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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DWUB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00988

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245332**

2. STATE VENDOR OR MEDICAID NO. (L2) **839427000**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE ESTATES AT EXCELSIOR LLC**
(L4) **515 DIVISION STREET**
(L5) **EXCELSIOR, MN** (L6) **55331**

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) **04/01/2006**

6. DATE OF SURVEY **03/22/2017** (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 **56** (L18)

13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:

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
	56			
(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 :
Kathy Sass, HPR-Dietary Specialist 03/29/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/7/2017 (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 **07/01/1986** (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. **00454** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245332

March 29, 2017

Ms. Jill Lubbesmeyer, Administrator
The Estates At Excelsior LLC
515 Division Street
Excelsior, MN 55331

Dear Ms. Lubbesmeyer:

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 March 17, 2017 the above facility is certified for:

56 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Program Assurance Unit
Licensing and Certification Program
Minnesota Department of Health
Email: Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 29, 2017

Ms. Jill Lubbesmeyer, Administrator
The Estates At Excelsior LLC
515 Division Street
Excelsior, MN 55331

RE: Project Number S5332026

Dear Ms. Lubbesmeyer:

On February 23, 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 9, 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 March 22, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 9, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 17, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 9, 2017, effective March 17, 2017 and therefore remedies outlined in our letter to you dated February 23, 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,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245332 Y1	A. Building B. Wing Y2	3/22/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT EXCELSIOR LLC	515 DIVISION STREET EXCELSIOR, MN 55331

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 F0274	Correction	ID Prefix F0334	Correction	ID Prefix F0371	Correction
Reg. # 483.20(b)(2)(ii)	Completed	Reg. # 483.80(d)(1)(2)	Completed	Reg. # 483.60(i)(1)-(3)	Completed
LSC	03/17/2017	LSC	03/17/2017	LSC	03/17/2017
ID Prefix F0441	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/17/2017	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/9/2017	☐ YES ☐ NO

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

March 29, 2017

Ms. Jill Lubbesmeyer, Administrator
The Estates At Excelsior LLC
515 Division Street
Excelsior, MN 55331

Re: Reinspection Results - Project Number S5332026

Dear Ms. Lubbesmeyer:

On March 22, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 9, 2017, with orders received by you on March 8, 2017. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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,

Kamala Fiske-Downing

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00988 Y1	A. Building B. Wing Y2	3/22/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT EXCELSIOR LLC	515 DIVISION STREET EXCELSIOR, MN 55331

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 20545	Correction	ID Prefix 21015	Correction	ID Prefix 21375	Correction
Reg. # MN Rule 4658.0400 Subp. 3 A-C	Completed	Reg. # MN Rule 4658.0610 Subp. 7	Completed	Reg. # MN Rule 4658.0800 Subp. 1	Completed
LSC	03/17/2017	LSC	03/17/2017	LSC	03/17/2017
ID Prefix 21426	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # MN St. Statute 144A.04 Subd. 3	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/17/2017	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/9/2017	☐ 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: DWUB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00988

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245332**

2. STATE VENDOR OR MEDICAID NO. (L2) **839427000**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE ESTATES AT EXCELSIOR LLC**
(L4) **515 DIVISION STREET**
(L5) **EXCELSIOR, MN** (L6) **55331**

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) **04/01/2006**

6. DATE OF SURVEY **02/09/2017** (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 **56** (L18)

13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(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 :
Magdalene Jares, HFE NE II 03/17/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/28/2017 (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 **07/01/1986** (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. **00454** (L31)

30. REMARKS
Change of ownership during survey cycle

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 23, 2017

Ms. Jill Lubbesmeyer, Administrator
Golden LivingCenter - Excelsior
515 Division Street
Excelsior, MN 55331

RE: Project Number S5332026

Dear Ms. Lubbesmeyer:

On February 9, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the 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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by 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 21, 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 9, 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 9, 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,

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

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
	245332	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT EXCELSIOR LLC	515 DIVISION STREET EXCELSIOR, MN 55331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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.	F 000		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a significant change of condition Minimum Data Set (MDS) for 1 of 3 (R45) residents observed for activities of daily living (ADLs).	F 274	F274 ~R45 has completed significant change MDS based on decline in residents status that was impacted in one or more area's of residents health and careplan was revised by IDT	3/17/17

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

Electronically Signed | 03/16/2017

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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	245332	A. BUILDING _____ B. WING _____	02/09/2017

