half to one hour for call light assistance. R51 further stated during shift change or during meal service R51 could not get any assistance, which happened frequently.

In an interview on 2/13/17, at 7:06 p.m. R81 stated should have received a shower at 9:15 a.m. but nursing assistant did not come until 10:45 a.m. R81's quarterly MDS dated 12/29/16, indicated R81 was cognitively intact. R81 stated they were short staffed at least once a week and had not been fully staffed the past day or two.

During an interview on 2/14/17, at 3:08 p.m. licensed practical nurse (LPN)-C stated was unable to get everything done during the shift when some duties had been carried over from the previous shift. LPN-C stated was often asked to work extra shifts once or twice a week and was currently working a double shift.

During an interview on 2/15/17, at 12:12 p.m. nursing assistant (NA)-D stated sometimes was

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not able to get work done during shift and passed it on to the next shift. NA-D further stated they were short staffed now, had been for about eight months, and tried to adjust the work load to complete duties. NA-D stated was burned out, and felt staff were looking for jobs elsewhere. NA-D further stated when new nursing assistants begin working, they don't like the heavy workload, so there is huge staff turnover.

During an interview on 2/15/17, at 12:30 p.m. LPN-D stated when they were short staffed, the work load was challenging, and would fall behind completing duties and work extra hours. LPN-D felt they should have a full-time health unit coordinator to process physician orders. LPN-D further indicated there was a facility nursing assistant shortage.

During an interview on 2/15/17, at 12:39 p.m. NA-E stated they were short staffed and were always short. The heavy care workload was time consuming taking 20 to 30 minutes per resident and only when you were experienced could you get work done within the allotted timeframe.

During an interview on 2/16/17, at 9:03 a.m. NA-F stated every week they were short staffed, most of the time had three nursing assistants or sometimes two, but should have four. NA-F stated this had been happening for about three years and year end was the worst. When new nursing assistant staff starts, they will see the heavy, short staffed work load and leave. NA-F further stated one day last week lunch trays sat for an hour before staff could distribute them and they had to heat them up to serve the meal. NA-F further stated the staff schedule listed four nursing assistants but only three were working.

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F 353	Continued From page 34 During an interview on 2/16/17, at 9:07 a.m. NA-G felt they needed a float nursing assistant on the first floor, was informed it was not in the budget, but we have extra help when State is here. NA-G indicated being unable to complete duties during the shift and could not complete every two hour checks or resident repositioning. Residents were left wet because there was no time for cares. NA-G further indicated would rush to complete duties, prioritize important duties, and may leave other duties to complete. During an interview with the director of nursing (DON) on 2/16/17, at 1:57 p.m. DON stated the call light report may not be accurate as sometimes staff would forget to turn off the light when they were in a room. If a resident stated they had the call light on for a long time, DON would talk to them about it. DON stated she, nurse managers and nursing assistants have pagers to assist with answering call lights. DON stated they had call light concerns a few months ago, pulled call light reports to view, and then got pagers. DON indicated used call light report as a tool, had not audited call lights lately on a regular basis, but would do that on an individual basis. During an interview with the DON on 2/16/17, at 2:03 p.m. DON stated staffing was consistent on long-term care units and would decrease if transitional care unit census was down. They may adjust long-term care units staff if census was down, would trim hours at the right time and at end of day shift times, not during high volume times. DON further stated she, nurses, and nurse managers, could help with toileting cares and included they also staff a weekend manager.	F 353		

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Review of the facility's device activity report from 1/14/2017 to 2/15/2017 p.m. listed call light reset times. Included below are 23 times when call lights remained on over 49 minutes.

2/10/17, for 78 minutes (m), 19 seconds (s)
2/9/17, for 71m, 25s
2/3/17, for 70m, 46s
2/12/17, for 70m, 16s
2/1/17, for 69m, 11s
2/8/17, for 68m, 48s
2/8/17, for 67m, 44s
2/8/17, for 62m, 36s
2/5/17, for 62m, 18s
2/2/17, for 61m, 35s
2/10/17, for 59m, 30s
2/11/17, for 58m, 41s
2//9/17, for 57m, 8s
2/10/17, for 56m, 10s
2/9/17, for 55m, 46s
2/14/17, for 55m, 10s
2/4/17, for 55m, 2s
2/9/17, for 54m, 36s
2/14/17, for 51m, 22s
2/5/17, for 50m, 12s
2/2/17, for 49m, 57s
2/9/17, for 49m, 47s
2/2/17, for 49m, 16s

The call light policy and procedure was requested, but not provided.

On 2/15/17, from 7:49 a.m. to 10:38 a.m., a total of 2 hours and 49 minutes, R37 was not observed to be asked to use the toilet or checked for urinary incontinence.

At 7:41 a.m. R37 was in bed and nursing assistant (NA)-A asked R37 about changing the

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incontinent pad, which NA-A stated was wet. R37 agreed and after pericare a new incontinent pad was placed. At 7:49 a.m. R37 requested of NA-A to use the toilet. NA-A assisted R37 to the toilet and R37 voided. Before being weighed, at 10:38 a.m., NA-A asked R37 about using the toilet, however R37 declined.

NA-A stated when he worked on the first floor, which NA-A stated was not often, he could get his work done and take his breaks. However, he generally worked second floor and it was hard to get the work done and take breaks.

R126 was not provided with incontinence care every two hours on 2/15/17, from 9:51 a.m. to 1:50 p.m. a total of 3 hours and 59 minutes.

On 2/15/17, at 9:30 a.m. R126 was observed during morning cares. At 9:37 a.m. R126's incontinent product was removed and noted to be wet and R126 was also incontinent of bowel. The condition of the pad was verified by nursing assistant (NA)-A who was providing incontinence care. At 9:51 a.m. NA-A had finished providing incontinence care for R126. At 10:12 a.m. R126 was gotten out of bed via a mechanical lift and three staff, and transferred into a wheelchair. At 12:42 p.m. R126 was served lunch in their room by NA-C and at 1:25 p.m. the lunch tray was picked up. R126 remained up in the wheelchair without being checked for urinary or bowel incontinence.

At 1:25 p.m. NA-C stated her shift ended at 2:00 p.m. When informed R126 had not been checked for urinary incontinence and repositioned for over three hours, NA-C verified the last time R126 had been checked for bladder and bowel incontinence

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F 353	Continued From page 37	F 353		

and repositioned was during morning cares. NA-A stated R126 was on an every two hour repositioning schedule, but sometimes staff could not get all their work done and sometimes staff did not get to take breaks. At 1:50 p.m. R126 was transferred back to bed via the mechanical lift and two staff. The incontinent pad was noted to be wet, and the condition of the pad was verified during incontinence care by NA-A. A dry scabbed over area was noted on R126's left buttock and a small open area was noted in the buttock crevice, near the coccyx.

A review of 12/8/16, resident council meeting minutes revealed residents were concerned about facility staffing.

On 2/16/17, at 11:10 a.m. R73 who frequently attended resident council meetings, stated staffing issues were brought up at every meeting, as were bedtime snacks. R73 stated the kitchen puts snacks out on the nursing desk counter every night and when there were only three people working on the second floor instead of four, snacks were not passed. R73 stated being able to go to the nursing desk and get their snack, as could several other residents, but there were some who were not able to get to the nursing desk independently.

R73 stated at 11:19 a.m. the staff issues were discussed and the executive director had acknowledged the issue. R73 stated it happened "fairly" often when there were only three staff on the second floor.

On 2/16/17, at 2:41 p.m. family member (FM)-B and FM-C stated R130 had mentioned it has taken over 20 minutes to have the call light

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F 353	Continued From page 38 answered when needing to use the restroom. FM-B and FM-C stated R130 was admitted to the facility on 2/12/17, and had for R130 to have a shower every day. FM-B and FM-C stated being told R130 would get a shower on 2/14/17, but that did not happen. Then FM-B and FM-C were told the shower would happen on 2/15/17, but R130 did not receive a shower on that date. FM-B and FM-C stated they were never told why R130 had not had a shower. FM-B and FM-C also stated there was one night when staff left R130's clothes on all night. The director of nurses (DON) stated at 3:30 p.m. R130 had received a shower when the family was speaking with the surveyor. The DON stated registered nurse (RN)-B had completed an incident report to investigate why R130 had not received a shower on either 2/14 or 2/15/17. Interview with R19's family on 2/13/17 at 5:15 p.m., indicated R19 has waited 20 - 30 minutes to receive assistance to go to the bathroom lately. R19's family explained that R19 could tell staff of the need to use the toilet and that R19 reported being incontinent of urine because staff did not come to assist R19 when family was not there to help. R19's family indicated when the State was in the building more staff were available to assist the residents.	F 353		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis:	F 356		3/28/17

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F 356	Continued From page 39 (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The	F 356		

