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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: EFPC
Facility ID: 00260

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245387**

2. STATE VENDOR OR MEDICAID NO.
(L2) **492242500**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST OLAF RESIDENCE**
(L4) **2912 FREMONT AVENUE NORTH**
(L5) **MINNEAPOLIS, MN** (L6) **55411**

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)

6. DATE OF SURVEY **09/18/2014** (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)
09/30

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

12.Total Facility Beds **80** (L18)

13.Total Certified Beds **80** (L17)

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(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 :
Becky Wong, HFE NE II 09/19/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 09/24/2014 (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
12/01/1986
(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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/27/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5387

September 24, 2014

Mr. David Uselman, Administrator
St Olaf Residence
2912 Fremont Avenue North
Minneapolis, Minnesota 55411

Dear Mr. Uselman:

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 September 11, 2014, the above facility is certified for:

80 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 80 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

September 24, 2014

Mr. David Uselman, Administrator
St Olaf Residence
2912 Fremont Avenue North
Minneapolis, Minnesota 55411

RE: Project Number S5387023

Dear Mr. Uselman:

On September 2, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective September 7, 2014. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on June 27, 2014, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on August 20, 2014. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On September 18, 2014, the Minnesota Department of Health completed a second PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on August 20, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 11, 2014. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on August 20, 2014, as of September 11, 2014. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 11, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of September 2, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective September 27, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective September 27, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective September 27, 2014, is to be rescinded.

In our letter of September 2, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 27, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on September 11, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124   Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245387	A. Building B. Wing	9/18/2014

Name of Facility	Street Address, City, State, Zip Code
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	**09/11/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**09/11/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	**09/11/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	**09/11/2014**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/AK	09/19/2014	30951	09/18/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/27/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: EFPC
Facility ID: 00260

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245387**

2. STATE VENDOR OR MEDICAID NO. (L2) **492242500**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST OLAF RESIDENCE**
(L4) **2912 FREMONT AVENUE NORTH**
(L5) **MINNEAPOLIS, MN** (L6) **55411**

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)

6. DATE OF SURVEY **08/20/2014** (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) **09/30**

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

12.Total Facility Beds **80** (L18)

13.Total Certified Beds **80** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(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 :
Becky Wong, HFE NE II 09/17/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 09/18/2014 (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 **12/01/1986** (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. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **08/27/2014** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4660

September 2, 2014

Mr. David Uselman, Administrator
St Olaf Residence
2912 Fremont Avenue North
Minneapolis, Minnesota 55411

RE: Project Number S5387023

Dear Mr. Uselman:

On July 15, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 27, 2014. 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 August 20, 2014, the Minnesota Department of Health and on August 11, 2014, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 27, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 8, 2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on June 27, 2014. The deficiencyies not corrected are as follows:

F0225 -- S/S: D -- 483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/report Allegations/individuals
F0226 -- S/S: D -- 483.13(c) -- Develop/implment Abuse/neglect, Etc Policies
F0280 -- S/S: D -- 483.20(d)(3), 483.10(k)(2) -- Right To Participate Planning Care-Revise Cp
F0323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

• State Monitoring effective September 7, 2014. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective September 27, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective September 27, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 27, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, St Olaf Residence is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 27, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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
Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 December 27, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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 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.

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124   Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

July 22, 2014

David Uselman, Administrator
St. Olaf Residence
2912 Fremont Avenue North
Minneapolis, MN 55411

Dear Mr. Uselman:

I am writing to advise you that St. Olaf Residence has been designated by the Centers for Medicare and Medicaid Services (CMS) as a "Special Focus Facility" (SFF) due to its history of noncompliance with quality of care and safety requirements under Medicare over the past three years. CMS includes results from standard surveys as well as deficiencies identified during complaint surveys. The purpose of this letter is to confirm our phone conversation of earlier today, and to notify you of the seriousness of this designation and explain more about it.

CMS began the SFF initiative to address the problem of facilities which had significant problems with compliance, but periodically make enough improvement to pass one survey, only to fail the next (often for many of the same problems as before). Facilities with such a "yo-yo" history rarely address the underlying systemic problems that give rise to repeated cycles of serious deficiencies.

What Does This Mean?

The SFF initiative is intended to promote more rapid and substantial improvement in the quality of care in identified nursing homes, and end the pattern of repeated cycles of non-compliance with quality of care requirements. SFF nursing homes are provided with more frequent survey and certification oversight. Specifically, the State Survey Agency (the Minnesota Department of Health) is required to survey SFF facilities twice a year.

CMS' policy of progressive enforcement means that any nursing home that reveals a pattern of persistent poor quality, as shown by deficiencies at a scope and severity of "harm" or higher or history of Substandard Quality of Care, is subject to increasingly stringent enforcement action. This may include stronger civil monetary penalties, denial of payment for new admissions, and/or termination of the Medicare provider agreement. It should be noted this progressive enforcement applies to all nursing homes but is viewed by CMS as particularly important in the case of SFF facilities because those nursing homes have already demonstrated a serious and persistent pattern of poor quality.

How Does a Facility Get Removed from the SFF Program?
A nursing home may "graduate" from the SFF program when it demonstrates at two consecutive standard surveys that it has deficiencies cited at a scope and severity level of no greater than "E" and no intervening complaint related deficiencies cited greater than "E." However, if a facility has been unable to achieve survey results at a level of "no actual harm" after three standard surveys (approximately 18 months), CMS may also remove a facility from the SFF program through termination of the Medicare provider agreement.

It should be noted that it is not necessary to have a "deficiency-free" survey in order to "graduate." Rather, a facility must have two consecutive surveys in which the highest deficiency cited is "E" or below, with no intervening complaints causing deficiencies at higher than "E."

Can This Be Appealed?
Your selection as a SFF is not subject to appeal. However, you still have the right to informal dispute resolution regarding the findings of a survey and the right to appeal the noncompliance that led to a remedy. Specific requirements for requesting a formal hearing are contained in the notice of the imposition of the remedy.

Please be advised that CMS has revised the procedures for notifying facilities that they have been designated as SFF; we are required to notify the facilities in writing, with copies to the chair of your governing body, the state ombudsman, the state Quality Improvement Organization, and the CMS Regional Office.

Further details about the CMS SFF Program for Nursing Facilities can be found in CMS S&C Letter 08-02 at:

http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter08-02.pdf.

If you have any questions, please contact me at 651-201-3700, or Mary Absolon, Director of Licensing and Certification, at 651-201-4100.

Sincerely,

Darcy Miner

Darcy Miner, Director
Compliance Monitoring Division

Cc: St. Olaf Residence Board Chairperson
Minnesota Ombudsman for Older Minnesotans
Stratis Health (Minnesota's Quality Improvement Organization)
CMS Chicago Regional Office

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING ______ B. WING ______	R 08/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

(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 An onsite resurvey was conducted by surveyors of this department on August 19 and 20, 2014, to determine compliance with Federal deficiencies issued during a recertification survey exited on June 27, 2014.	{F 000}	**F 225- D** Corrective Action: A. Facility has provided directions and education for staff to immediately report mistreatment/neglect/abuse to OHFC.	
{F 225} SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	{F 225}	Corrective Actions as it applies to other Residents: A. The Abuse Prevention Plan was reviewed and revised. Facility staff members were re-educated about the Abuse Prevention Plan and the definition of Immediate Reporting to OHFC. They were also educated on the requirement of filing Investigative Reports within 5 working days of the Initial Report to OHFC. The education occurred at the All Staff Meetings completed the week of 9-8-14. Date of Completion: September 11, 2014 Recurrence will be prevented by: A. Facility Staff received education related to the Abuse Prevention Plan, the definition of Immediate Reporting and the Requirement to file Investigative Reports within 5 working days of the Initial Report to OHFC at the All Staff Meetings completed the week of 9-8-14.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Executive Director | (X6) DATE 9/10/14

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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{F 225}	Continued From page 1 representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure timely reporting of allegations of mistreatment/neglect to the state agency in accordance with their policies for 4 of 5 residents for whom allegations were reviewed (R107). Findings include: A vulnerable adult incident report for R107, dated 8/8/14, indicated the resident had been found off campus by an off duty employee on 8/7/14. "An off duty environmental services (EVS)-A employee noted resident [R107] at the corner of Aldrich and Broadway, 1.1 miles from the facility (a large 4 lane street)." The report indicated R107's wheelchair had run out of power, and the resident had to take public transportation to get back to the facility. The Verification of Investigation report indicated the resident had left the facility premises again on 8/9/14, the police had been called, and R107 was returned to the facility by paramedics because the police had taken him to a local hospital. The Verification of Investigation document further indicated the provider had given R107 a manual wheelchair versus electric powered wheelchair until an assessment for safety could be conducted by occupational therapy. Although the report	{F 225}	B. Daily audits x 2 weeks, then weekly x 4 weeks then monthly x 3 months. Findings will be reported to the QAPI/QA Committee for review and follow up recommendations. The QAPI/QA Committee will determine when the audits may be discontinued. Responsible Person: Administrator or Designee RECEIVED SEP 15 2014 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	

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{F 225}	Continued From page 2 regarding the 8/7/14 elopement indicated the administrator had been notified of the incident on 8/7/14, the documentation indicated a report to the SA had not been made until 8/8/14. The incident of elopement from 8/9/14 was not clearly documented on an incident report, but had been added to the Verification of Investigation report for the 8/7/14 incident. Consequently, it was not able to be determined whether the incident had been reported to either the administrator or the SA in a timely manner. The nursing notes included additional detail regarding the 8/9/14 incident. According to the NN, on 8/9/14 at 10:30 a.m., the resident had asked the nurse if he could leave the facility to go to the bank and Burger King. The nurse had told the resident he was not allowed to leave the facility alone. The resident had told nurse he understood and would not leave. At 12:00 p.m., the nurse could not locate the resident and after initiating a grounds search without results, the police had been called. An entry at 2:00 p.m. on 8/9/14 included: "Resident has his wander guard on but it did not alarm when he left the building." An entry at 7:50 p.m. that evening indicated that paramedics had brought R107 back to the facility following an assessment in the hospital emergency room that same evening. On 8/19/14, at 2:57 p.m. the licensed social worker (LSW) was interviewed and stated she thought the facility had 24 hours (to report to the SA) if no harm, but if harm, then it needed to be reported within 2 hours. The LSW verified that the facility had reported to the supervisor and administrator immediately, but was missing the piece to report to the SA immediately. LSW further stated R107 eloped on 8/7, and then a	{F 225}		

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{F 225}	Continued From page 3 WanderGuard was put on. He eloped again on 8/9/14 left facility by ALF door and went out, it was recorded on video. There was a WanderGuard from the kitchen to hallway (to assisted living facility), I believe they did check it and it was working. The WanderGuard was working; R107 had his motorized wheelchair and had agreed to work with occupational Therapy (OT) for safe outings. "We had planned to do that initially (after first elopement) but R107 said he wouldn't do it again, and then he did." LSW verified the elopements had been reported late. On 8/19/14, at 3:11 p.m. the administrator verified R107 had gotten out the door on 8/7/14. The administrator further stated in regard to late reporting to the SA: "if it's on the weekend or late at night, they wait for us to report it the next day. The Supervisors report it to management. The (supervisors) have been educated (on how to report to the SA); it's just not what we have done for practice." On 8/20/14, at 9:35 a.m. LPN-A stated he had been trained to separate the resident's, protect them and call the supervisor, ADON, DON, and administrator and document the event and interventions used. LPN-A stated I do not do the report, but the DON and administrator do the report (to SA). The facility's Abuse Prevention Plan dated 9/20/13, identified neglect as a form of maltreatment. The plan further defined Neglect as: "the failure to provide goods and services necessary to avoid physical harm..." In addition, under the section Reporting of Maltreatment, the policy included: "...The facility professional who receives the report of suspected maltreatment is then responsible for immediately reporting the	{F 225}		