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F 274	Continued From page 1 Findings include: During an observation on 2/7/17, at 12:10 p.m. R45 was standing watching staff dish food up for lunch. Staff encouraged R45 to sit at the dining room table and eat a hot dog. R45 refused. The Alzheimer's care director offered R45 a chocolate ice cream. R45 sat down at the dining room table. -At 12:25 p.m. R45 stated was done with lunch. The hot dog remained on plate. R45 had eaten a chocolate magic cup (fortified thicken frozen supplement), a vanilla ice cream cup and had drunk a can of Pepsi. On 2/8/17, at 10:58 a.m. the executive director walked R45 to his room and talked R45 into allowing licensed practical nurse (LPN)-B help R45 to change into clean clothing. R45 refused to allow surveyor observe cares. R45's annual MDS dated 9/2/16, indicated R45 was severely cognitively impaired. The facility did not complete the delirium assessment of the MDS. The mood indicator noted minimal depression. In the mood section, indicated R45 displayed physical behaviors toward others and other behaviors not directed at others, one to three times a week. R45's MDS indicated R45 rejected assistance with cares one to three times a week. The MDS identified R45 as requiring limited assistance (resident is highly involved in the activity with staff providing guidance or non-weight bearing assistance) with toileting and personal hygiene, supervision (oversight and encouragement) with dressing and bed mobility and was independent with transfers, walking and locomotion on and off the unit and eating. The MDS also indicated R45 was occasionally incontinent of bladder and frequently incontinent	F 274	~MDS Coordinator and Interdisciplinary team re-educated on validation warnings of significant changes when completing MDS ~Review and identification of potential significant changes in residents physical and mental health will be completed at morning stand-up with Interdisciplinary team ~DNS or designee to audit 2 random MDS's on a monthly basis for validation warnings for possibility of significant changes ~The date of completion is 3/15/17 ~The facility QAPI committee will review the audits quarterly for further recommendations	

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F 274	Continued From page 2 of bowel. R45's Quarterly MDS dated 12/3/16, indicated R45 was severely cognitively impaired and behaviors included continuous inattention, and disorganized thinking. The mood indicator noted R45 to be mildly depressed. The mood section indicated R45 displayed physical and verbal behaviors toward others one to three times a week and behaviors not directed towards others four to six times a week but not daily. R45's MDS indicated R45 rejected assistance with cares daily. The quarterly MDS indicated a decline in all areas of activities of daily living. R45 required extensive assistance (resident involved in activity but staff provided weight bearing support) with bed mobility, dressing, toileting and personal hygiene, limited assistance with eating and locomotion on the unit and required supervision with transfers, walking in room and corridor and locomotion off the unit. The MDS also indicated R45 experienced a decline in bladder continence and was frequently incontinent of bladder. During interview on 2/8/17, at 11:38 a.m. LPN-B said, "[R45] prefers men only for cares. You cannot push him and we have to praise him and focus on how he would dress for work." During interview on 2/8/17, at 11:38 a.m. registered nurse (RN)-A, the MDS coordinator said." We probably should have done a significant change MDS. His decline was gradual and it was permanent. I think it was more behavioral. We should have talked about it at the quarterly and done a significant change MDS at that time." When asked for a policy RN-A said we follow the RAI (Resident Assessment Instrument) process.	F 274		

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F 274	Continued From page 3 According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated last revised on October 2016, "A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not 'self-limiting' (for declines only); 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan."	F 274		
F 334 SS=E	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (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:	F 334		3/17/17

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F 334	Continued From page 4 (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 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	F 334		

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F 334	Continued From page 5 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 implement the current standards of immunizations for pneumonia for 4 of 5 residents (R65, R54, R33, R6). Findings include: The Center for Disease Control (CDC) and Prevention identified, "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 (Pneumococcal Polysaccharide 23, a vaccine to reduce risk infection from 23 forms of pneumococcal bacteria) should receive a dose of pneumococcal 13-valent Conjugate Vaccine (PCV13). The dose of PCV13 should be administered at least one year after the most recent PPSV23 dose. R65's record indicated the 57 year old had resided at the facility since 1/31/17. R65's immunization record revealed resident had not been offered Influenza, PCV13 and PPSV23 since admit to the facility. R65's diagnoses included hypertension, benign prostatic hyperplasia without lower urinary tract symptoms, major depressive disorder, age-related cognitive decline, and abdominal pain obtained from the Medication Administration Record (MAR) for February 2017. On 2/8/17, at 3:10 p.m. during review of R65's immunization record, with the director of nursing (DON), it was revealed a undated consent indicated resident had refused the influenza	F 334	F334 ~R65, R54, R33 and R6 have been offered PPSV23 and PCV13 and Influenza immuniation, received education regarding the benefits of potential side effects of the immunization, provided opportunity to refuse immunization, and have documentation in the medical record ~ Forms were modified to indicate PPSV23 and PCV13 with the print outs of risks and benefits and forms will be completed upon admission and yearly. ~Re-education of licensed staff of admission process including completion of consent forms for PPSV23 and PCV13 and Influenza immunization ~DNS or designee to complete audit of all in-house resident charts and will be audited with every new admission chart review second check. ~The date of completion will be 3/15/17 ~The facility QAPI committee will review the audits quarterly for further recommendations	

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vaccine and a note had been entered in the medical record which indicated, "Refused consent per hospital [Health and Physical]." In addition, the consent did not indicate if either PV13 or PPV23 had been offered since admission to the facility. The DON verified the medical record lack evidence if the immunizations had been offered.
-At 3:11 p.m. DON stated, "It is supposed to be done on admit and is part of the forms that are supposed to be completed. My former ADON [assistant director of nursing] was responsible for making sure it was done but has since left and I am trying to keep up on that."