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F 356	Continued From page 40 facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility failed to post the required nurse staffing information to include the actual hours worked by licensed and unlicensed staff for 2 of 2 days reviewed. This practice had the potential to affect family, staff, visitors and all 57 residents residing at the facility. Findings include: Observations of the posted staffing forms dated 2/11/17, and 2/12/17, lacked documentation for the actual number of staff shift hours worked by licensed and unlicensed staff at the facility. During the initial facility tour on 2/13/17, at approximately 11:55 a.m., the facility nurse staffing posting dated 2/13/17, was observed posted on the lobby wall near the first floor receptionist desk. The form identified the name of facility, the date, census, number of licensed and unlicensed staff, shift hours, and identified the shifts as day, evening and night. During an interview on 2/16/17, at 1:20 p.m. the Human Resources Director (HRD) stated staffing pattern was determined by looking at daily staffing schedule and matching it to the posted daily staff posting. Review of Punch Detail - Report Nursing dated 2017/01/11-2017/02/12 revealed staff shift hours did not reflect the posted shift hours dated 2/11/17, and 2/12/17.	F 356	Posting during survey were updated to reflect the actual hours worked by licensed and unlicensed personnel. All resident may be affected, but none show any ill effect. Education provided to staffing department on the expectations that the posting reflect actual hours worked by licensed and unlicensed personnel, including any changes that may occur during that day. Audits of postings will be done three times per week to ensure accuracy of posting of hours worked. The Director of Nursing/Staffing Coordinator is responsible to assure compliance. Audits to be reviewed at QAPI for three months to ensure adherence to this policy is being followed. Deficient practice to be corrected by 3/28/2017	

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F 356	Continued From page 41 Posted nurse staffing form dated 2/11/17, indicated: Staff worked: 2 RN, 2 LPN, 5 CNA 2:00 - 10:00 p.m. and 1 CNA 6:00 - 10:00 pm. Actual staff worked: 1 RN, 3 LPN and 4 CNA 2:00 - 10:00 p.m. and 1 CNA 6:00 - 10:00 p.m. This indicated 1 CNA was lacking 2/11/17. Posted nurse staffing form dated 2/12/17, indicated: Staff worked: 2 RN, 2 LPN, 5 CNA 2:00 - 10:00 p.m., 1 CNA 4:00 - 10:00 p.m. and 1 CNA 2:00 - 8:00 p.m. Actual staff worked: 2 RN, 2 LPN, 4 CNA, 2:00 - 10:00 p.m., 1 CNA 4:00 - 10:00 p.m. and 1 CNA 2:00 - 8:00 p.m. This indicated 1 CNA was lacking 2/12/17. During an interview on 2/16/17, at 1:41 p.m., HRD verified the actual shift hours worked by nursing staff at the facility for 2/12/17, was lacking. HRD stated was not aware actual shift hours worked should include revised number of staff on the posted daily staff posting. HRD further stated going forward would change the report to reflect revised staff hours worked on the daily staff posting. The policy and procedure for staffing posting was requested, but not provided.	F 356		
F 412 SS=D	483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS (b) Nursing Facilities	F 412		3/28/17

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F 412	Continued From page 42 The facility- (b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; (b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; (b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R37) received the appropriate dental services to ensure proper fitting dentures. Findings include: On 2/13/17, at 5:09 p.m. R37 was observed to be edentulous (without teeth) and a set of dentures was noted to be soaking in a denture cup in R37's bathroom. On 2/14/17, at 3:35 p.m. R37 was observed wearing the upper denture, but not the lower, as the lower denture was in a denture cup	F 412	Resident #37 has an appointment with dentist for services on dentures. All Residents maybe affected, but none show any ill effect. All residents were assessed for presence of dental problems and need for dental care. Staff have been educated on communicating the need for dental care for residents who present with dental problems.	

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F 412	Continued From page 43 in the bathroom. On 2/15/17, at 7:30 a.m. nursing assistant (NA)-A cleansed R37's dentures; and at 8:03 a.m. offered the dentures to R37 for placement. R37 stated "these are the only one's I want" and grabbed the lower denture and atteempted to put it in the top of his mouth and gagged. NA-A assisted R37 with removing the denture. R37 then took the correct denture, placed adhesive on the upper denture and placed the denture in mouth. At 8:08 a.m. R37 was asked why he did not want to wear the lower denture and stated having tried wearing the lower denture on and off for a month and it did not fit. R37 stated people said to give it a chance and he is done giving it a chance. On 2/14/17, at 12:46 p.m. family member (FM)-A stated R37 tells FM-A the dentures are uncomfortable; and FM-A told R37 the dentures could not be adjusted until they are worn more. FM-A stated R37 could be "difficult" and if R37 did not want to put the dentures in, then R37 would not be wearing the dentures. R37 BIMS (brief interview for mental status) score from the most recent MDS (minimum data set) dated 12/11/16, was recorded as "10" indicating some cognitive impairment. On 2/14/17, at 3:44 p.m. NA-B stated R37 did not like to wear the lower denture and R37 had stated the dentures did not fit. On 2/15/17, at 10:28 a.m. registered nurse (RN)-A stated sometimes R37 would wear the dentures and sometimes not. On 2/16/17, at 8:55 a.m. RN-A said R37 had	F 412	Audits will be conducted weekly with care conferences. It is the responsibility of the Director of Nursing/designee to assure compliance. Audits will be reviewed at QAPI for three months to ensure adherence to policy is followed. Deficient practice to be corrected by 3/28/2017	

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F 412	Continued From page 44 stated at times, the lower denture did not fit. On 2/16/17, at 8:50 a.m. the health information manager (HIM)-A stated she had reviewed the medical record and found R37 had not been to the dentist since first admitted to the facility on 8/24/16. HIM-A stated she had been able to find documentation that R37 had dental appointments prior to admission. HIM-A provided documentation from a dental clinic which indicated R37 had received new dentures for the first time on 7/26/16. Additional documentation obtained from the dental clinic revealed R37 had been complaining of the dentures, especially the lower denture, not fitting well and causing discomfort. The dental progress notes revealed denture adjustments had been done on 7/26, 7/28 and 8/2/16. R37 had not returned to the dental clinic for additional denture adjustments despite telling FM-A and other facility staff members the lower denture did not fit. The facility's 11/16, revised policy titled Dental Service (General) indicated the facility was to provide or obtain from an outside resource, routine and emergency dental services to meet the needs of each resident.	F 412		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 431		3/28/17

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F 431	Continued From page 45 (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431		

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F 431	Continued From page 46 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure expired medications were removed from storage and not given to residents. This affected one resident (R53) and had the potential to affect all other residents on 2 west who may have been given stock medications. Findings include: During medication storage review on 2/13/17, at 7:10 p.m. in the 2 west medication cart, the following expired stock medications were observed. Licensed practical nurse (LPN)-B confirmed expiration dates and removed medications from the cart for destruction. - Bottle of ¼ full Tums 500mg (milligrams) tablets with pharmacy label expiration date of 3/25/15, and manufacturer label expiration date of 2/17. - Bottle of ½ full magnesium oxide 400mg tablets with pharmacy label expiration date of 3/7/15, and manufacturer label expiration date of 10/16. - Bottle of ¾ full calcium with vitamin D 600/200mg tablets with pharmacy label expiration date of 8/17/16, and illegible manufacturer expiration date. - Full bottle of mineral oil with pharmacy label expiration date of 6/10/16, and manufacturer label expiration date of 10/16. - Bottle of loperamide 2mg capsules (46 capsules remained) with pharmacy label expiration date of	F 431	Identified expired medication was removed from circulation and destroyed according to procedure. All Residents may be affected, but none show any ill effect. All medications were audited to ensure no more expired medication were in circulation. Staff educated on looking for expiration dates and discarding medications if they are expired. Audits will be conducted three times per week. it is the responsibility of the Director of Nursing or designee to ensure compliance. Audits will be reviewed at QAPI for three months to ensure adherence to policy is followed. Deficient practice to be corrected by 3/28/2017	

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F 431	Continued From page 47 6/10/16, and no manufacturer label expiration date. One box of ipratropium bromide and albuterol sulfate was observed which contained 16 unopened vials with a pharmacy label expiration date of 10/3/16, and manufacturer expiration date of 1/17. F53's signed physician medication orders dated 1/16/17, included "ipratropium/sol albuter inhale 1 vial per neb 4 times daily as needed". LPN-B verified expiration date and removed the box from the medication cart. Review of R53's February 2017 medication administration record (MAR) indicated R53 received the medication once on 2/4/17, 2/5/17, 2/6/17, 2/9/17 and twice on 2/7/17, 2/8/17. During interview with the director of nursing (DON) on 2/14/17, at 3:41 p.m. DON stated expired medications should not be stored in the medication cart. DON further indicated the pharmacist stated manufacturer expiration dates should be used, not the pharmacy label expiration date. Review of the facility's undated Merwin LTC Pharmacy Disposition of Unused Medications policy revealed: "10. Outdated, contaminated or deteriorated medications and those in containers that are cracked, soiled, unlabeled or without secure closures are immediately removed from stock, disposed of according to facility procedures for medication destruction and reordered from the pharmacy if a current order exists."	F 431		