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{F 225}	Continued From page 4 maltreatment to the facility Administrator or the Administrator's designee, the Minnesota Department of Health (SA) and the CEP (common entry point) as describe..."	{F 225}		
{F 226} SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure timely reporting of allegations of mistreatment/neglect to the state agency in accordance with their policies for 2 of 5 allegations reviewed (R107). Findings include: The facility's Abuse Prevention Plan dated 9/20/13, identified neglect as a form of maltreatment. The plan further defined Neglect as: "the failure to provide goods and services necessary to avoid physical harm..." In addition, under the section Reporting of Maltreatment, the policy included: "...The facility professional who receives the report of suspected maltreatment is then responsible for immediately reporting the maltreatment to the facility Administrator or the Administrator's designee, the Minnesota Department of Health (SA) and the CEP (common entry point) as describe..."	{F 226}	**F 226- D** Corrective Action: A. The Abuse Prevention Plan was reviewed and revised. Facility has provided directions and education for supervisory staff to immediately report mistreatment/neglect/abuse to OHFC. Corrective Actions as it applies to other Residents: A. The Abuse Prevention Plan was reviewed and revised. Facility staff members were re-educated about the Abuse Prevention Plan and the definition of Immediate Reporting to OHFC. They were also educated on the requirement of filing Investigative Reports within 5 working days of the Initial Report to OHFC. The education occurred at the All Staff Meetings completed the week of 9-8-14. Date of Completion: September 11, 2014 Recurrence will be prevented by: A. Facility Staff received education related to the Abuse Prevention Plan, the definition of Immediate	

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{F 226}	Continued From page 5 A vulnerable adult incident report for R107, dated 8/8/14, indicated the resident had been found off campus by an off duty employee on 8/7/14. "An off duty environmental services (EVS)-A employee noted resident [R107] at the corner of Aldrich and Broadway, 1.1 miles from the facility (a large 4 lane street)." The report indicated R107's wheelchair had run out of power, and the resident had to take public transportation to get back to the facility. The Verification of Investigation report indicated the resident had left the facility premises again on 8/9/14, the police had been called, and R107 was returned to the facility by paramedics because the police had taken him to a local hospital. The Verification of Investigation document further indicated the provider had given R107 a manual wheelchair versus electric powered wheelchair until an assessment for safety could be conducted by occupational therapy. Although the report regarding the 8/7/14 elopement indicated the administrator had been notified of the incident on 8/7/14, the documentation indicated a report to the SA had not been made until 8/8/14. The incident of elopement from 8/9/14 was not clearly documented, but had been added to the Verification of Investigation report for the 8/7/14 incident. Consequently, it was not able to be determined whether the incident had been reported to either the administrator or the SA in a timely manner. On 8/19/14, at 2:57 p.m. the licensed social worker (LSW) was interviewed and stated she thought the facility had 24 hours (to report to the SA) if no harm, but if harm, then it needed to be reported within 2 hours. The LSW verified that the facility had reported to the supervisor and administrator immediately, but was missing the	{F 226}	Reporting and the Requirement to file Investigative Reports within 5 working days of the Initial Report to OHFC at the All Staff Meetings completed the week of 9-8-14. B. Random daily audits x 2 weeks, then weekly x 4 weeks then monthly x 3 months. Findings will be reported to the QAPI/QA Committee for review and follow up recommendations. The QAPI/QA Committee will determine when the audits may be discontinued. Responsible Person: Administrator or Designee	

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{F 226}	Continued From page 6 piece to report to the SA immediately. LSW further stated R107 eloped on 8/7, and then a WanderGuard was put on. He eloped again on 8/9/14 left facility by ALF door and went out, it was recorded on video. There was a WanderGuard from the kitchen to hallway (to assisted living facility), I believe they did check it and it was working. The WanderGuard was working; R107 had his motorized wheelchair and had agreed to work with occupational Therapy (OT) for safe outings. "We had planned to do that initially (after first elopement) but R107 said he wouldn't do it again, and then he did." LSW verified the elopements had been reported late. On 8/19/14, at 3:11 p.m. the administrator verified R107 had gotten out the door on 8/7/14. The administrator further stated in regard to late reporting to the SA: "if it's on the weekend or late at night, they wait for us to report it the next day. The Supervisors report it to management. The (supervisors) have been educated (on how to report to the SA); it's just not what we have done for practice." On 8/20/14, at 9:35 a.m. LPN-A stated he had been trained to separate the resident's, protect them and call the supervisor, ADON, DON, and administrator and document the event and interventions used. LPN-A stated I do not do the report, but the DON and administrator do the report (to SA).	{F 226}		
{F 280} SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	{F 280}		

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{F 280}	Continued From page 7 participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared 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, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan for 1 of 3 residents (R45) reviewed for accidents/supervision including suicidal ideation. Findings include: On 8/19/14, at 12:33 p.m. R45 was observed seated on her wheelchair (w/c) at the dining room table. R45 was crying loudly. When asked, R45 told the surveyor she was tired as she had been up since 5:00 a.m. and wanted to go to sleep. When asked R45 verfied she had not eaten her lunch and stated she was not hungry but just wanted to go sleep. R45 was observed to say this while she wiped tears from her cheeks and wiped her nose.	{F 280}	**F 280-D** Corrective Action: A. The care plan of R45 has been revised to reflect her current safety and supervision needs. Corrective Action as it applies to other Residents: A. The Care Plan-Comprehensive policy has been implemented. Assessments of residents are on-going and care plans are revised as information about the resident and the residents condition changes. The care plans of current residents were reviewed and revised as appropriate. Date of Completion: September 11, 2014 Recurrence will be prevented by: A. Facility Staff were educated on the Care Plan-Comprehensive policy at the All Staff meetings completed the week of 9-8-14. B. Daily audits x 2 weeks, then weekly x 4 weeks then monthly x 3 months. Findings will be reported to the QAPI/QA Committee for review and follow up recommendations. The QAPI/QA Committee will determine when the audits may be discontinued. Responsible Person: DON or Designee	

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{F 280}	Continued From page 8 R45's Resident Admission Record, dated 1/13/14, identified diagnoses of depression, sleep disturbance, end stage renal disease (ESRD), dementia persisting alcohol induced and human immunodeficiency virus (HIV). A Resident Incident Report dated 8/9/14, 1300 (1:00 p.m.) included, "R45 was noted to try to go through the southwest stairway with her wheelchair (w/c) (while sitting on w/c) when asked resident stated, 'Am trying to kill myself.' 15 minute checks initiated and WanderGuard applied. Daughter called and R45 was encouraged to call family to decrease loneliness. Root cause indicated increased depressive mood when family visits decreased (son did not have transportation and daughter was ill). Resident was encouraged to phone children when she had feelings of loneliness. Children were in agreement with the plan." Physician Orders 8/9/14, included the use of a WanderGuard to right wrist and to utilize the WanderGuard protocol for monitoring. A physician's order dated 8/11/14, indicated R45 had been started on Zoloft (an anti-depressant) 50 milligrams (mg) by mouth every morning (AM) for major depression. Although the resident's plan of care dated 7/16/14, identified a problem of "depression". The goal included, "Will discuss feelings that lead to feeling down, depressed or hopeless." Interventions included, administer medications as ordered... encourage resident to verbalize feelings, observe for signs and symptoms of depression including tearfulness, hopelessness, loss of appetite. Interventions identified included:	{F 280}		

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

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{F 280}	Continued From page 9 treat primary mood disorder and depression. The care plan had not been revised to include the use of the WanderGuard, or the concern related to the resident's suicidal ideations. On 8/19/14, at 1:27 p.m. director of nursing (DON) verified the suicidal ideation and use of a WanderGuard had not been added to the care plan or the Team Assignment sheet. On 8/19/14, at 3:04 p.m. DON acknowledged the WanderGuard intervention should have been added to the care plan and further stated she had just talked to the licensed social worker (LSW) and had told her "We were dropping the ball. I just told her that the chart and the report will be brought to the daily stand up and this will make sure everything is done right there then." On 8/19/14, at 3:15 p.m. the LSW was interviewed and acknowledged the WanderGuard was supposed to have been added to the care plan after the suicidal ideation. The LSW looked through the entire care plan and verified the WanderGuard had not been added to the care plan, so she added it at that time under the problem area of "mood". When interviewed on 8/19/14, at 3:40 p.m. nursing assistant (NA)-A, who was assigned to R45 for the shift, stated she was not sure exactly why R45 had the WanderGuard, "Usually when residents have a wander guard it's because they wander." On 8/19/14, at 3:45 p.m. when asked if she knew why R45 had a WanderGuard, NA-B stated she did not know and told the surveyor she could find out from one of the nurses at the desk. When	{F 280}		

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{F 280}	Continued From page 10 asked if she had worked with R45 NA-B stated, "Yes we get rotated every two weeks and I just got done working with her this last weekend." NA-B also verified that when working on the floor all the staff can help any of the residents. On 8/19/14, at 3:47 p.m. when asked if she was aware why R45 had a WanderGuard on, licensed practical nurse (LPN)-B stated R45 had suicidal ideations and that it had been decided to put on the WanderGuard to alert staff if she would attempt to get through the (stairway) door. .	{F 280}		
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to notify staff of the risk for suicide for 1 of 3 residents (R45) who had suicidal ideation; and failed to implement adequate supervision for 1 of 1 resident (R107) reviewed who had eloped from the building. Findings include: On 8/19/14, at 12:33 p.m. R45 was observed	{F 323}		

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{F 323}

Continued From page 11

seated on her wheelchair (w/c) at the dining room table. R45 was crying loudly. When asked, R45 told the surveyor she was tired as she had been up since 5:00 a.m. and wanted to go to sleep. When asked R45 verfied she had not eaten her lunch and stated she was not hungry but just wanted to go sleep. R45 was observed to say this while she wiped tears from her cheeks and wiped her nose.

R45's Resident Admission Record, dated 1/13/14, identified diagnoses of depression, sleep disturbance, end stage renal disease (ESRD), dementia persisting alcohol induced and human immunodeficiency virus (HIV).

A Resident Incident Report dated 8/9/14, 1300 (1:00 p.m.) included, "R45 was noted to try to go through the southwest stairway with her wheelchair (w/c) (while sitting on w/c) when asked resident stated, 'Am trying to kill myself.' 15 minute checks initiated and WanderGuard applied. Daughter called and R45 was encouraged to call family to decrease loneliness. Root cause indicated increased depressive mood when family visits decreased (son did not have transportation and daughter was ill). Resident was encouraged to phone children when she had feelings of loneliness. Children were in agreement with the plan."

Physician Orders 8/9/14, included the use of a WanderGuard to right wrist and to utilize the WanderGuard protocol for monitoring.

A physician's order dated 8/11/14, indicated R45 had been started on Zoloft (an anti-depressant) 50 milligrams (mg) by mouth every morning (AM) for major depression.

{F 323}

F323- D

Corrective Action:

A. New interventions have been added to the care plan and group sheet for R45 and R107.
B. R107 working with Therapy Department for community safety.
C. R45 has been referred to and visited psychiatric services.