R54's medical record indicated R54 had resided at the facility since 11/17/16. R54's Immunization Report printed 2/9/17, revealed R54 had not received the PPSV23 prior to or since admit to the facility. R54's Admission Record printed 2/9/17, indicated R54 also had diagnosis of open wounds on left and right foot. Consent for immunization record requested but not provided.

On 2/9/17, at 8:03 a.m. during review of immunization record the DON verified the facility did not have a consent in R54's record and that the record lacked evidence that the PPSV23 was offered to R54.

R33's medical record indicated R33 had resided at the facility since 10/26/16. R33's Immunization Report printed 2/9/17, revealed R33 had received the PPSV23 on 12/11/13, prior to admission to the facility. R 33's Immunization record did not indicate if R33 had received the Prevnar-13 vaccine. R33's Admission Minimum Data Set (MDS) dated 11/4/16, indicated R33's diagnoses

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F 334	Continued From page 7	F 334		

included dementia, depression, and coronary artery disease. Consent for immunization record requested but not provided.

On 2/9/17, at 8:03 a.m. during review of immunization record the DON verified facility did not have a consent in R33's record and that the record lacked evidence that the PCV13 was offered.

R6's record indicated R6 had resided in the facility since 12/22/16. R6's Immunization Record printed 2/9/17, revealed R6 had not received the PPSV23 or the PCV13 in the facility and contained no record of R6 receiving either vaccine prior to admission. R6's admission MDS dated 12/30/16, indicated R6's diagnoses included Alzheimer's, atrial fibrillation (an irregular rapid heartbeat) and a pressure ulcer. Consent for immunization record requested but not provided.

During interview on 2/8/17, at 2:30 p.m. during review of immunization record the DON verified facility did not have a consent in R6's record and that the record lacked evidence that the PPSV23 or PCV13 were offered.

During interview on 2/8/17, at 11:11 a.m. the DON stated the facility had completed an audit for all resident in house on 8/25/16, for flu and Pneumococcal to include both PPSV23 and PCV13. The DON could not find the documentation from the audit. DON stated they now look at all residents on admission to follow up with need for vaccine. They call clinics/hospitals to get previous records of immunizations. The DON verified current consent

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F 334	Continued From page 8 did not differentiate between PPSV23 or PCV13 so it would not be possible to tell which vaccine consent had been given for. During interview on 2/9/17, at 8:03 a.m. the DON reiterated interview of 2/8/17, at 11:11 a.m. and said "I have updated our consent form to reflect what vaccine we are giving." The Influenza/ Pneumococcal Immunization Guideline Version #:2 effective 5/2/16, instructed staff, "LivingCenters will offer and encourage that all residents receive the Pneumococcal immunization (PPSV23 and/or PCV13) unless both were previously received. If both vaccines were previously received AND the PPSV23 was given prior to the resident being 65 years of age, then that patient may require another dose of PPSV23. See table for details. 1. The consent and/or need for the resident to receive the Pneumococcal will be confirmed per the following: check the resident's immunization history: -If the resident is admitted into the LivingCenter and has no history of ever having received either the Pneumococcal vaccine the vaccine should be offered following the table below. This information will be documented in the Immunization portal of the electronic health record. -If the resident's previous immunization history is unable to be obtained the request should be made that the resident receive the Pneumococcal vaccine. -If at the physician's discretion the vaccine is not indicated, an order will be obtained to defer vaccination. -If the immunization was refused, verify that the Immunization Consentand [sic] Declination Form was completed and signed.	F 334		

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F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain kitchen equipment in a clean and sanitary manner. This had the potential to effect 44 of 44 residents who were served food out of the kitchen. In addition, expired food was not removed from a communal refrigerator. Findings include: Kitchen:	F 371	F371 ~Facility Dietary Manager has cleaned the kitchen grill and threw out the expired crab salad. ~Re-education of kitchen staff of policy and procedure of removal of expired items in resident refridgerator and maintaining the kitchen equipment in a clean and sanitary manner. ~ED or designee to complete audits of the resident refridgerator and kitchen	3/17/17