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F 441	Continued From page 48	F 441		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to:	F 441		3/28/17

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F 441	Continued From page 49 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper handwashing during cares for 2 of 4 residents (R37, R126) reviewed for urinary incontinence, who were observed during cares. Findings include: On 2/15/17, at 7:35 a.m. prior to starting morning cares for R37, nursing assistant (NA)-A was	F 441	NA-A was educated on proper hand-washing techniques. All residents may be affected, but none show any ill effect. Staff have been educated on proper hand-washing technique to provided a safe and sanitary environment. It is the responsibility of the Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. BUILDING _____ B. WING _____	C 02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CHATEAU HEALTH CARE CENTER	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 50 observed to wash hands and then don a pair of gloves. Perineal care was provided to R37, who had been incontinent of urine and who wore incontinent products. NA-A verified R37's incontinent product had been wet with urine. After completion of perineal care NA-A removed the gloves, and without washing hands, donned a new pair of gloves and helped R37 put on shoes and sit up in bed. At 7:49 a.m. R37 indicated the need to use the toilet. NA-A removed the gloves and without washing hands donned a new pair of gloves and assisted R37 to the toilet. After voiding on the toilet R37 was assisted back into the wheelchair by NA-A and then NA-A removed gloves. Without washing hands, NA-A donned a new pair of gloves and proceeded to assist R37 with putting dentures in. On 2/15/17, during morning cares at 9:37 a.m. R126 was observed to be incontinent of a small amount of stool. While wearing gloves NA-A cleansed R126's skin with disposable wipes. After cleansing R126, NA-A removed the gloves, donned a new pair of gloves without handwashing, and applied a barrier skin cream to R126's buttocks. After applying the cream, NA-A removed the gloves, donned new gloves without handwashing and assisted NA-C with dressing R126. At 9:45 a.m. while being dressed, R126 was again incontinent of stool. At 9:47 a.m. NA-A removed R126's soiled pants and NA-C placed R126's soiled pants in a bag. Without removing gloves and handwashing, NA-C got a new pair of pants for R126 and began putting the pants on R126's lower extremities with NA-A's assistance. At 9:49 a.m. NA-C was observed to remove gloves, wash hands for less than five seconds	F 441	Nursing/designee to ensure compliance. Audits will be conducted three times per week and results reviewed at QAPI for three months to ensure adherence to this policy. Deficient practice to be corrected by 3/28/2017	

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F 441	Continued From page 51	F 441		

and don a new pair of gloves. At 9:51 a.m. after having helped NA-C put R126's pants on the lower extremities, NA-A removed a pair of gloves and without handwashing donned a new pair of gloves and began cleansing R126's skin after the bowel incontinence. NA-A removed the soiled gloves after cleansing R126, but did not wash hands before putting on a new pair of gloves and assisting NA-C with the rest of R126's dressing. At 9:56 a.m. NA-A took the trash bag out of the trash can, tied the bag and placed the trash bag on R126's wheelchair seat. NA-A then removed the gloves, performed handwashing and assisted NA-C with transferring R126 from the bed to wheelchair.

On 2/15/17, at 1:50 p.m. R126 was assisted back to bed and was noted to be incontinent of urine and stool. The incontinence was verified by NA-A. Prior to incontinent care NA-A was observed to perform handwashing prior to donning a pair of clean gloves. After cleansing R126's skin NA-A removed the soiled gloves and without handwashing donned a new pair of gloves before placing a new and clean incontinent product beneath R126.

The facility's 4/1/08, policy titled Hand Washing and Gloves, Non-Sterile indicated staff were to wash their hands after each direct resident contact for which hand-washing was indicated by accepted professional practices; and that gloves that were contaminated with body fluids for which standard precautions applies, were to be removed as soon as possible and hands were to be washed upon removal of gloves.

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	245028	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/14/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Highland Chateau Healthcare Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/17/2017

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.

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Highland Chateau Healthcare Center is a 2-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1963 and was determined to be of Type II(222) construction. In 1970, an addition was constructed to the south side of the building that was determined to be of Type II(222) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fire sprinkler protected throughout. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor and resident rooms, that is monitored for automatic fire department notification. The facility has a licensed capacity of 64 beds and had a census of 57 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 211 SS=F	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has failed to provide a proper exit to the outside. This deficient practice could affect the safe and rapid evacuation of all residents, visitors, and staff in the event of an emergency that may require quick evacuation in accordance with section 7.1. 19.2.1 Findings include: On facility tour between 08:00 AM and 11:30 AM on 02/14/2017, it was observed that the east stair 1st floor exit door to the outside was difficult to open and took several attempts to force the door open. This deficient practice was verified by the facility staff (I), at the time of discovery.	K 211	The first floor exit door to the outside of the facility was fixed 2/14/2017. Audits will be completed 3 times a week to assure that doors remains working properly. Director of Environmental services is responsible to assure that audits are completed and that the door is working properly. Audits will be reviewed at QAPI for next three months to assure door is working properly.	3/28/17
K 363 SS=D	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a	K 363		3/28/17

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K 363	Continued From page 3 means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observations and interview, the facility has failed to maintain smoke/fire barrier doors in accordance with LSC 19.3.7.5. This deficient practice could affect all patients. Findings include: On facility tour between 08:00 AM and 11:30 AM on 01/06/2016, observation revealed: The doors between 112E and 113E bind and do not close all of the way. This creates a gap over 1/8 of an inch between the closed doors.	K 363	A special ordered door will be installed by May 15th. Audits will be completed on fire doors to assure that they are closing properly weekly for the next 3 months. Monthly there after. The Director of Environmental Services will be responsible to review audits and to report to QAPI for review of findings from audits.	

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K 363	Continued From page 4 This deficient practice was verified by the facility staff (I), at the time of discovery.	K 363		

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
March 7, 2017

Ms. Heather Welter, Administrator
Highland Chateau Health Care Center
2319 West Seventh Street
Saint Paul, MN 55116

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5028027

Dear Ms. Welter:

The above facility was surveyed on February 13, 2017 through February 16, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5028042. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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 me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00494	A. BUILDING: _____ B. WING _____	C 02/16/2017

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HIGHLAND CHATEAU HEALTH CARE CENTER	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On February 13, 14, 15, and 16, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. In addition, investigation of complaint H5028042 was also completed at the time of the licensing survey. The complaint was substantiated. Correction order issued at State Licensing 1535, Chapter 4658.1315. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section.	2 302		3/28/17

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2 302	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consumers were provided in a written or electronic form, a description of facility staff training for the care of residents with dementia/Alzheimer's, categories of staff trained, frequency of training and topics covered in the training. Findings Include: On 2/16/17 the admission packet given to all new admissions was reviewed. The packet lacked a description of facility staff training for the care of residents with dementia/Alzheimer's, categories of staff trained, frequency of training and topics covered in the training. On 2/16/17, at 11:10 a.m., the Director of Nursing (DON) confirmed the facility did not have any consumer education or information related to dementia/Alzheimer's training. The DON indicated she was going to talk to the administrator about it. At 12:30 p.m., the administrator verified the statement was not in the admission packet nor given to new admits in any other way. SUGGESTED METHOD OF CORRECTION: The administrator or designee could provide the information describing the staff training program, categories of employees trained and the frequency of the training, as required. The administrator or designee could develop an auditing system to ensure compliance.	2 302	corrected	

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2 302	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 302		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan for 2 of 4 residents (R37, R126) reviewed for urinary incontinence. Findings include: R37 was admitted to the facility on 8/24/16, and readmitted on 9/15/16. According to the readmission Minimum Data Set (MDS) dated 9/22/16, R37 was continent of urine. A quarterly MDS dated 11/27/16, indicated R37 was always incontinent of urine. A form titled Bowel and Bladder Functional	2 555	corrected	3/28/17