Corrective Action as it applies to other Residents:

A. Current residents and documentation have been reviewed and care plans were updated as appropriate.

Date of Correction: September 11,, 2014

Recurrence will be prevented by:

A. Facility staff members were educated on new interventions and ongoing process for implementing and communicating interventions at All Staff Meetings completed the week of 9-8-14.
B. Daily audits x 2 weeks, then weekly x 4 weeks then monthly x 3 months. Findings will be reported to the QAPI/QA Committee for review and follow up recommendations. The QAPI/QA Committee will determine when the audits may be discontinued.

Responsible Person: DON and Administrator or Designee

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ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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{F 323}	Continued From page 12	{F 323}		

Although the resident's plan of care dated 7/16/14, identified a problem of "depression". The goal included, "Will discuss feelings that lead to feeling down, depressed or hopeless." Interventions included, administer medications as ordered... encourage resident to verbalize feelings, observe for signs and symptoms of depression including tearfulness, hopelessness, loss of appetite. Interventions identified included: treat primary mood disorder and depression. The care plan had not been revised to include the use of the WanderGuard, or the concern related to the resident's suicidal ideations.

On 8/19/14, at 1:27 p.m. director of nursing (DON) verified the suicidal ideation and use of a WanderGuard had not been added to the care plan or the Team Assignment sheet.

On 8/19/14, at 3:04 p.m. DON acknowledged the WanderGuard intervention should have been added to the care plan and further stated she had just talked to the licensed social worker (LSW) and had told her "We were dropping the ball. I just told her that the chart and the report will be brought to the daily stand up and this will make sure everything is done right there then."

On 8/19/14, at 3:15 p.m. the LSW was interviewed and acknowledged the WanderGuard was supposed to have been added to the care plan after the suicidal ideation. The LSW looked through the entire care plan and verified the WanderGuard had not been added to the care plan, so she added it at that time under the problem area of "mood".

When interviewed on 8/19/14, at 3:40 p.m.

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{F 323}	Continued From page 13 nursing assistant (NA)-A, who was assigned to R45 for the shift, stated she was not sure exactly why R45 had the WanderGuard, "Usually when residents have a wander guard it's because they wander." On 8/19/14, at 3:45 p.m. when asked if she knew why R45 had a WanderGuard, NA-B stated she did not know and told the surveyor she could find out from one of the nurses at the desk. When asked if she had worked with R45 NA-B stated, "Yes we get rotated every two weeks and I just got done working with her this last weekend." NA-B also verified that when working on the floor all the staff can help any of the residents. On 8/19/14, at 3:47 p.m. when asked if she was aware why R45 had a WanderGuard on, licensed practical nurse (LPN)-B stated R45 had suicidal ideations and that it had been decided to put on the WanderGuard to alert staff if she would attempt to get through the (stairway) door. According to a vulnerable adult incident report for R107, dated 8/8/14, the resident had been found off campus by an off duty employee on 8/7/14. The report included, "An off duty environmental services (EVS)-A employee noted resident [R107] at the corner of Aldrich and Broadway, 1.1 miles from the facility (a large 4 lane street)." The report indicated R107's wheelchair had run out of power, and the resident had to take public transportation to get back to the facility. The Verification of Investigation report indicated the resident had left the facility premises again on 8/9/14, the police had been called, and R107 was returned to the facility by paramedics because the police had taken him to a local hospital. The Verification of Investigation document further	{F 323}		

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{F 323}	Continued From page 14	{F 323}		

indicated the provider had given R107 a manual wheelchair versus electric powered wheelchair until an assessment for safety could be conducted by occupational therapy.

The nursing notes included additional detail regarding the 8/9/14 incident. According to the NN, on 8/9/14 at 10:30 a.m., the resident had asked the nurse if he could leave the facility to go to the bank and Burger King. The nurse had told the resident he was not allowed to leave the facility alone. The resident had told nurse he understood and would not leave. At 12:00 p.m., the nurse could not locate the resident and after initiating a grounds search without results, the police had been called. An entry at 2:00 p.m. on 8/9/14 included: "Resident has his wander guard on but it did not alarm when he left the building." An entry at 7:50 p.m. that evening indicated that paramedics had brought R107 back to the facility following an assessment in the hospital emergency room that same evening.

Although the resident's care plan had been updated on 8/8/14 to include the use of a Wanderguard for unsafe wandering and/or exit seeking behaviors, the resident had still been able to exit the builidng without staff noticing, nor the alarm sounding. In addition, there had been no intervention changes to ensure the resident's motorized wheelchair battery remained fully charged.

On 8/19/14, at 2:57 p.m. the licensed social worker (LSW) was interviewed and verified R107 had eloped on 8/7/14. The LSW stated a WanderGuard had been initiated, however R107 had eloped again on 8/9/14. The LSW said R107 had left the facility by going through a door into

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{F 323}	Continued From page 15 the assisted living. She said they had determined this by review of their hallway video recording. The LSW stated there was a WanderGuard from the kitchen to the AL hallway, and added "I believe they did check it and it was working." According to the LSW, R107 had now agreed to work with occupational Therapy (OT) to ensure safe use of the wheelchair for outings. "We had planned to do that initially (after the first elopement) but [R107] said he wouldn't do it again, but then he did."	{F 323}		

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{F 000}	INITIAL COMMENTS An onsite resurvey was conducted by surveyors of this department on August 19 and 20, 2014, to determine compliance with Federal deficiencies issued during a recertification survey exited on June 27, 2014.	{F 000}		
{F 225} SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	{F 225}		

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

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{F 225}	Continued From page 1 representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure timely reporting of allegations of mistreatment/neglect to the state agency in accordance with their policies for 4 of 5 residents for whom allegations were reviewed (R107). Findings include: A vulnerable adult incident report for R107, dated 8/8/14, indicated the resident had been found off campus by an off duty employee on 8/7/14. "An off duty environmental services (EVS)-A employee noted resident [R107] at the corner of Aldrich and Broadway, 1.1 miles from the facility (a large 4 lane street)." The report indicated R107's wheelchair had run out of power, and the resident had to take public transportation to get back to the facility. The Verification of Investigation report indicated the resident had left the facility premises again on 8/9/14, the police had been called, and R107 was returned to the facility by paramedics because the police had taken him to a local hospital. The Verification of Investigation document further indicated the provider had given R107 a manual wheelchair versus electric powered wheelchair until an assessment for safety could be conducted by occupational therapy. Although the report	{F 225}		

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{F 225}	Continued From page 2 regarding the 8/7/14 elopement indicated the administrator had been notified of the incident on 8/7/14, the documentation indicated a report to the SA had not been made until 8/8/14. The incident of elopement from 8/9/14 was not clearly documented on an incident report, but had been added to the Verification of Investigation report for the 8/7/14 incident. Consequently, it was not able to be determined whether the incident had been reported to either the administrator or the SA in a timely manner. The nursing notes included additional detail regarding the 8/9/14 incident. According to the NN, on 8/9/14 at 10:30 a.m., the resident had asked the nurse if he could leave the facility to go to the bank and Burger King. The nurse had told the resident he was not allowed to leave the facility alone. The resident had told nurse he understood and would not leave. At 12:00 p.m., the nurse could not locate the resident and after initiating a grounds search without results, the police had been called. An entry at 2:00 p.m. on 8/9/14 included: "Resident has his wander guard on but it did not alarm when he left the building." An entry at 7:50 p.m. that evening indicated that paramedics had brought R107 back to the facility following an assessment in the hospital emergency room that same evening. On 8/19/14, at 2:57 p.m. the licensed social worker (LSW) was interviewed and stated she thought the facility had 24 hours (to report to the SA) if no harm, but if harm, then it needed to be reported within 2 hours. The LSW verified that the facility had reported to the supervisor and administrator immediately, but was missing the piece to report to the SA immediately. LSW further stated R107 eloped on 8/7, and then a	{F 225}		

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{F 225}	Continued From page 3	{F 225}		

WanderGuard was put on. He eloped again on 8/9/14 left facility by ALF door and went out, it was recorded on video. There was a WanderGuard from the kitchen to hallway (to assisted living facility), I believe they did check it and it was working. The WanderGuard was working; R107 had his motorized wheelchair and had agreed to work with occupational Therapy (OT) for safe outings. "We had planned to do that initially (after first elopement) but R107 said he wouldn't do it again, and then he did." LSW verified the elopements had been reported late.

On 8/19/14, at 3:11 p.m. the administrator verified R107 had gotten out the door on 8/7/14. The administrator further stated in regard to late reporting to the SA: "if it's on the weekend or late at night, they wait for us to report it the next day. The Supervisors report it to management. The (supervisors) have been educated (on how to report to the SA); it's just not what we have done for practice."

On 8/20/14, at 9:35 a.m. LPN-A stated he had been trained to separate the resident's, protect them and call the supervisor, ADON, DON, and administrator and document the event and interventions used. LPN-A stated I do not do the report, but the DON and administrator do the report (to SA).
The facility's Abuse Prevention Plan dated 9/20/13, identified neglect as a form of maltreatment. The plan further defined Neglect as: "the failure to provide goods and services necessary to avoid physical harm..." In addition, under the section Reporting of Maltreatment, the policy included: "...The facility professional who receives the report of suspected maltreatment is then responsible for immediately reporting the

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{F 225}	Continued From page 4 maltreatment to the facility Administrator or the Administrator's designee, the Minnesota Department of Health (SA) and the CEP (common entry point) as describe..."	{F 225}		
{F 226} SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure timely reporting of allegations of mistreatment/neglect to the state agency in accordance with their policies for 2 of 5 allegations reviewed (R107). Findings include: The facility's Abuse Prevention Plan dated 9/20/13, identified neglect as a form of maltreatment. The plan further defined Neglect as: "the failure to provide goods and services necessary to avoid physical harm..." In addition, under the section Reporting of Maltreatment, the policy included: "...The facility professional who receives the report of suspected maltreatment is then responsible for immediately reporting the maltreatment to the facility Administrator or the Administrator's designee, the Minnesota Department of Health (SA) and the CEP (common entry point) as describe..."	{F 226}		

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{F 226}	Continued From page 5	{F 226}		

A vulnerable adult incident report for R107, dated 8/8/14, indicated the resident had been found off campus by an off duty employee on 8/7/14. "An off duty environmental services (EVS)-A employee noted resident [R107] at the corner of Aldrich and Broadway, 1.1 miles from the facility (a large 4 lane street)." The report indicated R107's wheelchair had run out of power, and the resident had to take public transportation to get back to the facility. The Verification of Investigation report indicated the resident had left the facility premises again on 8/9/14, the police had been called, and R107 was returned to the facility by paramedics because the police had taken him to a local hospital. The Verification of Investigation document further indicated the provider had given R107 a manual wheelchair versus electric powered wheelchair until an assessment for safety could be conducted by occupational therapy. Although the report regarding the 8/7/14 elopement indicated the administrator had been notified of the incident on 8/7/14, the documentation indicated a report to the SA had not been made until 8/8/14. The incident of elopement from 8/9/14 was not clearly documented, but had been added to the Verification of Investigation report for the 8/7/14 incident. Consequently, it was not able to be determined whether the incident had been reported to either the administrator or the SA in a timely manner.