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F 371	Continued From page 10 During initial tour of the kitchen on 2/6/17, at 11:36 a.m. with the dining service manager, the grill was observed to have brown build up on the top of the grill around the edge, the back of the grill and the front of the grill. There were white raised drops of dough that the dining service manager identified as pancake dough were observed on the grill. The dining service manager said "we clean the grill after lunch." During follow up tour of the kitchen on 2/8/17, at 3:08 p.m. the grill had been cleaned of the white matter, however, the grill still had brown build up on the front edge of the grill, back splash and right front of the grill. The dietary service manager verified brown build up could have been removed and said "we will get that done." Cleaning schedules directed staff to wipe down the stove after each shift, but did not specify frequency that grill was to be cleaned. The procedure for Cleaning Grills dated 2011, instructed staff to, "Follow the steps below to clean grills after each use..." Resident refrigerators: On 2/6/17, at 7:30 p.m. an open plastic container labeled crab salad was observed in the conference room resident refrigerator dated as open 1/29/17. The salad belonged to a resident. On 2/8/17, at 3:16 p.m. executive director (ED) verified the open container of crab salad was dated as opened on 1/29/17, and had a sell by date of 2/1/17. The ED said it was good for seven days once it was opened. The ED verified the conference room refrigerator was for resident food.	F 371	equipment to be completed monthly ~The date of completion will be 3/17/17 ~The facility QAPI committee will review the audits quarterly for further recommendations	

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F 371	Continued From page 11 -At 3: 30 p.m. dietary service manager verified the crab salad had expired and should have been thrown out. The Safe Food Procurement: Food from Outside Sources policy effective 11/16/16, instructed staff that, "Foods or beverages brought in from the outside will be labeled with the resident's name, room number and dated by nursing with the current date the item (s) was brought to the facility." The policy did not indicate the length of time open food could be kept.	F 371		
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	F 441		3/17/17

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F 441	Continued From page 12 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: (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	F 441		

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(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 13 program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper hand hygiene and glove use was provided for 2 of 3 residents (R41, R54) reviewed for pressure ulcers. Findings include: R41 had Physician Orders 2/9/17, for wound care as followed: Add Cavillon skin prep over heel decubitus prior to non adhesive dressing every evening shift for wound treatment and wash heel wound with saline, then apply Santyl (treatment to actively and selectively targets collagen without harm to healthy or newly formed tissue), then cover with Adaptic (non-adhering dressing) and wrap with Kerlix (gauze dressing) every evening shift for heel wound. R41's quarterly Minimum Data Set (MDS) dated 1/24/17, indicated R41 was admitted on 10/12/16, had an unstageable pressure ulcer (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar) and received pressure ulcer care. R41 was observed on 2/8/17, at 7:00 a.m. all dressed up lying in bed. At 7:04 a.m. the wound doctor (MD) was observed enter the room with a nursing assistant (NA). The wound MD cleansed his hands then applied a pair of gloves and the measured the left heel wound. The measurements were 3 centimeters (cm) by 2 cm by 0.5 cm. After removing the old dressing which had a moderate amount of drainage, the wound	F 441	F441 ~R41 and R54 has wound care completeed with proper hand hygiene and glove use ~Re-education of policy and procedure of nursing staff regarding infection control, proper hand hygiene and wound care techniques ~DNS or designee to complete 2 random audits of wound care monthly ~The date of completion will be 3/17/17 ~The facility QAPI committee will review the audits quarterly for further recommendations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245332	A. BUILDING _____ B. WING _____	02/09/2017

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F 441	Continued From page 14	F 441		

MD indicated the wound was doing well and had been infected. The wound MD then sprayed the wound bed with benzocaine (used to relieve discomfort), took a wound debriding tool and scraped the wound bed. The wound MD stated was all necrotic tissue and would be doing that until the wound base had healing tissue. Resident through the process tolerated it well and was smiling and the staff was asking how she was doing. Wound doctor at 7:05 a.m. completed removed gloves and left the room. At 7:06 a.m. licensed practical nurse (LPN)-A was observed complete wound care. LPN-A moisten the gauze with normal saline and cleansed the wound. There was red drainage on the gauze with tissue debris. The process was repeated twice. LPN-A then cleansed the peri-wound with a wet wipe using the same soiled gloves he had used to clean the wound. LPN-A took a pea size Santyl and applied the Santyl in the wound bed using a gloved finger. LPN-A unwrapped a Telfa (non-stick) dressing and applied it on top of the wound. LPN-A then removed the soiled gloves, never washed their hands, and reapplied another pair of gloves to secure the wound with a Kerlix (mesh like dressing). At 7:10 a.m. LPN-A completed the wound care removed gloves and went to bathroom and washed his hands. At 7:12 a.m. LPN-A acknowledged he had continued to use the same gloves after cleaning the wound. LPN-A stated the facility policy was to remove gloves wash hands and continue.

R54's admission MDS dated 11/24/16, indicated R41 was admitted on 11/17/16, had two arterial ulcers (also known as ischemic ulcers or ischemic wounds) are mostly located on the lateral surface of the ankle or the distal digits) and

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F 441	Continued From page 15	F 441		

received ulcer care.