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2 555	Continued From page 5 Evaluation Tool-HDGR dated 12/12/16, indicated R37 was incontinent of bowel and bladder; and staff were to encourage and assist R37 with toileting every two hours and as needed. The care plan revised on 12/6/16, addressed R37's urinary incontinence and staff were to assist with toileting needs "as determined." However, the care plan was not revised after completion of the 12/12/16, urinary incontinence assessment, which directed staff to encourage and assist R37 with toileting every two hours and as needed. On 2/14/17, at 12:45 p.m. R37's family member-(A) stated R37 used incontinent products and went from being continent of urine when first admitted to the facility, to being incontinent. On 2/15/17, at 7:53 a.m. nursing assistant (NA)-A stated R37 never took self to the toilet as R37 was too unsteady. R126 was admitted to the facility on 1/31/17, with an indwelling Foley catheter. The care plan was revised on 2/6/17, indicating the catheter was removed and R126 was on a check and change program. However, the care plan was not revised to indicate the frequency of the check and change program, which had been identified in a Bowel and Bladder Functional Evaluation Tool-HDGR assessment dated 2/7/17. The 2/7/17, assessment verified the Foley catheter had been removed on 2/6/17, and indicated staff were to provide incontinence care every two hours and when necessary following each episode of incontinence. The facility's 11/1/16, revised policy titled Care Plans-Comprehensive indicated the care plan	2 555		

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2 555	Continued From page 6 was to be reviewed and revised after each assessment. The facility's 11/16, revised policy titled Bowel and Bladder Management-HDGR indicated a resident who was incontinent of bladder was to receive the appropriate treatment and services to prevent urinary tract infection and "restore continence to the extent possible." SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop a system to ensure a care plan is developed to reflect each residents' current care needs. The DON or designee could educate all appropriate staff on the system, and monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 555		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to develop the care plan	2 560	corrected	3/28/17

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2 560	Continued From page 7 for 1 of 3 residents (R37) with dental needs. Findings include: R37 was originally admitted to the facility on 8/24/16, and readmitted after hospitalizations on 9/15 and 11/10/16. The care plan dated as being initiated on 12/6/16, indicated R37 required assistance with grooming and if R37 refused cares, to re-approach at a later time. However, the care plan was not developed to indicate R37 at times refused to wear the lower denture due to concerns of it not fitting. On 2/13/17, at 5:09 p.m. R37 was observed to be edentulous and a set of dentures was noted to be soaking in a denture cup in R37's bathroom. On 2/14/17, at 3:35 p.m. R37 was observed wearing the upper denture, but not the lower, as the lower denture was in a denture cup in the bathroom. On 2/15/17, at 7:30 a.m. nursing assistant (NA)-A cleansed R37's dentures; and at 8:03 a.m. offered the dentures to R37 for placement. R37 stated "these are the only one's I want" and grabbed the lower denture, tried to put it in top of mouth and gagged. NA-A assisted R37 with removing the denture. R37 then took the correct denture, placed adhesive on the upper denture and placed the denture properly in mouth. At 8:08 a.m. R37 was asked about not wearing the lower denture. R37 stated had tried wearing the lower denture on and off for a month and it did not fit. R37 stated people said to give it a chance and that he is done giving it a chance. On 2/14/17, at 12:46 p.m. family member (FM)-A stated R37 told FM-A the dentures are	2 560		

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2 560	Continued From page 8 uncomfortable; and FM-A stated R37 was told that the dentures could not be adjusted until they were worn more. FM-A stated R37 could be "difficult" and if R37 did not want to put the dentures in, then R37 would not be wearing the dentures. A 8/24/16, document titled Nursing Comprehensive Admission Data Collection and Assessment indicated R37 had full dentures, but the dentures were not present at the time of the admission. A new Nursing Comprehensive Admission Data Collection and Assessment completed at the time of a readmission on 9/15/18, indicated R37's dentures were not present at the time of the readmission; and another Nursing Comprehensive Admission Data Collection and Assessment dated 11/10/16, completed at the time of another readmission, indicated R37 had full dentures which were present at the time of the admission. On 2/14/17, at 3:44 pm NA-B stated R37 did not like to wear the lower denture and R37 had stated the denture did not fit. On 2/15/17, at 10:28 a.m. registered nurse (RN)-A stated sometimes R37 would wear the dentures and sometimes not. On 2/16/17, at 8:55 a.m. RN-A stated R37 had stated at times, the lower denture did not fit. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could assure the policy and procedures are reviewed, revised as needed, staff trained and systems assessed, monitored and evaluated to assure the	2 560		

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2 560	Continued From page 9 comprehensive plan of care is developed and lists measurable objectives and timetables to meet each residents individual needs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement the care plan to ensure the necessary treatment and services were provided to minimize the development and promote healing of pressure ulcers for 1 of 2 residents (R126) identified with a pressure ulcer. Findings include: R126 was not repositioned on 2/15/17, from 10:12 a.m. to 1:50 p.m. a total of 3 hours and 38 minutes. An undated Initial Care plan directed staff to reposition R126 every two hours. At 10:12 a.m. R126 was assisted out of bed via a mechanical lift and three staff, and transferred into a wheelchair. At 12:42 p.m. R126 was served lunch in room by NA-C and at 1:25 p.m. the lunch tray was picked up. However, there was no	2 565	corrected	3/28/17

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2 565	Continued From page 10 attempt or offer to reposition R126 during either interaction. At 1:25 p.m. NA-C stated shift ended at 2:00 p.m. When informed R126 had not been repositioned since being transferred from the bed to the wheelchair, NA-C verified R126 had been up in the wheelchair since 10:12 a.m., which was after morning cares. NA-A verified R126 was on an every two hour repositioning schedule. At 1:50 p.m. R126 was transferred back to bed via the mechanical lift and two staff. An 11/16, revised policy titled Person-centered Plan of Care-Comprehensive indicated services were furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including	2 800		3/28/17

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2 800	Continued From page 11 registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure enough staff were available to meet the needs of residents residing in the facility. This affected 9 of 9 residents (R3, R96, R51, R81, R37, R126, R73, R130, R19) and had the potential to affect all 57 residents in the facility. Findings include: During stage one resident interviews, the following complaints were made regarding facility insufficient staffing: On 2/13/17, at 7:00 p.m. R3's room was observed with a smell of urine closer to the bed. R3's admission Minimum Data Set (MDS) dated 8/25/16, indicated R3 was cognitively intact. R3 stated "Since I have moved up here to second floor, it is almost impossible to get up at all", and indicated wanting to get up after lunch. It began about a month or two ago, if rooms were not completely full, they only staff the unit with one nurse and one nursing assistant. R3 was told "we are too busy, we can't help you" and R3 stated "I wanna get up too!" R3 indicated pushing the call button for assistance sometime after breakfast around 9:00 a.m. thinking staff should have time to assist with cares and explained that a nursing assistant came into the room and practically	2 800	corrected	

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2 800	Continued From page 12	2 800		

yelled, stating there were lots of other residents, not just you! R3 stated, answering "ok", and explained just wanting to get out of bed. R3 stated the director of nursing (DON) was told about it and the DON said it would be looked into but there had been no response. R3 further stated the physician did not want R3 to independently transfer, but to use a Hoyer lift with assist of two, and staff told R3 they don't have time.

On 2/13/17, at 7:04 p.m. when asked if R96 felt there were enough staff available to provide care and assistance without waiting a long time stated "not nearly." R96's admission MDS dated 12/9/16, indicated R96 was cognitively intact. R96 stated there was one nursing assistant and one nurse working both east and west units. R96 further indicated staffing was the worst after 10:00 p.m. and busiest in the mornings and afternoons.

On 2/13/17, at 7:04 p.m. when asked about call light response, R51 stated nursing assistants should respond to the call light within 10 minutes. R51's quarterly MDS dated 12/22/16, indicated R51 was cognitively intact. R51 stated staff would come into the room, turn off the call light and leave, stating they would return or were busy. Sometimes it took one-half to one hour for call light assistance. R51 further stated during shift change or during meal service R51 could not get any assistance, which happened frequently.

In an interview on 2/13/17, at 7:06 p.m. R81 stated should have received a shower at 9:15 a.m. but nursing assistant did not come until 10:45 a.m. R81's quarterly MDS dated 12/29/16, indicated R81 was cognitively intact. R81 stated they were short staffed at least once a week and

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2 800	Continued From page 13 had not been fully staffed the past day or two. During an interview on 2/14/17, at 3:08 p.m. licensed practical nurse (LPN)-C stated was unable to get everything done during the shift when some duties had been carried over from the previous shift. LPN-C stated was often asked to work extra shifts once or twice a week and was currently working a double shift. During an interview on 2/15/17, at 12:12 p.m. nursing assistant (NA)-D stated sometimes was not able to get work done during shift and passed it on to the next shift. NA-D further stated they were short staffed now, had been for about eight months, and tried to adjust the work load to complete duties. NA-D stated was burned out, and felt staff were looking for jobs elsewhere. NA-D further stated when new nursing assistants begin working, they don't like the heavy workload, so there is huge staff turnover. During an interview on 2/15/17, at 12:30 p.m. LPN-D stated when they were short staffed, the work load was challenging, and would fall behind completing duties and work extra hours. LPN-D felt they should have a full-time health unit coordinator to process physician orders. LPN-D further indicated there was a facility nursing assistant shortage. During an interview on 2/15/17, at 12:39 p.m. NA-E stated they were short staffed and were always short. The heavy care workload was time consuming taking 20 to 30 minutes per resident and only when you were experienced could you get work done within the allotted timeframe. During an interview on 2/16/17, at 9:03 a.m. NA-F stated every week they were short staffed, most	2 800		