On 8/19/14, at 2:57 p.m. the licensed social worker (LSW) was interviewed and stated she thought the facility had 24 hours (to report to the SA) if no harm, but if harm, then it needed to be reported within 2 hours. The LSW verified that the facility had reported to the supervisor and administrator immediately, but was missing the

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{F 226}	Continued From page 6 piece to report to the SA immediately. LSW further stated R107 eloped on 8/7, and then a WanderGuard was put on. He eloped again on 8/9/14 left facility by ALF door and went out, it was recorded on video. There was a WanderGuard from the kitchen to hallway (to assisted living facility), I believe they did check it and it was working. The WanderGuard was working; R107 had his motorized wheelchair and had agreed to work with occupational Therapy (OT) for safe outings. "We had planned to do that initially (after first elopement) but R107 said he wouldn't do it again, and then he did." LSW verified the elopements had been reported late. On 8/19/14, at 3:11 p.m. the administrator verified R107 had gotten out the door on 8/7/14. The administrator further stated in regard to late reporting to the SA: "if it's on the weekend or late at night, they wait for us to report it the next day. The Supervisors report it to management. The (supervisors) have been educated (on how to report to the SA); it's just not what we have done for practice." On 8/20/14, at 9:35 a.m. LPN-A stated he had been trained to separate the resident's, protect them and call the supervisor, ADON, DON, and administrator and document the event and interventions used. LPN-A stated I do not do the report, but the DON and administrator do the report (to SA).	{F 226}		
{F 280} SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	{F 280}		

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{F 280}	Continued From page 7 participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared 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, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan for 1 of 3 residents (R45) reviewed for accidents/supervision including suicidal ideation. Findings include: On 8/19/14, at 12:33 p.m. R45 was observed seated on her wheelchair (w/c) at the dining room table. R45 was crying loudly. When asked, R45 told the surveyor she was tired as she had been up since 5:00 a.m. and wanted to go to sleep. When asked R45 verfied she had not eaten her lunch and stated she was not hungry but just wanted to go sleep. R45 was observed to say this while she wiped tears from her cheeks and wiped her nose.	{F 280}		

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{F 280}	Continued From page 8	{F 280}		

R45's Resident Admission Record, dated 1/13/14, identified diagnoses of depression, sleep disturbance, end stage renal disease (ESRD), dementia persisting alcohol induced and human immunodeficiency virus (HIV).

A Resident Incident Report dated 8/9/14, 1300 (1:00 p.m.) included, "R45 was noted to try to go through the southwest stairway with her wheelchair (w/c) (while sitting on w/c) when asked resident stated, 'Am trying to kill myself.' 15 minute checks initiated and WanderGuard applied. Daughter called and R45 was encouraged to call family to decrease loneliness. Root cause indicated increased depressive mood when family visits decreased (son did not have transportation and daughter was ill). Resident was encouraged to phone children when she had feelings of loneliness. Children were in agreement with the plan."

Physician Orders 8/9/14, included the use of a WanderGuard to right wrist and to utilize the WanderGuard protocol for monitoring.

A physician's order dated 8/11/14, indicated R45 had been started on Zoloft (an anti-depressant) 50 milligrams (mg) by mouth every morning (AM) for major depression.

Although the resident's plan of care dated 7/16/14, identified a problem of "depression". The goal included, "Will discuss feelings that lead to feeling down, depressed or hopeless." Interventions included, administer medications as ordered... encourage resident to verbalize feelings, observe for signs and symptoms of depression including tearfulness, hopelessness, loss of appetite. Interventions identified included:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING ______ B. WING ______	R 08/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	**2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411**

(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 280}	Continued From page 9	{F 280}		

treat primary mood disorder and depression. The care plan had not been revised to include the use of the WanderGuard, or the concern related to the resident's suicidal ideations.

On 8/19/14, at 1:27 p.m. director of nursing (DON) verified the suicidal ideation and use of a WanderGuard had not been added to the care plan or the Team Assignment sheet.

On 8/19/14, at 3:04 p.m. DON acknowledged the WanderGuard intervention should have been added to the care plan and further stated she had just talked to the licensed social worker (LSW) and had told her "We were dropping the ball. I just told her that the chart and the report will be brought to the daily stand up and this will make sure everything is done right there then."

On 8/19/14, at 3:15 p.m. the LSW was interviewed and acknowledged the WanderGuard was supposed to have been added to the care plan after the suicidal ideation. The LSW looked through the entire care plan and verified the WanderGuard had not been added to the care plan, so she added it at that time under the problem area of "mood".

When interviewed on 8/19/14, at 3:40 p.m. nursing assistant (NA)-A, who was assigned to R45 for the shift, stated she was not sure exactly why R45 had the WanderGuard, "Usually when residents have a wander guard it's because they wander."

On 8/19/14, at 3:45 p.m. when asked if she knew why R45 had a WanderGuard, NA-B stated she did not know and told the surveyor she could find out from one of the nurses at the desk. When

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING ______ B. WING ______	R 08/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	**2912 FREMONT AVENUE NORTH** **MINNEAPOLIS, MN 55411**

(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 280}	Continued From page 10 asked if she had worked with R45 NA-B stated, "Yes we get rotated every two weeks and I just got done working with her this last weekend." NA-B also verified that when working on the floor all the staff can help any of the residents. On 8/19/14, at 3:47 p.m. when asked if she was aware why R45 had a WanderGuard on, licensed practical nurse (LPN)-B stated R45 had suicidal ideations and that it had been decided to put on the WanderGuard to alert staff if she would attempt to get through the (stairway) door. .	{F 280}		
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to notify staff of the risk for suicide for 1 of 3 residents (R45) who had suicidal ideation; and failed to implement adequate supervision for 1 of 1 resident (R107) reviewed who had eloped from the building. Findings include: On 8/19/14, at 12:33 p.m. R45 was observed	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING ______ B. WING ______	R 08/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

(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 323}	Continued From page 11	{F 323}		

seated on her wheelchair (w/c) at the dining room table. R45 was crying loudly. When asked, R45 told the surveyor she was tired as she had been up since 5:00 a.m. and wanted to go to sleep. When asked R45 verfied she had not eaten her lunch and stated she was not hungry but just wanted to go sleep. R45 was observed to say this while she wiped tears from her cheeks and wiped her nose.

R45's Resident Admission Record, dated 1/13/14, identified diagnoses of depression, sleep disturbance, end stage renal disease (ESRD), dementia persisting alcohol induced and human immunodeficiency virus (HIV).

A Resident Incident Report dated 8/9/14, 1300 (1:00 p.m.) included, "R45 was noted to try to go through the southwest stairway with her wheelchair (w/c) (while sitting on w/c) when asked resident stated, 'Am trying to kill myself.' 15 minute checks initiated and WanderGuard applied. Daughter called and R45 was encouraged to call family to decrease loneliness. Root cause indicated increased depressive mood when family visits decreased (son did not have transportation and daughter was ill). Resident was encouraged to phone children when she had feelings of loneliness. Children were in agreement with the plan."

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 323}	Continued From page 12 Although the resident's plan of care dated 7/16/14, identified a problem of "depression". The goal included, "Will discuss feelings that lead to feeling down, depressed or hopeless." Interventions included, administer medications as ordered... encourage resident to verbalize feelings, observe for signs and symptoms of depression including tearfulness, hopelessness, loss of appetite. Interventions identified included: treat primary mood disorder and depression. The care plan had not been revised to include the use of the WanderGuard, or the concern related to the resident's suicidal ideations. On 8/19/14, at 1:27 p.m. director of nursing (DON) verified the suicidal ideation and use of a WanderGuard had not been added to the care plan or the Team Assignment sheet. On 8/19/14, at 3:04 p.m. DON acknowledged the WanderGuard intervention should have been added to the care plan and further stated she had just talked to the licensed social worker (LSW) and had told her "We were dropping the ball. I just told her that the chart and the report will be brought to the daily stand up and this will make sure everything is done right there then." On 8/19/14, at 3:15 p.m. the LSW was interviewed and acknowledged the WanderGuard was supposed to have been added to the care plan after the suicidal ideation. The LSW looked through the entire care plan and verified the WanderGuard had not been added to the care plan, so she added it at that time under the problem area of "mood". When interviewed on 8/19/14, at 3:40 p.m.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 13	{F 323}		

nursing assistant (NA)-A, who was assigned to R45 for the shift, stated she was not sure exactly why R45 had the WanderGuard, "Usually when residents have a wander guard it's because they wander."

On 8/19/14, at 3:45 p.m. when asked if she knew why R45 had a WanderGuard, NA-B stated she did not know and told the surveyor she could find out from one of the nurses at the desk. When asked if she had worked with R45 NA-B stated, "Yes we get rotated every two weeks and I just got done working with her this last weekend." NA-B also verified that when working on the floor all the staff can help any of the residents.

On 8/19/14, at 3:47 p.m. when asked if she was aware why R45 had a WanderGuard on, licensed practical nurse (LPN)-B stated R45 had suicidal ideations and that it had been decided to put on the WanderGuard to alert staff if she would attempt to get through the (stairway) door.

According to a vulnerable adult incident report for R107, dated 8/8/14, the resident had been found off campus by an off duty employee on 8/7/14. The report included, "An off duty environmental services (EVS)-A employee noted resident [R107] at the corner of Aldrich and Broadway, 1.1 miles from the facility (a large 4 lane street)." The report indicated R107's wheelchair had run out of power, and the resident had to take public transportation to get back to the facility. The Verification of Investigation report indicated the resident had left the facility premises again on 8/9/14, the police had been called, and R107 was returned to the facility by paramedics because the police had taken him to a local hospital. The Verification of Investigation document further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING ______ B. WING ______	R 08/20/2014

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ST OLAF RESIDENCE	**2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411**

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{F 323}	Continued From page 14	{F 323}		

indicated the provider had given R107 a manual wheelchair versus electric powered wheelchair until an assessment for safety could be conducted by occupational therapy.

The nursing notes included additional detail regarding the 8/9/14 incident. According to the NN, on 8/9/14 at 10:30 a.m., the resident had asked the nurse if he could leave the facility to go to the bank and Burger King. The nurse had told the resident he was not allowed to leave the facility alone. The resident had told nurse he understood and would not leave. At 12:00 p.m., the nurse could not locate the resident and after initiating a grounds search without results, the police had been called. An entry at 2:00 p.m. on 8/9/14 included: "Resident has his wander guard on but it did not alarm when he left the building." An entry at 7:50 p.m. that evening indicated that paramedics had brought R107 back to the facility following an assessment in the hospital emergency room that same evening.

Although the resident's care plan had been updated on 8/8/14 to include the use of a Wanderguard for unsafe wandering and/or exit seeking behaviors, the resident had still been able to exit the builidng without staff noticing, nor the alarm sounding. In addition, there had been no intervention changes to ensure the resident's motorized wheelchair battery remained fully charged.

On 8/19/14, at 2:57 p.m. the licensed social worker (LSW) was interviewed and verified R107 had eloped on 8/7/14. The LSW stated a WanderGuard had been initiated, however R107 had eloped again on 8/9/14. The LSW said R107 had left the facility by going through a door into

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 15 the assisted living. She said they had determined this by review of their hallway video recording. The LSW stated there was a WanderGuard from the kitchen to the AL hallway, and added "I believe they did check it and it was working." According to the LSW, R107 had now agreed to work with occupational Therapy (OT) to ensure safe use of the wheelchair for outings. "We had planned to do that initially (after the first elopement) but [R107] said he wouldn't do it again, but then he did."	{F 323}		

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245387	A. Building B. Wing	8/20/2014

Name of Facility	Street Address, City, State, Zip Code
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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).