R54's wound care on the right back ankle was observed on 2/7/17, at 2:12 p.m. LPN-B washed his hands and donned a pair of gloves. LPN-B removed the dressing from R54 by cutting away the soiled bandage. LPN-B laid the soiled scissors down on R54's over bed table. LPN-B then cleansed the wound area with normal saline, wiped the surrounding skin with Skin Prep (a protective film to help reduce friction during removal of tapes and films). LPN-B did not remove the soiled gloves before applying the Santyl treatment to the clean wound using his soiled gloved finger. LPN-B used the same soiled scissors to cut a clean dressing from the Telfa and gauze that they used to remove the soiled dressing. LPN-B then the wrapped the wound with Telfa and gauze. LPN-B did not wash his hands, did not don new gloves, and did not disinfect the scissors going from dirty to clean.

LPN-B then performed wound care on the left foot. LPN-B followed the same procedure as stated above to complete the dressing change on the left foot. After the treatment was completed LPN-B put the clean dressings back into a zip lock baggie with the soiled scissors. Again, LPN-B used the same soiled scissors to cut a clean dressing from the gauze that they used to remove the soiled dressing from both legs. LPN-B, between the two wound cares, did not wash his hands going from dirty to clean and LPN-B did not disinfect the scissors after use. At 2:37 p.m. LPN-B verified not changing his gloves after removing the soiled dressing. He should have removed the soiled gloves in between the right and left leg dressing's changes. He acknowledged placing the Santyl on the soiled

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gloved finger for both of the wound cares and indicated that could cause the resident to get an infection.

On 2/07/17, at 2:37 p.m. LPN-B verified not changing gloves after put Santyl on the finger tip of glove and applying it to the wound on the right ankle. LPN-B verified using the same soiled glove to do the wound care on the left foot including to apply Santyl to the wound.

On 2/9/17, at 8:29 a.m. the director of nursing services (DNS) was interviewed regarding hand washing and gloving during wound care. The DNS expected staff to change their gloves from one wound to another. She also remarked the expectation was once the soiled dressing was removed, remove the soiled gloves, wash their hands, don a new pair of gloves and complete the dressing process. The DNS further commented, "They would change their gloves prior to applying wound prep because their gloves were dirty. I would put the ointment on a gauze pack or a Q-tip I would not expect them to use their fingers. I would expect staff to clean scissors before returning them to the dressing supply bag. Staff should not return any contaminated supplies to the supply bag because that would contaminate all of the supplies. The supplies would need to be thrown." In addition, the DNS stated, "During wound care I would expect to change their gloves from one wound to another."

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	245332	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/08/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - EXCELSIOR	**515 DIVISION STREET EXCELSIOR, MN 55331**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on February 08, 2017. At the time of this survey, Golden Livingcenter Excelsior was found 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. This 1-story building was determined to be of Type II(222) construction. It has a partial basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 56 beds and had a census of 42 beds at the time of the survey.	K 000		

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

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

Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
February 23, 2017

Ms. Jill Lubbesmeyer, Administrator
Golden LivingCenter - Excelsior
515 Division Street
Excelsior, MN 55331

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5332026

Dear Ms. Lubbesmeyer:

The above facility was surveyed on February 6, 2017 through February 9, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the 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 contact Gloria Derfus, Unit Supervisor at (651) 201-3792.

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,

Kamala Fiske-Downing

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

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
	00988	A. BUILDING: _____ B. WING _____	02/09/2017

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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 6th through February 9th 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 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		
2 545	MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency Subp. 3. Frequency. Comprehensive resident assessments must be conducted: A. within 14 days after the date of admission; B. within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a significant change of condition Minimum Data Set (MDS) for 1 of 3 (R45) residents observed for activities of daily living (ADLs). Findings include: During an observation on 2/7/17, at 12:10 p.m. R45 was standing watching staff dish food up for lunch. Staff encouraged R45 to sit at the dining room table and eat a hot dog. R45 refused. The Alzheimer's care director offered R45 a chocolate ice cream. R45 sat down at the dining room table. -At 12:25 p.m. R45 stated was done with lunch. The hot dog remained on plate. R45 had eaten a chocolate magic cup (fortified thicken frozen supplement), a vanilla ice cream cup and had drunk a can of Pepsi.	2 545	Completion Date 03/17/2017	3/17/17