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2 800	Continued From page 14 of the time had three nursing assistants or sometimes two, but should have four. NA-F stated this had been happening for about three years and year end was the worst. When new nursing assistant staff starts, they will see the heavy, short staffed work load and leave. NA-F further stated one day last week lunch trays sat for an hour before staff could distribute them and they had to heat them up to serve the meal. NA-F further stated the staff schedule listed four nursing assistants but only three were working. During an interview on 2/16/17, at 9:07 a.m. NA-G felt they needed a float nursing assistant on the first floor, was informed it was not in the budget, but we have extra help when State is here. NA-G indicated being unable to complete duties during the shift and could not complete every two hour checks or resident repositioning. Residents were left wet because there was no time for cares. NA-G further indicated would rush to complete duties, prioritize important duties, and may leave other duties to complete. During an interview with the director of nursing (DON) on 2/16/17, at 1:57 p.m. DON stated the call light report may not be accurate as sometimes staff would forget to turn off the light when they were in a room. If a resident stated they had the call light on for a long time, DON would talk to them about it. DON stated she, nurse managers and nursing assistants have pagers to assist with answering call lights. DON stated they had call light concerns a few months ago, pulled call light reports to view, and then got pagers. DON indicated used call light report as a tool, had not audited call lights lately on a regular basis, but would do that on an individual basis. During an interview with the DON on 2/16/17, at	2 800		

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2 800	Continued From page 15 2:03 p.m. DON stated staffing was consistent on long-term care units and would decrease if transitional care unit census was down. They may adjust long-term care units staff if census was down, would trim hours at the right time and at end of day shift times, not during high volume times. DON further stated she, nurses, and nurse managers, could help with toileting cares and included they also staff a weekend manager. Review of the facility's device activity report from 1/14/2017 to 2/15/2017 p.m. listed call light reset times. Included below are 23 times when call lights remained on over 49 minutes. 2/10/17, for 78 minutes (m), 19 seconds (s) 2/9/17, for 71m, 25s 2/3/17, for 70m, 46s 2/12/17, for 70m, 16s 2/1/17, for 69m, 11s 2/8/17, for 68m, 48s 2/8/17, for 67m, 44s 2/8/17, for 62m, 36s 2/5/17, for 62m, 18s 2/2/17, for 61m, 35s 2/10/17, for 59m, 30s 2/11/17, for 58m, 41s 2//9/17, for 57m, 8s 2/10/17, for 56m, 10s 2/9/17, for 55m, 46s 2/14/17, for 55m, 10s 2/4/17, for 55m, 2s 2/9/17, for 54m, 36s 2/14/17, for 51m, 22s 2/5/17, for 50m, 12s 2/2/17, for 49m, 57s 2/9/17, for 49m, 47s 2/2/17, for 49m, 16s The call light policy and procedure was	2 800		

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2 800	Continued From page 16 requested, but not provided. On 2/15/17, from 7:49 a.m. to 10:38 a.m., a total of 2 hours and 49 minutes, R37 was not observed to be asked to use the toilet or checked for urinary incontinence. At 7:41 a.m. R37 was in bed and nursing assistant (NA)-A asked R37 about changing the incontinent pad, which NA-A stated was wet. R37 agreed and after pericare a new incontinent pad was placed. At 7:49 a.m. R37 requested of NA-A to use the toilet. NA-A assisted R37 to the toilet and R37 voided. Before being weighed, at 10:38 a.m., NA-A asked R37 about using the toilet, however R37 declined. NA-A stated when he worked on the first floor, which NA-A stated was not often, he could get his work done and take his breaks. However, he generally worked second floor and it was hard to get the work done and take breaks. R126 was not provided with incontinence care every two hours on 2/15/17, from 9:51 a.m. to 1:50 p.m. a total of 3 hours and 59 minutes. On 2/15/17, at 9:30 a.m. R126 was observed during morning cares. At 9:37 a.m. R126's incontinent product was removed and noted to be wet and R126 was also incontinent of bowel. The condition of the pad was verified by nursing assistant (NA)-A who was providing incontinence care. At 9:51 a.m. NA-A had finished providing incontinence care for R126. At 10:12 a.m. R126 was gotten out of bed via a mechanical lift and three staff, and transferred into a wheelchair. At 12:42 p.m. R126 was served lunch in their room by NA-C and at 1:25 p.m. the lunch tray was	2 800		

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	00494	A. BUILDING: _____ B. WING _____	C 02/16/2017

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2 800	Continued From page 17 picked up. R126 remained up in the wheelchair without being checked for urinary or bowel incontinence. At 1:25 p.m. NA-C stated her shift ended at 2:00 p.m. When informed R126 had not been checked for urinary incontinence and repositioned for over three hours, NA-C verified the last time R126 had been checked for bladder and bowel incontinence and repositioned was during morning cares. NA-A stated R126 was on an every two hour repositioning schedule, but sometimes staff could not get all their work done and sometimes staff did not get to take breaks. At 1:50 p.m. R126 was transferred back to bed via the mechanical lift and two staff. The incontinent pad was noted to be wet, and the condition of the pad was verified during incontinence care by NA-A. A dry scabbed over area was noted on R126's left buttock and a small open area was noted in the buttock crevice, near the coccyx. A review of 12/8/16, resident council meeting minutes revealed residents were concerned about facility staffing. On 2/16/17, at 11:10 a.m. R73 who frequently attended resident council meetings, stated staffing issues were brought up at every meeting, as were bedtime snacks. R73 stated the kitchen puts snacks out on the nursing desk counter every night and when there were only three people working on the second floor instead of four, snacks were not passed. R73 stated being able to go to the nursing desk and get their snack, as could several other residents, but there were some who were not able to get to the nursing desk independently. R73 stated at 11:19 a.m. the staff issues were	2 800		

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2 800	Continued From page 18 discussed and the executive director had acknowledged the issue. R73 stated it happened "fairly" often when there were only three staff on the second floor. On 2/16/17, at 2:41 p.m. family member (FM)-B and FM-C stated R130 had mentioned it has taken over 20 minutes to have the call light answered when needing to use the restroom. FM-B and FM-C stated R130 was admitted to the facility on 2/12/17, and had for R130 to have a shower every day. FM-B and FM-C stated being told R130 would get a shower on 2/14/17, but that did not happen. Then FM-B and FM-C were told the shower would happen on 2/15/17, but R130 did not receive a shower on that date. FM-B and FM-C stated they were never told why R130 had not had a shower. FM-B and FM-C also stated there was one night when staff left R130's clothes on all night. The director of nurses (DON) stated at 3:30 p.m. R130 had received a shower when the family was speaking with the surveyor. The DON stated registered nurse (RN)-B had completed an incident report to investigate why R130 had not received a shower on either 2/14 or 2/15/17. Interview with R19's family on 2/13/17 at 5:15 p.m., indicated R19 has waited 20 - 30 minutes to receive assistance to go to the bathroom lately. R19's family explained that R19 could tell staff of the need to use the toilet and that R19 reported being incontinent of urine because staff did not come to assist R19 when family was not there to help. R19's family indicated when the State was in the building more staff were available to assist the residents.	2 800		

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2 800	Continued From page 19 SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could monitor, assess and evaluate to assure necessary staffing is provided to assure the needs of residents are met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in	2 840		3/28/17

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2 840	Continued From page 20 determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R126) dependent on staff for urinary incontinence care, received the appropriate services to minimize urinary incontinence. Findings include: R126 was not provided with incontinence care every two hours on 2/15/17, from 9:51 a.m. to 1:50 p.m. a total of 3 hours and 59 minutes. On 2/15/17, at 9:30 a.m. R126 was observed during morning cares. At 9:37 a.m. R126's incontinent product was removed and noted to be wet and R126 was also incontinent of bowel. The condition of the pad was verified by nursing assistant (NA)-A who was providing incontinence care. At 9:51 a.m. NA-A had finished providing incontinence care for R126. At 10:12 a.m. R126	2 840	corrected	