(Y4) Item: ID Prefix	Reg. #	LSC	(Y5) Date Correction Completed
F0155	483.10(b)(4)		08/08/2014
F0244	483.15(c)(6)		08/08/2014
F0246	483.15(e)(1)		08/08/2014
F0247	483.15(e)(2)		08/08/2014
F0250	483.15(g)(1)		08/08/2014
F0253	483.15(h)(2)		08/08/2014
F0282	483.20(k)(3)(ii)		08/08/2014
F0283	483.20(l)(1)&(2)		08/08/2014
F0309	483.25		08/08/2014
F0312	483.25(a)(3)		08/08/2014
F0329	483.25(l)		08/01/2014
F0431	483.60(b), (d), (e)		08/08/2014
F0441	483.65		08/01/2014
F0514	483.75(l)(1)		08/08/2014

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	09/02/2014	30951	08/22/2014
CMS RO				

Followup to Survey Completed on: 6/27/2014

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245387	A. Building 01 - MAIN BUILDING 01 B. Wing	8/11/2014

Name of Facility	Street Address, City, State, Zip Code
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0020	08/08/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/AK	Date: 09/02/2014	Signature of Surveyor: 28120	Date: 08/11/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 6/30/2014		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

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: EFPC
Facility ID: 00260

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245387**

2. STATE VENDOR OR MEDICAID NO. (L2) **492242500**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST OLAF RESIDENCE**
(L4) **2912 FREMONT AVENUE NORTH**
(L5) **MINNEAPOLIS, MN** (L6) **55411**

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)

6. DATE OF SURVEY **06/26/2014** (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) **09/30**

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

12.Total Facility Beds **80** (L18)

13.Total Certified Beds **80** (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: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(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 :
Becky Wong, HFE NE II 07/30/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 08/26/2014 (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
12/01/1986
(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.
03001
(L31)

30. REMARKS
Posted 08/27/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Certified Mail # 7013 2250 0001 6356 5231

July 15, 2014

Mr. David Uselman, Administrator
St Olaf Residence
2912 Fremont Avenue North
Minneapolis, Minnesota 55411

RE: Project Number S5387023

Dear Mr. Uselman:

On June 26, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

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 August 9, 2014, 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 August 9, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 September 26, 2014 (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 December 26, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124   Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 07/15/2014
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING ______ B. WING ______	06/27/14 per GD ~~06/26/2014~~

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

(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	Received 7-29-14	
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. accepted 7-29-14	F 155	**F 155- D** Corrective Action: A. R71 has been educated on the risk/benefit of consuming alcohol and missing medications and treatments while being out on LOA. B. R71 has been offered Chemical Dependency Counseling. C. The care plan of R 71 has been updated to include goals and interventions to minimize her risks from missing medications and becoming intoxicated while out on LOA. Corrective Action as it applies to other Residents: A. The Care Plan policy has been reviewed and revised as appropriate. B. The Alcohol Consumption Policy has been reviewed and revised as appropriate. Date of Completion: August 8, 2014 Recurrence will be ~~prevented by~~:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Executive Director | (X6) DATE 7/25/14

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.

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

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F 155	Continued From page 1	F 155		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide education as to the risk and benefit of consuming alcohol and missing physician-ordered medications and treatments for 1 of 2 residents (R71) whose LOAs were reviewed.

Findings include:

R71 was consuming alcohol on leaves of absence (LOAs) from the facility, was reporting under-treated pain, and missed prescribed medication, blood sugar testing, and breathing treatments due to her absences. The resident reported and evidence in the record was lacking regarding staff discussion with the resident as to the risk/benefit ratio of both alcohol consumption and not following physician orders.

R71 was observed in her room on 6/24/14, at 11:55 a.m. As the resident rubbed her upper left arm, she reported experiencing some pain "20 out of 10" on her left forehead, back of head, neck, left shoulder and upper left arm. R71 stated, "My head is killing me. I've been having a serious headache the same way for about a week." R71 said she had a follow up appointment with the physician and would like pain relief. The following day at 7:50 a.m. R71 reported having mid-abdominal pain of an "8 or 9" as well as pain in her head and neck had pain on the left side. In addition, her abdomen had been tender the last couple of days and she planned to inform the nurse. On 6/27/14, at 3:35 p.m. R71 reported she had neuropathy and always experienced pain on the bottoms of her feet. R71 rated her pain 20 out

A. Staff education was provided on the revised Alcohol and Care Plan policy at the All Staff meetings completed the week of 7-28-14.
B. Daily audits x 2 weeks, then weekly x 4 weeks then monthly x 3 months. Findings will be reported to the QAPI/QA Committee for review and follow up recommendations. The QAPI/QA Committee will determine when the audits may be discontinued.

Responsible Person:
DON and Administrator or Designee

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING ______ B. WING ______	06/27/14

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 155	Continued From page 2 of 10, and said when her left foot was touched pain radiated on the entire left side of her body. Physician progress notes for R71 dated 5/27/14, revealed diagnoses including alcohol abuse. IDT notes revealed the resident had returned to the facility after drinking alcohol, becoming intoxicated and/or very intoxicated while on LOA on 4/24/14, 5/6/14, 5/8/14, 6/9/14, and 6/12/14. Although R71's physician orders included Neurontin 8:00 a.m., 12:00 p.m. and 8:00 p.m., Tylenol every 6 hours as needed for pain, including at night for gout pain, as well as Robaxin every 8 hours as needed for pain in feet, the 6/14 Medication Administration Record (MAR) showed R71 did not receive her 8:00 p.m. medications eight times including Tylenol 500 mg due to LOAs. LSW-A explained on 6/26/14, at 8:30 a.m. that she had only worked for a couple weeks at the facility, and was unaware R71 had been drinking. R71's drinking had never come up in IDT meetings or in conversations with the resident. LSW-A thought R71 seemed rather frail and ill, but she did not ask her about her LOAs. LSW-A was unable to find any documentation R71 had been offered chemical dependency (CD) treatment or counseling. At 9:21 a.m. LPN-A stated R71 went out drinking nearly every night, and returned "bubbly." Staff were aware when the resident had been drinking, and her medications were then held and the supervisor was notified. Incidents were documented in the progress notes and on the 24-hour status record.	F 155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 155	Continued From page 3	F 155		

At 10:53 a.m. LSW-A stated she did not know if the facility had a policy or assessed residents related to LOAs, but there would be a physician order regarding this in a resident's record. At 11:07 a.m. LSW-A verified that R71 had no orders in either 5/14 or 6/14 for LOA from the facility included in the physician's orders. In addition, R71's physician orders specified alcoholic beverages were not allowed.

At 12:50 p.m. R71 was standing near the elevator and announced, I'm leaving...checking on an apartment." At 1:31 p.m. LPN-A stated regarding R71, "That's our party girl. Everybody knows she likes to party." LPN-A stated R71 left nearly everyday after lunch, arranging her own taxi transportation, and sometimes returning with alcohol. At 1:46 p.m. LPN-A reported staff was aware R71 was not to have alcohol, "but what can you do when [R71] drinks on the street?" Although staff tried to encourage her not to drink, the resident also denied drinking.

On 6/26/14, at 3:35 p.m. R71's physician was interviewed at 3:35 p.m. and stated he was aware she was drinking, wished she would stop, but legally he could not prevent her from drinking. The physician reported R71 made poor choices, but the facility was not a jail, therefore, she was free to take LOAs.

On 6/27/14, at 10:36 a.m. a licensed practical nurse (LPN)-F explained that when a resident left on a LOA, they were to sign out at the reception area. LPN-F reported residents were not evaluated regarding LOAs, rather it was based on whether the resident had a physician's orders for LOA either with or without medications. "If there is an order, the resident can leave."

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F 155	Continued From page 4 R71's care plan dated 4/8/14, indicated the resident had intact cognition. The plan did not include the problem of R71 becoming intoxicated and missing medication doses while on LOA, nor was there a goal statement or interventions to minimize risks to the resident. The facility's Care Planning IDT policy dated 5/11 noted, "The care planning process begins during pre-admission/intake and continues on a regular and periodic basis throughout the resident stay. The resident and/or their representative, along with the entire care team is involved in the care planning process."	F 155		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the	F 225	**F 225- D** Corrective Action: A. R10 and R 71 have been referred to Psychiatric Services. The safety of both residents has been assured. B. OHFC was notified of the incident on 6/24/14. C. The Social Services Director has been visiting with R10 and R71 to assure safety. D. LPN-J was terminated due to lack of reporting abuse at the time of the incident. E. The Investigative Report from R 98 was submitted late to OHFC as per the 2567 statement. F. The Investigative Report from R 76 was submitted late to OHFC as per the 2567 statement. Corrective Actions as it applies to other Residents:	

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F 225	Continued From page 5 State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report resident abuse for 1 of 4 residents (R71). In addition, the facility failed to file the investigative report in a timely manner for 2 of 4 reportable events for residents (R98, R76) reviewed for abuse prohibition. Findings include: R71 The administrator was asked to provide any incidents and/or reports for R71 on 6/24/14, at 1:03 p.m. At 3:55 p.m. the administrator stated a new incident had been reported to him regarding a recent resident altercation with R71 being slapped by another resident and that the nurse working had not told the supervisor or him about the resident altercation on 6/13/14. The report stated R10 had been struck four times	F 225	A. The Abuse Prevention Plan was reviewed. Facility staff members were re-educated about the Abuse Prevention Plan and the definition of Immediate Reporting to OHFC. They were also educated on the requirement of filing Investigative Reports within 5 working days of the Initial Report to OHFC. The education occurred at the All Staff Meetings completed the week of 7-28-14. Date of Completion August 8, 2014 Recurrence will be prevented by: A. Facility Staff received education related to the Abuse Prevention Plan, the definition of Immediate Reporting and the Requirement to file Investigative Reports within 5 working days of the Initial Report to OHFC at the All Staff Meetings completed the week of 7-28-14. B. Daily audits x 2 weeks, then weekly x 4 weeks then monthly x 3 months. Findings will be reported to the QAPI/QA Committee for review and follow up recommendations. The QAPI/QA Committee will determine when the audits may be discontinued. Responsible Person: Administrator or Designee	

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F 225	Continued From page 6 in the face by R71 on 6/13/14. It also stated the social services director (SSD) would perform visits to both residents involved for the next two days to assure their safety. Both residents were referred to psychiatric services 6/24/14, for consultation. A police report was also filed 6/24/14. The administrator and the SSD assured R10 and R71's safety. The report stated licensed practical nurse (LPN)-J had been suspended for failure to report abuse. It also stated that it was facility practice to terminate employees for failure to report suspected and/or abuse. LPN-J had been educated on 12/20/13, and again in May 2014 on the Vulnerable Adult (VA) policies and procedures. The report stated Human Resources (HR) had started re-education to all staff of the abuse reporting policy and procedure and staff would not be allowed to work a shift until they had received education. On 6/24/14, at 3:55 p.m. the administrator stated the LPN-J who had worked on 6/13/14, and had not reported the abuse would be fired for lack of reporting. The administrator submitted the first report to the Office of Health Facility Complaints (OHFC) for the 6/13/14, incident on 6/24/14, at 2:35 p.m. R98 On 1/29/14, R98 reported missing her wedding bands and a police report was filed. The incident was submitted to the OHFC on 1/29/14. It was determined after investigation that R98's sister had mostly likely taken the rings to sell for drugs	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 7 after visiting R98. The investigation report was submitted untimely to OHFC on 3/13/14, 38 days after the acceptable time frame for reporting. R76 R76 stated she had fallen on 2/14/14. Incident report was submitted on 2/14/14. It was found that allegations of a fall were not substantiated. The investigation report was submitted untimely to OHFC on 3/13/14, 22 days after the acceptable time frame for reporting. The facility Abuse Prevention Plan dated 9/20/13, and their Vulnerable Adult Law/Abuse Reporting procedure states that suspected abuse or abuse be reported IMMEDIATELY. "Immediately" means as soon as possible from the time initial knowledge that the incident occurred has been received. The policy also states that the Vulnerable Adult Internal Investigation Procedure must be completed within five days of the incident. And the internal investigation results must be reported to the Minnesota Department of health (MDH) and facility Administrator or Administrator's designee within five working days of the initial report.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 226		F 226		

Continued From page 8
by:
The facility failed to operationalize the policies for immediate reporting of resident abuse to administrator and state agency (SA) for 1 of 4 residents (R71). In addition, the facility failed to timely submit internal investigation reports to the SA for 2 of 4 residents (R98, R76) when reviewed for abuse prohibition.