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2 545	Continued From page 3 On 2/8/17, at 10:58 a.m. the executive director walked R45 to his room and talked R45 into allowing licensed practical nurse (LPN)-B help R45 to change into clean clothing. R45 refused to allow surveyor observe cares. R45's annual MDS dated 9/2/16, indicated R45 was severely cognitively impaired. The facility did not complete the delirium assessment of the MDS. The mood indicator noted minimal depression. In the mood section, indicated R45 displayed physical behaviors toward others and other behaviors not directed at others, one to three times a week. R45's MDS indicated R45 rejected assistance with cares one to three times a week. The MDS identified R45 as requiring limited assistance (resident is highly involved in the activity with staff providing guidance or non-weight bearing assistance) with toileting and personal hygiene, supervision (oversight and encouragement) with dressing and bed mobility and was independent with transfers, walking and locomotion on and off the unit and eating. The MDS also indicated R45 was occasionally incontinent of bladder and frequently incontinent of bowel. R45's Quarterly MDS dated 12/3/16, indicated R45 was severely cognitively impaired and behaviors included continuous inattention, and disorganized thinking. The mood indicator noted R45 to be mildly depressed. The mood section indicated R45 displayed physical and verbal behaviors toward others one to three times a week and behaviors not directed towards others four to six times a week but not daily. R45's MDS indicated R45 rejected assistance with cares daily. The quarterly MDS indicated a decline in all areas of activities of daily living. R45 required extensive assistance (resident involved in activity	2 545		

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2 545	Continued From page 4 but staff provided weight bearing support) with bed mobility, dressing, toileting and personal hygiene, limited assistance with eating and locomotion on the unit and required supervision with transfers, walking in room and corridor and locomotion off the unit. The MDS also indicated R45 experienced a decline in bladder continence and was frequently incontinent of bladder. During interview on 2/8/17, at 11:38 a.m. LPN-B said, "[R45] prefers men only for cares. You cannot push him and we have to praise him and focus on how he would dress for work." During interview on 2/8/17, at 11:38 a.m. registered nurse (RN)-A, the MDS coordinator said." We probably should have done a significant change MDS. His decline was gradual and it was permanent. I think it was more behavioral. We should have talked about it at the quarterly and done a significant change MDS at that time." When asked for a policy RN-A said we follow the RAI (Resident Assessment Instrument) process. According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated last revised on October 2016, "A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not 'self-limiting' (for declines only); 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan." SUGGESTED METHOD OF CORRECTION: The DON or her designee could develop a system to identify when a significant change MDS should be	2 545		

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2 545	Continued From page 5 completed and provide education to staff on when the MDS should be completed. The DON or her designee could develop a monitoring system of completed assessments to ensure no annual assessments were missed. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 545		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain kitchen equipment in a clean and sanitary manner. This had the potential to effect 44 of 44 residents who were served food out of the kitchen. In addition, expired food was not removed from a communal refrigerator. Findings include: Kitchen: During initial tour of the kitchen on 2/6/17, at 11:36 a.m. with the dining service manager, the grill was observed to have brown build up on the top of the grill around the edge, the back of the grill and the front of the grill. There were white raised drops of dough that the dining service manager identified as pancake dough were observed on the grill. The dining service manager	21015	Completion Date: 03/17/2017	3/17/17

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21015	Continued From page 6 said "we clean the grill after lunch." During follow up tour of the kitchen on 2/8/17, at 3:08 p.m. the grill had been cleaned of the white matter, however, the grill still had brown build up on the front edge of the grill, back splash and right front of the grill. The dietary service manager verified brown build up could have been removed and said "we will get that done." Cleaning schedules directed staff to wipe down the stove after each shift, but did not specify frequency that grill was to be cleaned. The procedure for Cleaning Grills dated 2011, instructed staff to, "Follow the steps below to clean grills after each use..." Resident refrigerators: On 2/6/17, at 7:30 p.m. an open plastic container labeled crab salad was observed in the conference room resident refrigerator dated as open 1/29/17. The salad belonged to a resident. On 2/8/17, at 3:16 p.m. executive director (ED) verified the open container of crab salad was dated as opened on 1/29/17, and had a sell by date of 2/1/17. The ED said it was good for seven days once it was opened. The ED verified the conference room refrigerator was for resident food. -At 3: 30 p.m. dietary service manager verified the crab salad had expired and should have been thrown out. The Safe Food Procurement: Food from Outside Sources policy effective 11/16/16, instructed staff that, "Foods or beverages brought in from the outside will be labeled with the resident's name, room number and dated by nursing with the	21015		

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21015	Continued From page 7 current date the item (s) was brought to the facility." The policy did not indicate the length of time open food could be kept. SUGGESTED METHOD OF CORRECTION: The dietitian, dietary director and/or designee will educate/inservice dietary staff on proper use of clean stove surfaces as well as proper storage, labeling and dating of opened foods taht are brought into the facility. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21015		
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 hand hygiene and glove use was provided for 2 of 3 residents (R41, R54) reviewed for pressure ulcers. Findings include: R41 had Physician Orders 2/9/17, for wound care as followed: Add Cavillon skin prep over heel decub prior to non adhesive dressing every evening shift for wound treatment and wash heel wound with saline, then apply Santyl (treatment to actively and selectively targets collagen without	21375	Completion Date: 03/17/2017	3/17/17

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harm to healthy or newly formed tissue), then cover with adaptic and wrap with Kerlix (gauze dressing) every evening shift for heel wound.