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2 840	Continued From page 21 was assisted out of bed via a mechanical lift and three staff, and transferred into a wheelchair. At 12:42 p.m. R126 was served lunch in room by NA-C and at 1:25 p.m. the lunch tray was picked up. R126 remained up in the wheelchair without being checked for urinary or bowel incontinence. At 1:25 p.m. NA-C stated shift ended at 2:00 p.m. When informed R126 had not been checked for urinary incontinence NA-C verified the last time R126 had been checked for urinary incontinence was during morning cares. NA-A stated R126 was on an every two hour repositioning/check and change schedule. At 1:50 p.m. R126 was transferred back to bed via the mechanical lift and two staff. The incontinent pad was noted to be wet, and the condition of the pad was verified during incontinence care by NA-A. A Bowel and Bladder Functional Evaluation Tool-HDGR was completed for R126 on 2/7/17, and identified an indwelling Foley catheter had been removed on 2/6/17. The assessment indicated staff were to provide incontinence care every two hours and when necessary following each episode of incontinence. The facility's 11/16, revised policy titled Bowel and Bladder Management-HDGR indicated a resident who was incontinent of bladder was to receive the appropriate treatment and services to prevent urinary tract infection and "restore continence to the extent possible." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review policies and procedures, revise as needed, train staff, assess the system, monitor, evaluate to assure residents who are incontinent of urine,	2 840		

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2 840	Continued From page 22 receive the necessary services and care related to incontinence. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R126) with facility identified pressure ulcers received the appropriate treatment and services to maximize healing and minimize the development of pressure ulcers. Findings include: R126 was admitted to the facility on 1/31/17, and	2 900	corrected	3/28/17

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2 900	Continued From page 23 according to a 2/1/17, Admission Skin Assessment there were no pressure ulcers at the time of admission. A nurses noted dated 2/2/17, revealed R126 developed a 2 centimeter long open area in the crevice of the buttocks. A Pathway Health Services Comprehensive Evaluation of Skin Risk Factors form dated 2/3/17, indicated the resident was bedfast, incontinent of bowel; and was assisted by two staff and hoyer for transfers and bed mobility and off loading/repositioning. Undated initial care plan directed staff to reposition R126 every two hours and there was a wound on R126's coccyx. A Wound Care Specialist Initial Evaluation document dated 2/7/17, revealed the area in the crevice was a stage III pressure ulcer on the coccyx and now measured 1 x 0.4 x 0.1 cm. Page two of the wound care sheet revealed "Wound is occurring amidst background of fairly significant moisture associated dermatitis. For that reason will trial barrier cream for wound care as it appears to be the causative event." The note further indicated a surgical debridement was performed and the coccyx area then measured 3 x 0.4 x 0.1 cm. The wound specialist saw R126 again on 2/14/17, and the pressure ulcer on the coccyx was noted to measure 0.8 x 0.2 x 0.1 cm, having gotten smaller. However, a new area on the left buttock, which measured 1 x 0.6 x 0.1 cm had developed and the wound care specialist indicated the area was caused by shearing. On 2/15/17, morning cares for R126 were observed. There was a dry, non-draining scabbed	2 900		

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2 900	Continued From page 24 area noted on the left buttock and an open area noted in the buttock crevice, on the coccyx. After completion of cares, at 10:12 a.m., R126 was transferred via mechanical lift and three staff from the bed to the wheelchair. R126 remained in room watching TV from 10:12 a.m. and at 12:42 p.m., was served lunch. At 1:25 p.m. nursing assistant (NA)-C picked up the lunch tray, placed it on a cart and took the cart to the kitchen. NA-C returned to the unit at 2:00 p.m. and when interviewed at this time verified R126 had not been repositioned since after morning cares. NA-C stated R126 was to be an every two hour repositioning. R126 was transferred back to bed, via a mechanical lift and two staff at 1:50 p.m. After completion of incontinence care, R126's skin was observed at 2:10 p.m. and the areas noted on the wound specialist documentation were measured by registered nurse (RN)-B and observed by nurse practitioner (NP)-B. RN-B stated the area on the left buttock measured 1.2 x 1 cm and stated there was no depth to the area. RN-B verified there was no drainage from the area and the area was scabbed over and dry. On 2/15/17, at 3:38 p.m. physical therapist (PT)-C stated she had worked with R126 after the transfer to the wheelchair. PT-C stated R126 did some leg exercises and some chair presses. However, PT-C stated she couldn't say R126 had cleared the wheelchair cushion to totally off- load. When asked about being able to off-load for at least a minute, PT-C stated R126 had low motivation and doubted R126 could clear the wheelchair cushion for that long.	2 900		

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2 900	Continued From page 25 The facility's 11/16, revised policy titled Pressure Injury/Skin Integrity/Wound Management-HDGR indicated residents who were at risk or who had a loss of skin integrity were to receive the appropriate treatment/services which might include: repositioning or "off-loading" as per resident assessment and care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to	2 910		3/28/17

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2 910	Continued From page 26 prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 1 of 4 residents (R37) reviewed for urinary incontinence was provided with the necessary treatment and services to minimize urinary incontinence and improve bladder function. Findings include: On 2/15/17, from 7:49 a.m. to 10:38 a.m., a total of 2 hours and 49 minutes, R37 was not observed to be asked to use the toilet or checked for urinary incontinence. At 7:41 a.m. R37 was in bed and nursing assistant (NA)-A asked R37 about changing the incontinent pad, which NA-A stated was wet. R37 agreed and after pericare a new incontinent pad was placed. At 7:49 a.m. R37 requested of NA-A to use the toilet. NA-A assisted R37 to the toilet and R37 voided. Before being weighed, at 10:38 a.m., NA-A asked R37 about using the toilet, however R37 declined. A form titled Bowel and Bladder Functional Evaluation Tool-HDGR dated 12/12/16, identified R37 was incontinent of bowel and bladder; and staff were to encourage and assist R37 with toileting every two hours and as needed. Record review revealed R37 had a urology appointment on 1/20/17. According to the urology	2 910	corrected	

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2 910	Continued From page 27	2 910		

referral document the urologist placed R37 on the antibiotic Cipro 250 milligrams (mg) for 10 days. The referral form directed staff to contact the urologist after completion of the antibiotic if there was no improvement in R37's urinary incontinence. The referral summary also indicated that after the facility contacted the urologist with a progress report, the urologist would pursue, "anatomical evaluation with imaging and cysto."

A review of nurses notes dated 1/20/17 to 1/31/17, revealed the only documentation regarding R37's urinary incontinence was referenced on 1/31/17, indicating R37 was incontinent of urine. There was no documentation to determine if R37's urinary incontinence had improved or if the urologist had been notified due to lack of urinary incontinence improvement. The Medication Administration Record dated 1/31/17, had a check mark in a box indicating the urologist had been updated, but there was no indication as to who had notified the urologist or what the conversation had entailed.

The care plan revised on 1/31/17, indicated a three-day voiding data collection to evaluate voiding patterns was to be completed. On 2/15/17, at 10:18 a.m. the three-day voiding data was requested and at 11:58 a.m. was provided by registered nurse (RN)-B. Review of the data collection form revealed data was collected from 2/7 to 2/9/17, however, many sections of the form were blank with no data collection. When this was pointed out, RN-B stated "Correct" and explained not having time to analyze the data.

The facility's 11/16, revised policy titled Bowel and Bladder Management-HDGR indicated a resident who was incontinent or bladder was to receive the

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2 910	Continued From page 28 appropriate treatment and services to prevent urinary tract infection and "restore continence to the extent possible." The policy also indicated the three-day bowel and bladder tracking tool was to be completed for incontinent residents with any significant change in incontinence and a person centered care plan was to be updated and revised to include the resident's bowel and bladder needs, goals and preferences. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for incontinence to assure they are receiving the necessary treatment/services to prevent incontinence. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk forincontinence. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the	21325		3/28/17

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21325	Continued From page 29 community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R37) received the appropriate dental services to ensure proper fitting dentures. Findings include: On 2/13/17, at 5:09 p.m. R37 was observed to be edentulous (without teeth) and a set of dentures was noted to be soaking in a denture cup in R37's bathroom. On 2/14/17, at 3:35 p.m. R37 was observed wearing the upper denture, but not the lower, as the lower denture was in a denture cup in the bathroom. On 2/15/17, at 7:30 a.m. nursing assistant (NA)-A cleansed R37's dentures; and at 8:03 a.m. offered the dentures to R37 for placement. R37 stated "these are the only one's I want" and grabbed the lower denture and atteempted to put it in the top of his mouth and gagged. NA-A assisted R37 with removing the denture. R37 then took the correct denture, placed adhesive on the upper denture and placed the denture in mouth. At 8:08 a.m. R37 was asked why he did not want to wear the lower denture and stated having tried wearing the lower denture on and off for a month and it did not fit. R37 stated people said to give it a chance and he is done giving it a chance. On 2/14/17, at 12:46 p.m. family member (FM)-A stated R37 tells FM-A the dentures are uncomfortable; and FM-A told R37 the dentures could not be adjusted until they are worn more. FM-A stated R37 could be "difficult" and if R37 did	21325	correct	