Findings include:

The facility Abuse Prevention Plan dated 9/20/13, and their Vulnerable Adult Law/Abuse Reporting procedure states that suspected abuse or abuse be reported IMMEDIATELY. "Immediately" means as soon as possible from the time initial knowledge that the incident occurred has been received. The policy also states that the Vulnerable Adult Internal Investigation Procedure must be completed within five days of the incident. And the internal investigation results must be reported to the Minnesota Department of health (MDH) and facility Administrator or Administrator's designee within five working days of the initial report.

R71
The administrator was asked to provide any incidents and/or reports for R71 on 6/24/14, at 1:03 p.m. At 3:55 p.m. the administrator stated a new incident had been reported to him regarding a recent resident altercation with R71 being slapped by another resident and that the nurse working had not told the supervisor or him about the resident altercation on 6/13/14.

The report stated R10 had been struck four times in the face by R71 on 6/13/14. It also stated the social services director (SSD) would perform

F 226- D
Corrective Action:

G. R10 and R 71 have been referred to Psychiatric Services. The safety of both residents has been assured.
H. OHFC was notified of the incident on 6/24/14.
I. The Social Services Director has been visiting with R10 and R71 to assure safety.
J. LPN-J was terminated due to lack of reporting abuse at the time of the incident.
K. The Investigative Report from R 98 was submitted late to OHFC as per the 2567 statement.
L. The Investigative Report from R 76 was submitted late to OHFC as per the 2567 statement.

Corrective Actions as it applies to other Residents:

B. The Abuse Prevention Plan was reviewed. Facility staff members were re-educated about the Abuse Prevention Plan and the definition of Immediate Reporting to OHFC. They were also educated on the requirement of filing Investigative Reports within 5 working days of the Initial Report to OHFC. The education occurred at the All Staff Meetings completed the week of 7-28-14.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING ____ B. WING ____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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F 226	Continued From page 9 visits to both residents involved for the next two days to assure their safety. Both residents were referred to psychiatric services 6/24/14, for consultation. A police report was also filed 6/24/14. The administrator and the SSD assured R10 and R71's safety. On 6/24/14, at 3:55 p.m. the administrator stated the LPN-J who had worked on 6/13/14, and had not reported the abuse would be fired for lack of reporting. The administrator submitted the first report to the Office of Health Facility Complaints (OHFC) for the 6/13/14, incident on 6/24/14 (11 days later), at 2:35 p.m. R98 On 1/29/14, R98 reported missing her wedding bands and a police report was filed. The incident was submitted to the OHFC on 1/29/14. It was determined after investigation that R98's sister had mostly likely taken the rings to sell for drugs after visiting R98. The investigation report was submitted untimely to OHFC on 3/13/14, 38 days after the acceptable time frame for reporting. R76 R76 stated that she had fallen on 2/14/14. Incident report was submitted on 2/14/14. It was found that allegations of a fall were not substantiated. The investigation report was submitted untimely to OHFC on 3/13/14, 22 days after the acceptable time frame for reporting.	F 226	Date of Completion: August 8, 2014 Recurrence will be prevented by: C. Facility Staff received education related to the Abuse Prevention Plan, the definition of Immediate Reporting and the Requirement to file Investigative Reports within 5 working days of the Initial Report to OHFC at the All Staff Meetings completed the week of 7-28-14. D. Random daily audits x 2 weeks, then weekly x 4 weeks then monthly x 3 months. Findings will be reported to the QAPI/QA Committee for review and follow up recommendations. The QAPI/QA Committee will determine when the audits may be discontinued. Responsible Person: Administrator or Designee	
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents	F 244		

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F 244	Continued From page 10 and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure prompt responses related to grievances of missing laundry for 9 of 10 monthly resident council meeting minutes (September 2013 through June 2014) and nurse staffing concerns for five of 10 monthly resident council meeting minutes (October 2013 through May 2014). Findings include: Resident council meeting minutes from September 2013 through June 2014 were reviewed and revealed the following: Review of the resident council meeting minutes dated September 19, 2013, revealed concerns related to missing laundry within the facility. The minutes did not reflect if the facility had responded to the concern or discussed a plan for addressing the identified concern. Review of the resident council meeting minutes dated October 10, 2013, revealed concerns related to nursing and missing clothing within the facility. The old business section of the minutes indicated "there was no old business." The minutes did not reflect if the facility had responded to the concerns or discussed a plan for addressing the issues related to nursing and missing clothing.	F 244	**F 244-D** Corrective Action: A. Missing laundry, call light and nurse staffing concerns have been addressed at the Resident Council meeting. B. The follow up to these concerns is addressed in the minutes from the Resident Council meeting. C. Bed and mattress requests have also been addressed at this meeting and the follow up is addressed in the Resident Council meeting minutes. Corrective Actions as it applies to other r Residents: A. The Missing Items and Resident Grievance Policy has been reviewed and revised. B. The Resident Council policy has been reviewed and revised. C. The Resident Complaint/Grie~~vance/Missing Items~~ form has been revised. Date of Completion: August 8, 2014 Recurrence will be prevented by: A. Facility staff received education related to the Complaint/Grievance policy, the Complaint/Grievance/Missing Items form, the Resident Council policy, and the Resident Council Meeting Minute format at the All	

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OMB NO. 0938-0391

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F 244	Continued From page 11 Review of the resident council meeting minutes dated November 14, 2013, old business section of the minutes indicated "there was no old business." The minutes did not reflect if the facility had responded to the concerns or discussed a plan for addressing the issues from the previous month (nursing and missing clothing). Review of the resident council meeting minutes dated December 12, 2013, revealed concerns related to nursing and missing clothing within the facility. The old business section of the minutes indicated "there was no old business." The minutes did not reflect if the facility had responded to the concerns or discussed a plan for addressing the identified issues. Review of the resident council meeting minutes dated January 9, 2014, revealed concerns related to missing clothing within the facility. Nothing was written in the old business section of the minutes. The minutes did not reflect if the facility had responded to the concern or discussed a plan for addressing the issue. Review of the resident council meeting minutes dated February 13, 2014, revealed concerns related to call lights not being answered in a timely manner and missing clothing within the facility. The old business section of the minutes indicated "there was no old business." The minutes did not reflect if the facility had responded to the concerns or discussed a plan for addressing the issues. Review of the resident council meeting minutes dated March 13, 2014, revealed concerns related to call lights not being answered in a timely	F 244	Staff Meetings completed the week of 7-28-14. B. Random daily audits x 2 weeks, then weekly x 4 weeks then monthly x 3 months. Findings will be reported to the QAPI/QA Committee for review and follow up recommendations. The QAPI/QA Committee will determine when the audits may be discontinued. Responsible Person: Administrator, Social Services Director, Activities Director, DON or their Designee.	

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F 244	Continued From page 12 manner and missing clothing within the facility. The old business section of the minutes indicated "there was no old business." The minutes did not reflect if the facility had responded to the concerns or discussed a plan for addressing the issues. Review of the resident council meeting minutes dated April 10, 2014, old business section of the minutes indicated the clothing was still missing from the previous month. The minutes did not reflect if the facility had responded to the concern or discussed a plan for addressing this issue. Review of the resident council meeting minutes dated May 8, 2014, revealed concerns related to a request for a new bed, a new mattress, maintenance on an existing bed, nursing concerns and missing clothing within the facility. The old business section of the minutes indicated the clothing was still missing from the previous month. The minutes did not reflect if the facility had responded to the concerns or discussed a plan for addressing the issues. Review of the resident council meeting minutes dated June 12, 2014, revealed concerns related to missing clothing within the facility. The old business section of the minutes indicated the request for a new bed had not been addressed, but the mattress had been replaced. The minutes did not reflect if the facility had responded to the previous month ' s concerns or discussed a plan for addressing the issues. During an interview on 6/25/14, at 2:23 p.m. the activities director (AD) stated when a concern was registered during resident council meetings, she would cut the information out of the resident	F 244		

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F 244	Continued From page 13 council minutes and tape it on an "Action Response Form" and give it to the department heads. AD stated she would typically get the response form back, but "I have not been giving the response forms to the departments lately, sometimes I just verbally tell them, if it ' s missing clothing you go down to the laundry and look for them and most often they are found." AD stated she had not followed up with any of the departments to see if they addressed the issue, "I shouldn't have put 'no old business' in there." AD stated "the action response forms fell thru the cracks, the last one I got returned was in 2012, I probably haven't followed up on it as well as I should." AD stated she did summarize the minutes for the quarter and bring them to quality assurance meetings. During an interview on 6/26/14, at 9:15 a.m. the AD stated she went thru all of the closets for the residents that registered concerns from last August 2013 thru June 2014 looking for missing clothing and noted that they were either found, still missing or replaced. AD stated she did nott know what happened with the nursing concerns. During an interview on 6/26/14, at 1:20 p.m., the administrator stated the AD will talk about resident council meeting concerns at interdisciplinary team meetings (IDT) and "I remember that a call light audit tool was used to address nursing concerns." Administrator stated the AD had used the response form in the past, " but lately I review the meeting minutes and if it ' s missing clothing, the AD or environmental services director (ESD) will look for them. " The Administrator stated "unless the resident asks again we would not know if it's been addressed, but we get back to them on the grievance form	F 244		

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F 244	Continued From page 14 that they fill out. " During an interview on 6/26/14, at 11:35 a.m. the ESD stated they do have a lost and found; he never gets an action response form but reviews the council meeting minutes. ESD stated laundry, the AD or nursing aides come down here to look for lost items and 90% of the missing items are found, further stating "this has been an ongoing issue." A resident council procedure policy was requested but was not provided. The facility was unable to produce documentation that would identify whether the above grievances had been addressed.	F 244		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 2 residents (R83, R34) call lights were readily accessible reviewed for environmental concerns. Findings include: R83's call light was not at reach.	F 246		