R41's quarterly Minimum Data Set (MDS) dated 1/24/17, indicated R41 was admitted on 10/12/16, had an unstageable pressure ulcer (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar) and received pressure ulcer care.

R41 was observed on 2/8/17, at 7:00 a.m. all dressed up lying in bed. At 7:04 a.m. the wound doctor (MD) was observed enter the room with a nursing assistant (NA). The wound MD cleansed his hands then applied a pair of gloves and the measured the left heel wound. The measurements were 3 centimeters (cm) by 2 cm by 0.5 cm. After removing the old dressing which had a moderate amount of drainage, the wound MD indicated the wound was doing well and had been infected. The wound MD then sprayed the wound bed with benzocaine (used to relieve discomfort), took a wound debriding tool and scraped the wound bed. The wound MD stated was all necrotic tissue and would be doing that until the wound base had healing tissue. Resident through the process tolerated it well and was smiling and the staff was asking how she was doing. Wound doctor at 7:05 a.m. completed removed gloves and left the room. At 7:06 a.m. licensed practical nurse (LPN)-A was observed complete wound care. LPN-A moisten the gauze with normal saline and cleansed the wound. There was red drainage on the gauze with tissue debris. The process was repeated twice. LPN-A then cleansed the peri-wound with a wet wipe using the same soiled gloves he had used to clean the wound. LPN-A took a pea size Santyl

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and applied the Santyl in the wound bed using a gloved finger. LPN-A unwrapped a Telfa (non-stick) dressing and applied it on top of the wound. LPN-A then removed the soiled gloves, never washed their hands, and reapplied another pair of gloves to secure the wound with a Kerlix (mesh like dressing). At 7:10 a.m. LPN-A completed the wound care removed gloves and went to bathroom and washed his hands. At 7:12 a.m. LPN-A acknowledged he had continued to use the same gloves after cleaning the wound. LPN-A stated the facility policy was to remove gloves wash hands and continue.

R54's admission MDS dated 11/24/16, indicated R41 was admitted on 11/17/16, had two arterial ulcers (also known as ischemic ulcers or ischemic wounds) are mostly located on the lateral surface of the ankle or the distal digits) and received ulcer care.

R54's wound care on the right back ankle was observed on 2/7/17, at 2:12 p.m. LPN-B washed his hands and donned a pair of gloves. LPN-B removed the dressing from R54 by cutting away the soiled bandage. LPN-B laid the soiled scissors down on R54's over bed table. LPN-B then cleansed the wound area with normal saline, wiped the surrounding skin with Skin Prep (a protective film to help reduce friction during removal of tapes and films). LPN-B did not remove the soiled gloves before applying the Santyl treatment to the clean wound using his soiled gloved finger. LPN-B used the same soiled scissors to cut a clean dressing from the Telfa and gauze that they used to remove the soiled dressing. LPN-B then the wrapped the wound with Telfa and gauze. LPN-B did not wash his hands, did not don new gloves, and did not

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21375	Continued From page 10 disinfect the scissors going from dirty to clean. LPN-B then performed wound care on the left foot. LPN-B followed the same procedure as stated above to complete the dressing change on the left foot. After the treatment was completed LPN-B put the clean dressings back into a zip lock baggie with the soiled scissors. Again, LPN-B used the same soiled scissors to cut a clean dressing from the gauze that they used to remove the soiled dressing from both legs. LPN-B, between the two wound cares, did not wash his hands going from dirty to clean and LPN-B did not disinfect the scissors after use. At 2:37 p.m. LPN-B verified not changing his gloves after removing the soiled dressing. He should have removed the soiled gloves in between the right and left leg dressing's changes. He acknowledged placing the Santyl on the soiled gloved finger for both of the wound cares and indicated that could cause the resident to get an infection. On 2/07/17, at 2:37 p.m. LPN-B verified not changing gloves after put Santyl on the finger tip of glove and applying it to the wound on the right ankle. LPN-B verified using the same soiled glove to do the wound care on the left foot including to apply Santyl to the wound. On 2/9/17, at 8:29 a.m. the director of nursing services (DNS) was interviewed regarding hand washing and gloving during wound care. The DNS expected staff to change their gloves from one wound to another. She also remarked the expectation was once the soiled dressing was removed, remove the soiled gloves, wash their hands, don a new pair of gloves and complete the dressing process. The DNS further commented, "They would change their gloves prior to applying	21375		