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21325	Continued From page 30 not want to put the dentures in, then R37 would not be wearing the dentures. R37 BIMS (brief interview for mental status) score from the most recent MDS (minimum data set) dated 12/11/16, was recorded as "10" indicating some cognitive impairment. On 2/14/17, at 3:44 p.m. NA-B stated R37 did not like to wear the lower denture and R37 had stated the dentures did not fit. On 2/15/17, at 10:28 a.m. registered nurse (RN)-A stated sometimes R37 would wear the dentures and sometimes not. On 2/16/17, at 8:55 a.m. RN-A said R37 had stated at times, the lower denture did not fit. On 2/16/17, at 8:50 a.m. the health information manager (HIM)-A stated she had reviewed the medical record and found R37 had not been to the dentist since first admitted to the facility on 8/24/16. HIM-A stated she had been able to find documentation that R37 had dental appointments prior to admission. HIM-A provided documentation from a dental clinic which indicated R37 had received new dentures for the first time on 7/26/16. Additional documentation obtained from the dental clinic revealed R37 had been complaining of the dentures, especially the lower denture, not fitting well and causing discomfort. The dental progress notes revealed denture adjustments had been done on 7/26, 7/28 and 8/2/16. R37 had not returned to the dental clinic for additional denture adjustments despite telling FM-A and other facility staff members the lower denture did not fit.	21325		

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21325	Continued From page 31 The facility's 11/16, revised policy titled Dental Service (General) indicated the facility was to provide or obtain from an outside resource, routine and emergency dental services to meet the needs of each resident. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure appropriate dental care is sought for residents who present with dental problems. Monitoring systems could be developed to ensure ongoing compliance and report the findings to the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21325		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper handwashing during cares for 2 of 4 residents (R37, R126) reviewed for urinary incontinence, who were observed during cares. Findings include:	21375	corrected	3/28/17

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21375	Continued From page 32 On 2/15/17, at 7:35 a.m. prior to starting morning cares for R37, nursing assistant (NA)-A was observed to wash hands and then don a pair of gloves. Perineal care was provided to R37, who had been incontinent of urine and who wore incontinent products. NA-A verified R37's incontinent product had been wet with urine. After completion of perineal care NA-A removed the gloves, and without washing hands, donned a new pair of gloves and helped R37 put on shoes and sit up in bed. At 7:49 a.m. R37 indicated the need to use the toilet. NA-A removed the gloves and without washing hands donned a new pair of gloves and assisted R37 to the toilet. After voiding on the toilet R37 was assisted back into the wheelchair by NA-A and then NA-A removed gloves. Without washing hands, NA-A donned a new pair of gloves and proceeded to assist R37 with putting dentures in. On 2/15/17, during morning cares at 9:37 a.m. R126 was observed to be incontinent of a small amount of stool. While wearing gloves NA-A cleansed R126's skin with disposable wipes. After cleansing R126, NA-A removed the gloves, donned a new pair of gloves without handwashing, and applied a barrier skin cream to R126's buttocks. After applying the cream, NA-A removed the gloves, donned new gloves without handwashing and assisted NA-C with dressing R126. At 9:45 a.m. while being dressed, R126 was again incontinent of stool. At 9:47 a.m. NA-A removed R126's soiled pants and NA-C placed R126's soiled pants in a bag. Without removing gloves and handwashing, NA-C got a new pair of pants for R126 and began putting the pants on R126's lower extremities with NA-A's assistance. At 9:49 a.m. NA-C was observed to remove	21375		

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21375	Continued From page 33	21375		

gloves, wash hands for less than five seconds and don a new pair of gloves. At 9:51 a.m. after having helped NA-C put R126's pants on the lower extremities, NA-A removed a pair of gloves and without handwashing donned a new pair of gloves and began cleansing R126's skin after the bowel incontinence. NA-A removed the soiled gloves after cleansing R126, but did not wash hands before putting on a new pair of gloves and assisting NA-C with the rest of R126's dressing. At 9:56 a.m. NA-A took the trash bag out of the trash can, tied the bag and placed the trash bag on R126's wheelchair seat. NA-A then removed the gloves, performed handwashing and assisted NA-C with transferring R126 from the bed to wheelchair.

On 2/15/17, at 1:50 p.m. R126 was assisted back to bed and was noted to be incontinent of urine and stool. The incontinence was verified by NA-A. Prior to incontinent care NA-A was observed to perform handwashing prior to donning a pair of clean gloves. After cleansing R126's skin NA-A removed the soiled gloves and without handwashing donned a new pair of gloves before placing a new and clean incontinent product beneath R126.

The facility's 4/1/08, policy titled Hand Washing and Gloves, Non-Sterile indicated staff were to wash their hands after each direct resident contact for which hand-washing was indicated by accepted professional practices; and that gloves that were contaminated with body fluids for which standard precautions applies, were to be removed as soon as possible and hands were to be washed upon removal of gloves.

SUGGESTED METHOD OF CORRECTION: The

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21375	Continued From page 34 director of nursing or designee, could review policies and procedures related to infection control, specific to proper hand washing techniques, train staff and monitor to assure proper techiniques are being utilized. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTIONS: Twenty one (21) days	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced	21426		3/28/17

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21426	Continued From page 35 by: Based on document review and interview, the facility failed to ensure 3 of 5 residents (R96, R103, and R124) and 1 of 5 employees (RN-B) had baseline screening for tuberculosis. Findings include: The Regulations of Tuberculosis Control in Minnesota Health Care Settings, July 2013, directed all residents must receive a baseline tuberculosis (TB) screening within 72 hours of admission or within 3 months prior to admission, and baseline TB screening is required for all Health Care Workers (HCWs). The screening must include an assessment of the resident's or employee's current symptoms of active TB disease, risk factors for TB, and any current TB symptoms, and testing for the presence of infection with Mycobacterium tuberculosis by administering either a two step tuberculin sensitivity test (TST), or a single Interferon Gamma Release Assay (IGRA). R96 was admitted to the facility on 12/2/16. R96's "Baseline TB Screening Tool of Residents Template", indicated R96 received a TST - First step on 12/13/16, eleven days after admission. R103 was admitted to the facility on 9/25/16. R103's medical record lacked documentation of the date and time the TST-first step was read, the Tuberculin manufacturer, the date the screening form was completed, and the administration of the second step. R124 was admitted to the facility on 1/25/17. R124's medical record lacked documentation of any TB screening upon admission.	21426	corrected	

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21426	Continued From page 36 Review of registered nurse (RN) -B's Baseline TB Screening Tool for HCW's Template dated 11/21/16, lacked a TST-second step. On 2/16/17, at 11:00 a.m., the Director of Nursing (DON) verified the lack of documentation for R103 and R124, the timing of R 96's baseline TST and RN-B's lack of a two step TST. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review policies and procedures related to the components of the infection control and TB monitoring program. Facility staff could be educated on the TB regulations and the two step Mantoux process. The director of nursing and/or designee could develop a monitoring system to ensure ongoing compliance with TB screening. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section	21535		3/28/17

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21535	Continued From page 37 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure appropriate monitoring for 2 of 6 residents (R103, R129) reviewed for unnecessary medications. Findings include: Staff failed to monitor and document target behaviors for R103. R103 admitted to the facility on 9/25/16. Review of the undated Medical Data Sheet in R103's chart revealed diagnoses of Alzheimer's dementia, anxiety, and depression. R103's chart included current orders for Ativan and Paxil. The physician ordered 0.5 mg (milligrams) of Ativan to be given twice daily for agitation, and another 0.5 mg Ativan to be given as needed twice daily. The physician ordered 20 mg of Paxil daily for anxiety and depression. Review of R103's care plan, dated 10/7/16, revealed a focus on R103's use of antianxiety medications Ativan and Paxil, related to anxiety disorder. Interventions listed in the care plan required staff to monitor and record occurrences	21535	corrected	

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21535	Continued From page 38 of target behavior symptoms, and document them per facility protocol. Review of the Unnecessary Drugs - Antipsychotic Drugs policy, last revised 4/09, revealed the following requirement: "All target behaviors must be quantitatively and objectively documented in the resident's medical record and/or on the medication administrative record, to monitor the effectiveness or the side effects of the antipsychotic." In an interview on 2/16/17, at 12:50 p.m., when asked where staff documented target behaviors, registered nurse (RN)-G said staff should document all behaviors on the Flow Record in the medication administrative record (MAR). RN-G continued that staff should always monitor behaviors, whether the medication was scheduled to be given at regular intervals, or to be given only as needed. RN-G looked through the MAR to find the Flow Records for February, saying "they have to be here." After looking through the records for R103's Flow Record, at 1:05 p.m. RN-G stated, "I can't find the February one." RN-G created a new Flow Sheet for Ativan and Paxil, to monitor and document target behaviors for the rest of February. Review of the Record of Medication Regimen Review revealed the pharmacist most recently reviewed R103's medication regimen on 2/14/17. The pharmacist wrote a short-hand comment for staff to monitor for the Ativan. In an interview on 2/16/17, at 4:28 p.m. the pharmacist confirmed visiting the facility on 2/14/17, and said she did not see evidence of staff monitoring target behaviors in February. The pharmacist confirmed noting on the Record of	21535		