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F 246	Continued From page 15 On 6/24/14, at 8:54 a.m. R83's both call lights were observed hanging on the wall around the call light button. On 6/24/14, at 2:15 p.m. R83 was observed lying in bed which was lowered to the floor and both call lights were observed still hanging on the wall not accessible for R83. On 6/26/14, at 3:15 p.m. R83 was again observed lying in his bed with call light hanging on the wall not accessible. R83's fall care plan dated 12/23/13, directed staff to "Keep call light in reach at all times." R83's Minimum Data Set (MDS) dated 6/9/14, noted R83 to have functional limitations of range of motion (ROM) one side of the body and utilized a wheelchair. The MDS further noted R83 had no falls in the last 180 days. R34's call light was not kept at reach. On 6/23/14, at 4:01 p.m. R34 call light was observed hanging on the bedside pull table across from resident seated on the recliner not at reach. Resident started she used the call light when she needed help. On 6/27/14, during the environmental tour at 9:00 a.m. two call lights were observed on top of the bedside pull table by R34's foot of bed and R34 was observed sitting in her recliner across from the pull table which was not accessible. ESD reached over untwisted the call lights and gave R34 one of the call lights. On 6/27/14, the	F 246	**F 246-D** Corrective Action: A. The call lights of R83 and R34 have been placed within reach of the residents. Corrective Action as it applies to other Residents: A. The Call Light policy has been revised to include that staff ensure the call lights are within reach of the resident when they are in their rooms. Date of Completion: August 8, 2014 Recurrence will be prevented by: A. The Call Light policy was reviewed with facility staff members at the All Staff meetings completed the week of 7-28-14. B. Daily audits x 2 weeks, then weekly x 4 weeks then monthly x 3 months. Findings will be reported to the QAPI/QA Committee for review and follow up recommendations. The QAPI/QA Committee will determine when the audits may be discontinued. Responsible Person: DON or Designee	

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F 246	Continued From page 16 administrator stated resident call light needed to be at reach and accessible. R34's activities of daily living functional /rehabilitation care plan dated 3/11/14, identified R34 with an alteration in mobility and locomotion related to weakness. The Goal was "Will continue to ambulate safely." The care plan directed staff "Call light within reach." R34's MDS dated 6/4/14, noted R34 to have no functional limitations of range of motion, needed supervison and cues for decision making, and utilized a walker. The MDS further noted R34 had no falls in the last 180 days. However, R34 needed human assistance to steady during locomotion and transfers. When interviewed on 6/27/14, at 11:53 a.m. interim director of nursing (IDON) stated "Resident's call lights need to be within reach when in bed and when in wheelchair unless they are independent." Review of the facility Call Light policy revised 7/14, lacked information on staff ensuring residents call lights were within reach.	F 246		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 247		

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F 247	Continued From page 17 facility failed to provide the appropriate notices of roommate changes for 2 of 4 residents (R17, R19) who got new roommates reviewed for admission, transfer and discharge. Findings include: R17 had a new roommate and was not provided prior notice. When interviewed on 6/24/14, at 10:10 a.m. R17 stated she had gotten a new roommate about a few months ago "New roommate just showed up one day." A review of R17's recent Brief Inventory for Mental Status (BIMS-tool used to measure cognition) obtained from the quarterly Minimum Data Set (MDS) dated 6/17/14, noted a score of 13 indicating intact cognition. Nurses Notes dated 1/3/7/14, through 6/18/14, and Social Progress Notes dated 8/2/13, through 6/17/14, lacked documentation on R17 being informed of new roommate R2 who was admitted to the facility on 4/8/14. On 6/25/14, at 11:16 a.m. the licensed social worker (LWS) verified R17's medical record lacked documentation R17 had been informed of the new roommate and no follow up after new roommate had been documented either. LSW further stated her expectation was to notify the resident receiving the new roommate prior and she would introduce residents and write a note in the social service progress notes. R19 had a new roommate and was not provided	F 247	**F 247-D** Corrective Action: A. The Social Services Director interviewed R17 and R19 to ascertain any adjustment issues they may have related to their roommates. B. The Social Services Director documented the results of the interview in the medical records of R17 and R19. C. The care plans of R17 and R19 were reviewed and revised as appropriate. Corrective Actions as it applies to other Residents: A. The Room Change/Roommate Assignment Policy has been revised. B. All future Room change/Roommate assignments will be documented in the medical records and the care plans of the residents involved will be reviewed and revised as appropriate. Date of Completion: August 8, 2014 Recurrence will be prevented by: A. Facility ~~staff members~~ has been educated on the Room Change/Roommate policy at the All Staff meetings completed the week of 7-28-14.	

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F 247	Continued From page 18 prior notice. On 6/23/14, at 5:09 p.m. when asked if he had been moved to a different room or had a roommate change in the last nine months R19 stated "Yes third room" when asked if he was given notice before a room change or a change in roommate R19 stated "No notice was given, second time I got a new roommate and was surprised, did not know ahead of time." A review of R19's recent BIMS obtained from the quarterly MDS dated 4/22/14, noted a score of 11 indicated moderate impaired cognition. Nurses Notes dated 9/3/14 through 6/17/14, and Social Progress Notes lacked documentation on R17 being informed of new roommate R2 who was admitted to the facility on 4/8/14. Review of Notification of Room Change dated 10/29/13, revealed R90 had been moved from 330 to 127-1 with R90. When interviewed on 6/26/14, at 7:57 a.m. the health unit coordinator (HUC) indicated Mary R90 had been moved from the third floor to first floor but was not sure if R90 had always been at the same room. When interviewed on 6/26/14, at 8:10 a.m. licensed practical nurse (LPN)-F nurse manager stated R90 had been moved to room 127-1 with R19 who later requested to be moved from the room because R90 had urinary problems. On 6/26/14, at 11:37 a.m. LSW verified the chart lacked documentation on R19 had received a notice or had been informed of a new roommate.	F 247	B. Daily audits x 2 weeks, then weekly x 4 weeks then monthly x 3 months. Findings will be reported to the QAPI/QA Committee for review and follow up recommendations. The QAPI/QA Committee will determine when the audits may be discontinued. Responsible Person: Social Services Director or Designee	

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F 247	Continued From page 19 LSW stated she was going to look in the thinned chart to see if there was any information. -At 11:48 a.m. LSW returned stated there was no more documentation. Ecumen Room Changes policy revised May 2011, directed "6. All room changes will be documented in the patient's chart. The documentation will include: a. The reason's for the change. b. The patient's reaction. c. The patient is notified of new roommate d. Follow up on patient and roommate adjustment to the change.	F 247		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide medically-related social services to attain or maintain the highest practicable, physical, mental and psychosocial well-being for 1 of 3 residents (R2) with behavioral outbursts and the facility failed to determine interventions and implement the interventions for medically-related social services, and pursue the provision of these services for residents known to use alcohol 1 of 2 residents (R71).	F 250	**F250- D** Corrective Action: A. The care plan of R2 has been updated to include non-pharmacological interventions to be used to manage behaviors. A Psychiatric Consult has been obtained for R2. The behavior monitoring sheets of R2 were reviewed and staff members were educated on the non-pharmacological interventions they need to use for R2. B. R71 has been educated on the Risk/Benefits of missing her blood glucose checks, her nebulizer, her diabetic medications and her pain meds when she is out on LOA. She has been offered Chemical Dependency Counseling. Her care plan has been updated to include that she goes on LOA and misses medications as well as becomes intoxicated. Her goals and interventions now reflect the need to minimize the risk to the resident.	

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F 250	Continued From page 20 Findings Include: Behavior: During observation and interview on 6/25/14, at 12:14 p.m. R2 was observed to independently transfer from her bed, used a four wheeled walker and ambulated over to the scooter and got in without difficulty. R2 was sitting in the scooter, right hand was shaking and called surveyor over and whispered "they have mold in the water and I am allergic to it, they are supposed to have the best ice and water here." During observation and interview on 6/26/14, at 7:21 a.m. R2 was dressed, sitting in her scooter at the doorway of her room. R2 stated "I'm going to sue these people, and I have it all written down, I was up until 1:00 a.m. with a lot on my mind, I needed to sit and write, it's broken you know [referring to leg fracture]." R2 then got angry and loudly yelled "just say broken will you, I checked it for gangrene, I know what it looks like and I saw skin cancer too." R2 then apologized for the outburst. R2's diagnoses included schizophrenia, brain injury, morbid obesity and muscle weakness obtained from the Resident Admission Record dated 1/16/13. The care plan dated 10/16/13, identified potential for alteration in thought process due to schizophrenia. The staff was directed to allow R2 time when speaking, repeat questions if resident does not understand and be patient and social service to obtain order for in house psychiatric (psych) to see as needed. The care plan lacked evidence of non-pharmacological interventions used for behavior. The medical record lacked	F 250	Corrective Actions as it applies to other Residents: A. The Care Plan-Comprehensive policy has been implemented. This policy includes the need to incorporate risk factors associated with identified problems. B. Care Plans of current residents were reviewed and revised as appropriate. Date of Completion: August 8, 2014 Recurrence will be prevented by: A. Facility staff members were educated on the Care Plan-Comprehensive policy at the All Staff Meetings completed the week of 7-28-14. B. Daily audits x 2 weeks, then weekly x 4 weeks then monthly x 3 months. Findings will be reported to the QAPI/QA Committee for review and follow up recommendations. The QAPI/QA Committee will determine when the audits may be discontinued. Responsible Person: DON or Designee	

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F 250	Continued From page 21 evidence of social services obtaining a pyschiatric consult for the increased for one to two times behavioral outbursts. R2's quarterly Minimum Data Set (MDS) dated 5/9/14, indicated R2 had intact cognition, used a wheelchair and walker for mobility and was independent with transfers. The MDS also noted R2 displayed no behaviors in the last week. R2's medications obtained from physician orders dated 5/21/14, included ziprasidone (an antipsychotic medication), clonazepam (a medication used for anxiety) and paroxetine (a medication used for depression). Review of Behavior Monitoring Records dated June 2014 indicated R2 had increased behaviors averaging one to three times per day such as obsessive statements and anxiousness regarding treatments, health, appointments and staff, inability to calm, weepiness, paranoia - obsessive complaints regarding health concerns. Even though the Behavior Monitoring Records had alternative non-pharmacological interventions, the facility did not utilize the interventions to determine effectiveness. Additional Behavior Monitoring Records for the past three months were requested but not provided. During an interview on 6/26/14, at 7:42 a.m. licensed practical nurse (LPN)-A stated R2 "wants things immediately and if you don't do it immediately she gets worked up, she will borrow cigarettes in the smoking room and will get very angry when she is out and doesn't get them back."	F 250		

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During an interview on 6/27/14, at 7:52 p.m. licensed social worker (LSW) stated R2 was angry yesterday because she borrowed cigarettes and didn't get them back. "We have noticed when that happens she is angry and yells a lot, I checked with her and she started yelling, getting mad, so I said I would check back."

During an interview on 6/27/14, at 8:07 a.m. LPN-F stated he saw R2 that morning and she immediately started yelling about the day she fell and got her leg fracture. LPN-F stated "I tried to talk with her and she went off and started yelling, she does fixate a lot and gets delusional."

During an interview on 6/27/14, at 2:11 p.m. LPN-I stated R2 has not received psych services that "I know of, unless she saw in house psych services, I'm not sure."

During an interview on 6/27/14, at 3:37 p.m. LSW stated to her knowledge R2 had not seen psychiatric services, "unless she went out to see one." LSW stated she did contact the in house psych doctor to see her, but she needed an medical doctor order, "I don't see anything in her file that she has seen one in the past."