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21375	Continued From page 11 wound prep because their gloves were dirty. I would put the ointment on a gauze pack or a Q-tip I would not expect them to use their fingers. I would expect staff to clean scissors before returning them to the dressing supply bag. Staff should not return any contaminated supplies to the supply bag because that would contaminate all of the supplies. The supplies would need to be thrown." In addition, the DNS stated, "During wound care I would expect to change their gloves from one wound to another." SUGGESTED METHOD OF CORRECTION: The DON or designee could train staff and perform audits to ensure infection control techniques are being followed. TIME PERIOD FOR CORRECTION: 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	21426		3/17/17

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21426	Continued From page 12 be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the agency failed to ensure 4 of 5 employees (E-2, E-3, E-4, E-5) had proper interpretation for Tuberculin Skin Test (TST) result, 2 of 5 employees (E-2, E-4) had the TST read in less than 48 hours and 1 of 5 employees (E-1) did not have a tuberculosis (TB) symptom screen. In addition, the facility failed to ensure 5 of 5 resident (R46, R32, R33, R9, R63) had TST's and a symptom screening completed as recommended per State guidelines. Findings include: Employees: E-1's personnel file revealed a hire date of 11/3/16. E-1's file indicated E-1 had a IGRAs (TB blood tests for M. tuberculosis) on 9/27/16, but file did not include a TB symptom screen. E-2's personnel file revealed a hire date of 11/3/16. E-2's file indicated a step one Tuberculin Skin Test (TST) had been administered on 10/18/16, at 10:45 a.m., and read 10/20/16, at 9:00 a.m. which was less than 48 hour between time given and time read. E2's file indicated a step two TST had been administered on 12/20/16, and read 12/22/16, with 0 millimeters (mm) no interpretation either "Positive or Negative."	21426	Completion Date: 03/17/2017	

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21426	Continued From page 13 E-3's personnel file revealed a hire date of 10/7/16. E3's file indicated a step two TST had been administered on 11/5/16, and read 11/7/16, with 0 millimeters (mm) no interpretation either "Positive or Negative." E-4's personnel file revealed a hire date of 10/13/16. E4's file indicated a step one TST had been administered on 10/5/16, and read 10/7/16, with 0 millimeters (mm) no interpretation either "Positive or Negative." E-4's file indicated a step two TST had been administered on 10/25/16, at 10:45 a.m., and read 10/27/16, at 10:30 a.m. which was less than 48 hour between time given and time read. In addition the step two TST indicated 0 millimeters (mm) no interpretation either "Positive or Negative." E-5's personnel file revealed a hire date of 12/21/16. E5's file indicated a step one TST had been administered on 12/21/16, and read 12/23/16, with 0 millimeters (mm) no interpretation either "Positive or Negative." Residents: R33 was admitted to the facility on 10/26/16. R33's medical record indicted resident had not had the TB symptom screening, R47 was admitted to the facility on 6/11/16. R47's medical record indicated R47's step two TST had been administered on 6/26/16, at 10:30 a.m., and read 6/28/16 at 8:30 a.m. which was less than 48 hour between time given and time read. R6 was admitted to the facility on 12/22/16. R's medical record indicated R6's step two TST had been administered on 1/6/17 and read on 1/8/17 but lacked time the TST was given or read.	21426		

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21426	Continued From page 14 R54 was admitted to the facility on 11/17/16. R54's medical record indicted R54's step one TST had been administered on 11/19/16, at 2:50 p.m., and read 11/21/16, at 7:30 a.m. which was less than 48 hour between time given and time read. R54's step two TST had been administered on 12/3/16, at 10:00 a.m., and read 12/5/16, at 7:30 a.m. which was less than 48 hour between time given and time read. The second TST was never administered. During interview on 2/9/17, at 8:20 a.m. The director of nurses (DON) said, "The floor nurses give the Mantoux [TST] to the residents and employees. I have not gone over the form with them but it is on the form you guess they would read the form and fill it out. They are not waiting long enough to read it [the TST]." DON verified R33 did not have a symptom screen upon admission to the facility and that R6 did not have times R6's TST lacked times given and read. Tuberculosis Screening - Administration and Interpretation of Tuberculin Skin Tests policy dated 12/1/14, instructed staff "A qualified nurse or healthcare practitioner will interpret the TST forty-eight (48) to seventy -two (72) hours after administration. All test results must be read in mm. Regulation for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, Screening Health Care Workers (HCW's) directed: "TST documentation should include the date of the test (i.e., month, day, year), the number of millimeters of induration (if no induration, document "0" mm) and interpretation (i.e., positive or negative)... In addition the regulation directed "Screening should be initiated within 72 hours of admission and "Baseline TB screening	21426		

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21426	Continued From page 15 consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing for TB risk factors and TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA..." SUGGESTED METHOD FOR CORRECTION: The Director of Nursing and/or designee could monitor to assure tuberculin screening procedures were developed and implemented to ensure staff was free of tuberculosis prior to working with residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		