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21535	Continued From page 39 Medication Regimen Review that staff needed to monitor target behaviors for R103. R129 did not receive medications per physician orders. Review of R129's medical record indicated R129 was admitted to the facility on 1/6/16 with diagnosis including status post epilepsy surgery, intractable epilepsy, Cerebral Palsy with right spastic hemiparesis, mental retardation, depression, obsessive behavior and somnolence. R129's medications ordered on admit included: armodafinil (Nuvigil) 150 mg tab Take 1 tablet by mouth once daily. Review of R129's Medication Administration Record for January/February 2016 revealed an order for Nuvigil tab 150 mg. 1 tablet orally daily. The medication was scheduled to be given in the AM. The medication administration record had nurses initials circled every day from 1/7/16 through 2/4/16. Six of the days had the letters NA written underneath the signatures, and the back side of the medication administration record had nothing written on it. Interview with the director of nursing (DON) on 2/15/17 at 12:51 p.m., indicated the facility did not have a policy regarding what the procedure was for when a medication was not available. DON indicated the expectation would be for the nurse to circle his or her initials and notify the physician of why the resident did not get the medication. DON explainednot being familiar with R129's case and would call the pharmacist to see if there was information regarding this and would also ask the staff. DON indicated if a resident's medication was not delivered by the pharmacy, the pharmacy should notify the facility. On 2/16/17 the DON verified there was no further information on why	21535		

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21535	Continued From page 40 R129 did not receive the medications ordered by the physician, and the current staff did not recall the patient. The DON verified the physician was not notified in a timely manner of the resident not receiving the medication. Interview with registered nurse (RN)-A on 2/15/17 at 1:50 p.m., stated that if a resident's medication was not delivered by the pharmacy, she would call the pharmacy. If the medication still wasn't delivered she would contact the resident's physician. If the physician was not responsive to the request, she would contact the medical director. RN-A did not know if there was a policy for medications not being available. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could work in conjunction with the consultant pharmacist to develop policies and procedures related to monitoring behaviors of residents who are prescribed antipsychotic medications, and ensuring residents receive medications as ordered. The DON could educate staff related to these changes in policy and procedure, and audit resident records to ensure process changes are implemented. Results of audits could be reported to the quality assurance committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled	21620		3/28/17

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21620	Continued From page 41 in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure expired medications were removed from storage and not given to residents. This affected one resident (R53) and had the potential to affect all other residents on 2 west who may have been given stock medications. Findings include: During medication storage review on 2/13/17, at 7:10 p.m. in the 2 west medication cart, the following expired stock medications were observed. Licensed practical nurse (LPN)-B confirmed expiration dates and removed medications from the cart for destruction. - Bottle of ¼ full Tums 500mg (milligrams) tablets with pharmacy label expiration date of 3/25/15, and manufacturer label expiration date of 2/17. - Bottle of ½ full magnesium oxide 400mg tablets with pharmacy label expiration date of 3/7/15, and manufacturer label expiration date of 10/16. - Bottle of ¾ full calcium with vitamin D 600/200mg tablets with pharmacy label expiration date of 8/17/16, and illegible manufacturer expiration date. - Full bottle of mineral oil with pharmacy label expiration date of 6/10/16, and manufacturer label expiration date of 10/16. - Bottle of loperamide 2mg capsules (46 capsules remained) with pharmacy label expiration date of 6/10/16, and no manufacturer label expiration date.	21620	corrected	

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21620	Continued From page 42 One box of ipratropium bromide and albuterol sulfate was observed which contained 16 unopened vials with a pharmacy label expiration date of 10/3/16, and manufacturer expiration date of 1/17. F53's signed physician medication orders dated 1/16/17, included "ipratropium/sol albuter inhale 1 vial per neb 4 times daily as needed". LPN-B verified expiration date and removed the box from the medication cart. Review of R53's February 2017 medication administration record (MAR) indicated R53 received the medication once on 2/4/17, 2/5/17, 2/6/17, 2/9/17 and twice on 2/7/17, 2/8/17. During interview with the director of nursing (DON) on 2/14/17, at 3:41 p.m. DON stated expired medications should not be stored in the medication cart. DON further indicated the pharmacist stated manufacturer expiration dates should be used, not the pharmacy label expiration date. Review of the facility's undated Merwin LTC Pharmacy Disposition of Unused Medications policy revealed: "10. Outdated, contaminated or deteriorated medications and those in containers that are cracked, soiled, unlabeled or without secure closures are immediately removed from stock, disposed of according to facility procedures for medication destruction and reordered from the pharmacy if a current order exists." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise	21620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00494	A. BUILDING: _____ B. WING _____	C 02/16/2017

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21620	Continued From page 43 policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of labeling medications properly and discarding expired medications. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		
21710	MN Rule 4658.1415 Subp. 7 Plant Housekeeping, Operation, & Maintenance Subp. 7. Hot water temperature. Hot water supplied to sinks and bathing fixtures must be maintained within a temperature range of 105 degrees Fahrenheit to115 degrees Fahrenheit at the fixtures. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure water temperatures in resident bathrooms and/or bathing rooms were maintained at a comfortable range. This had the potential to affect 16 residents identified by the facility on 2/16/17, at 12:10 p.m. as having diagnoses that included Alzheimer's, dementia or other related diagnoses of the 57 residents who resided in the facility. Findings include: On 2/13/17, at 5:30 p.m. the water in the bathroom of room 111 was noted to feel overly warm to the touch by two different surveyors. At this time, water temperatures were tested with the executive director (ED) and two surveyors	21710	corrected	3/28/17

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21710	Continued From page 44 utilizing a thermometer provided and operated by the ED. Water temperatures were noted in the following areas on 2/13/17, to be greater than 120 degrees Fahrenheit (F). At 5:57 p.m. the water in room 104-west (W) registered 132° (degrees) (F) using a laser heat gun. The ED agreed the water felt hot to the touch. At 6:01 p.m. water in room 111-W registered at 110° F using the laser thermometer. The ED, who was testing the water, touched the water and stated "That's hotter than 110, I know my temperatures." The ED stated he was going to get a different thermometer, which he personally used when testing water temperatures, and compared the two thermometers. When the water in room 111-W was retested using the ED's thermometer, the water temperature registered at 125° F. At 6:01 p.m. the water in room 105-W registered at 123.4° F with the ED's thermometer and 107° F with the laser thermometer. At 6:09 p.m. the water in room 112-E registered at 128.8° F. The ED stated "the gun needs calibrating" At 6:12 p.m. the water in room 114-E registered at 126.4° F with the ED's thermometer. The resident in the room stated the water temp felt fine. At this time the ED again stated the laser gun thermometer needed to be recalibrated. All water temps taken after this, were taken using the ED's thermometer.	21710		

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21710	Continued From page 45 At 6:18 p.m. the water in room 240-E registered at 124.2° F. The resident in room 240-E stated had not used the bathroom, but the resident in 239-E did, as it was a shared bathroom. The resident in 239-E was not available for interview. At 6:20 p.m. the water in room 228-E registered at 127.5° F; at 6:22 p.m. the water in the 2 East shower registered at 126.7° F. At 6:25 p.m. the resident in room 221-CE stated the water heated up quickly, but liked hot water. When tested the water in the bathroom of 221-CE registered 125.3° F. At 6:31 p.m. the water in room 207-W registered at 118.5. When asked if the water temperature was still rising, the ED said it was still slowly rising, and that "I imagine that if we left it running it would continue to slowly rise." A review of water temperature logs from 1/17 and 2/17, revealed water temperatures ranged from temps 100° to 123° F. The log indicated water temperatures were taken once a day in different areas of the facility. At 7:34 p.m. the ED stated the maintenance staff had just determined there was a mixing valve problem. On 2/15/17, at 7:56 a.m. R37 was observed to turn on both the hot and cold water valves in the bathroom sink, while the nursing assistant was in the bedroom. When asked how the water temperature was he stated it was "warmer than average". SUGGESTED METHOD OF CORRECTION: The maintenance supervisor, administrator or	21710		

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21710	Continued From page 46 designee could review and revise policies and procedures related to ensuring hot water supplied to sinks and bathing fixtures is maintained within a temperature range of 105 degrees Fahrenheit to 115 degrees Fahrenheit at the fixtures. The maintenance supervisor, administrator or designee could develop a system to educate staff and develop a monitoring system to ensure hot water supplied to sinks and bathing fixtures is maintained within a temperature range of 105 degrees Fahrenheit to 115 degrees Fahrenheit at the fixtures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21710		