Alcohol Use:
R71 reported on 6/26/14, at 5:35 p.m. that no one from the facility had talked to her about the risk versus benefit of missing her accuchecks for diabetes as well as medications including sliding scale insulin, oral glycemic (medication given for diabetes for blood sugar control), and pain medication while on frequent leave of absences (LOAs) from the facility during medication administration times. R71 reported she only drank

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three beers when on LOA, and did not bring any alcohol into the facility. R71 stated she did not want to argue with staff upon her return but R71 stated she would like her evening Trazodone (anti-depressant) to help her sleep at night. R71 stated she takes sliding scale insulin (medication to control blood sugars), but did not take scheduled insulin anymore. R71 stated she can feel when her blood sugars are elevated because the bottom of her feet get real, real cold and her fingertips get numb. R71 stated no one has ever talked to her about the risks/benefits regarding drinking alcohol, missing medications, missing accuchecks checks, and/or sliding scale insulin with her diagnoses. R71 stated she knew she was on pills for diabetes but was unaware that she took an evening dosage of Glucophage for her diabetes. R71 reported she only drank three beers when on LOA, and did not bring any alcohol into the facility. She stated no one had talked to her about consuming alcohol while gone from facility nightly and missing medications /treatments or getting with the chemical dependency.

R71's care plan dated 4/8/14, indicated accuchecks as ordered, medications/insulin as ordered. The care plan did not include the problem of R71's becoming intoxicated and missing medication doses while on LOA, nor was there a goal statement or interventions to minimize risks to the resident.

R71 had a Minimum Data Set (MDS) dated 4/14/14, R71's Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition.

Interdisciplinary Team (IDT) notes from 4/24/14,

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F 250	Continued From page 24 going forward, revealed R71 had returned to the facility after drinking alcohol, becoming intoxicated, and/or very intoxicated while on leave of absence (LOA) on 4/24/14, 5/6/14, 5/8/14, 6/9/14, and 6/12/14. R71's May Medication Administration Record (MAR) showed R71 did not get her 8:00 p.m. Ventolin nebulizer (medication assist in breathing) treatment 14 times, her nightly insulin Lantus 10 units (used to control blood sugar), because of returning from LOA in the community with having had drank alcohol with no documentation showing R71 had had risks/benefits explained to her. R71's May Treatment Administration Record (TAR) showed R71 did not get her 8:00 p.m. blood sugar accuchecks six times because of returning from LOA in the community with having had drank alcohol with no documentation showing R71 had had risks/benefits explained to her. The June 2014 MAR showed R71 did not receive her 8:00 p.m. medications including Glucophage (medication used for blood sugar control), Tylenol 500 mg eight times due to LOAs. R71's June 2014 TAR showed that R71 had missed 8:00 p.m. accuchecks checks 15 times in June because of returning from LOA in the community with having had drank alcohol with no documentation showing R71 had had risks/benefits explained to her. R71's Physician Orders for June 2014 indicated the evening medications and treatments included Advair, Albuterol, Aspirin, Celexa, Ferrous	F 250		

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Sulfate, Neurontin, Glucophage, Simvastatin, Detrol, Trazodone, Lantus, Check blood sugar twice daily at alternating times 8:00 a.m. and 12:00 p.m., 4:00 p.m. and 8:00 p.m., Novolog sliding scale injection for blood sugars of 120-149=2 units, 150-199=3 units, 200-249=6 units, 250-299=9 units, 300-349=12 units, >350=15 units, Ibuprofen, Tylenol every 6 hours as needed for pain, and Tylenol orally at night as needed for gout pain, and Robaxin every 8 hours as needed for pain in feet.

On 6/26/14, at 8:30 a.m. licensed social worker (LSW)-A explained she had only worked for a couple weeks at the facility, and was unaware R71 had been drinking. LSW-A stated R71's drinking had never come up in IDT meetings or in conversations with the resident. LSW-A thought R71 seemed rather frail and ill, but stated she had not asked R71 about her nor offered R71 any chemical dependency (CD) counseling. LSW-A was unable to find any documentation that R71 had been offered CD treatment or counseling. Alcoholics Anonymous (AA) meetings were reported to be held across the street and no documentation was found that R71 had been offered to attend.

- At 9:21 a.m. LPN-A stated R71 went out drinking nearly every night." LPN-A stated staff were aware when the resident had been drinking, and R71's medications were then held and the supervisor was notified. Incidents were documented in the progress notes and on the 24-hour status record.
- At 9:55 a.m. the daytime receptionist (R)-K reported she had often witnessed R71 leave the facility.
- At 12:50 p.m. LPN-A stated R71 left nearly every day after lunch, arranged her own taxi

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transportation, and returned with smell of alcohol.
- At 1:18 p.m. LPN-H stated R71 went out so much and missed her evening medications and treatments. LPN-H verified no insulin was given to R71 6/1/14 through 6/4/14.
- At 2:26 p.m. the interim director of nursing (IDON) stated he expected all staff to follow the resident's care plan and for nursing staff to update resident's care plan as needed.
- At 3:17 p.m. RN-B who worked for R71's primary physician at the clinic was interviewed via telephone. RN-B stated R71 had told a physician she consumed one to two beers per night.

The facility's Care Planning IDT policy dated 5/11 noted, "The care planning process begins during pre-admission/intake and continues on a regular and periodic basis throughout the resident stay. The resident and/or their representative, along with the entire care team is involved in the care planning process. Care is planned to help attain or maintain the resident's highest practicable physical, mental and psychosocial well being. The comprehensive care plan is reviewed during the initial care conference and on an ongoing basis. The care plan is updated on an ongoing basis to meet the needs of the resident. The comprehensive care plan is used by all personnel involved in the care of the resident."

The Interdisciplinary Stand Up Meeting policy dated 5/11, noted, "The facility promotes communication between the interdisciplinary team to positively affect outcomes for the residents, and to provide an ongoing process of interdisciplinary communication with a focus on positive outcomes for the residents. The IDT will review residents and make changes necessary to assessments or care plan interventions to help

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F 250	Continued From page 27 improve outcomes for residents."	F 250		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R2) motorized scooter was kept clean, and failed to maintain a clean and sanitary environment for 11 of 13 residents (R105, R8, R71, R67, R47, R17, R43, R37, R19, R11, R84). In addition failed to ensure privacy for 1 of 3 general Resident Restroom reviewed for environmental concerns. Findings include: On 6/27/14, at approximately 9:00 a.m. an environmental tour was conducted with the administrator, environmental services director (ESD) and housekeeping staff. During the tour the following concerns were identified R2's motorized scooter was not clean. On 6/23/14, at 4:00 p.m. R2 was observed wheeling herself in a motorized scooter which was noted to have built up of food particles on the base of the feet and thick fluffy material all around the entire frame of the motorized scooter. On 6/25/14, at 6:54 a.m. observed R2 wheeling into the elevator when asked who cleaned her	F 253	**F 253-D** Corrective Action: A. The scooter of R2 has been cleaned. B. The rooms of R105, R8, R71, R67, R47, R17, R43, R37, R19, R11 and R84 have been cleaned and routine maintenance has been completed. C. The translucent privacy window covering has been replaced in the Second Floor Resident Bathroom. Corrective Actions as it applies to other Residents: A. Resident wheelchairs and scooters have been cleaned according to the schedule and also PRN. B. Resident rooms have been audited. They have been cleaned ~~and repairs have been completed~~ according to the facility plan. Date of Completion: August 8, 2014 Recurrence will be prevented by: A. Facility staff members have been educated on the Wheelchair Cleaning, Resident Room Cleaning and the Facility Maintenance expectations at the All Staff Meetings completed the week of 7-28-14. B. Daily audits x 2 weeks, then weekly x 4 weeks then monthly x 3 months. Findings will be reported	

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F 253	Continued From page 28 scooter, resident stated "I wish they could clean it for me." On 6/27/14, administrator verified the motorized scooter was not clean. ESD stated "Wheelchairs are cleaned once a month and are wiped down if they have spills." R2's quarterly Minimum Data Set dated 5/9/14, indicated R2 had intact cognition, used a wheelchair and walker for mobility and was independent with transfers. During review of the facility Audit Cleaning Of Wheelchairs log, it was revealed several wheelchairs had been cleaned on 5/14/14, but there were no names or room numbers of the wheelchairs in the log. No records provided for June 2014. Wheelchair Cleaning policy revised 7/09 - 4/01/14, indicated all wheelchairs were to be checked and cleaned on a monthly basis. In addition the policy directed "Any wheelchair that needs to be cleaned more than once a month will be cleaned on the 4th Wednesday of the month." ROOM ODOR: R105's room was not kept free of smells. On 6/24/14, at 8:38 a.m. a strong malodorous smell in R105's room was noticed which seemed to be concentrated by the entryway. On 6/25/14, at 7:50 a.m. noted still a fainter odor of urine in the room than on 6/24/14, licensed practical nurse (LPN)-M was asked but stated she had to get the manager to walk into room 329	F 253	to the QAPI/QA Committee for review and follow up recommendations. The QAPI/QA Committee will determine when the audits may be discontinued. Responsible Person: Environmental Service Director, DON, Administrator or their Designee.	

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F 253	Continued From page 29 and identify the malodorous scent. -At approximately 8:08 a.m. interim director of nursing (IDON) verified a faint urine odor in the room, and stated it was more noticeable in the entry way. On 6/27/14, the administrator stated an extraction had been done on Monday and Wednesday using urine-off substance. R105's was admitted to the facility on 4/28/14, admission MDS dated 5/4/14, indicated R105 had moderately impaired cognition, required limited to extensive assistance with activities of daily living (ADL's) including toileting and had a functional limitation in range motion impairment to one side of both upper and lower extremities. Review of 3RD Floor Deep Clean dated May-14, revealed room 329 where R105 resided had been deep cleaned last on 5/15/14. R8's bathroom was noted to be in ill repair. On 6/23/14, at 4:55 p.m. R8's bathroom archway metal was noted to be heavily scraped up, with paint chipped off, the mid lower closet doors were all scraped up and lower bathroom door frame was noted to be scraped up which created jagged edges. On 6/27/14, both administrator and ESD verified. R8's annual MDS dated 5/22/14, indicated R8 had intact cognition and required limited to extensive assistance with ADL's which included toileting. R71's room radiator was noted to be in ill repair.	F 253		

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F 253	Continued From page 30 On 6/24/14, at 10:45 a.m. the air vent radiator metal in R71's room was noted to have several rusty patches and paint was scratched and scraped up. In addition the archway to bathroom metal was scraped up and with paint chipped. On 6/27/14, ESD verified the findings stated not all the time he identified the concerns. R71's admission MDS dated 4/14/14, indicated R71 had intact cognition, was independent with toileting and used a walker and wheelchair for mobility. R67's bathroom was noted to be in ill repair. On 6/23/14, at 5:41 p.m. during R67's bathroom archway metal into bathroom was observed with to have multiple scrapes and with chipped paint. On 6/27/14, ESD verified the finding stated "Yes I see" R67's quarterly MDS dated 3/24/14, indicated R67 was independent with toileting and had moderately impaired cognition. R47's room entry and bathroom doors were noted to be in ill repair. On 6/23/14, at 4:59 p.m. during R47's edges of the room entry and bathroom doors were observed to be heavily scuffed, scraped and gouged. On 6/27/14, ESD verified. R47's quarterly MDS dated 5/7/14, indicated R47 was independent with toileting and had intact	F 253		

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F 253	Continued From page 31 cognition. R17's room was with ill repair. On 6/23/14, at 5:15 p.m. R17's lower frame of the bathroom door, closet door, and entry room door were noted to be scratched up, metal on the archway scraped, missing paint into bathroom. In addition two of the air vents radiator metals were noted to have rusty patches and with scraped up and missing paint. On 6/27/14, ESD verified. R17's quarterly MDS dated 4/22/14, indicated R17 cognition was moderately impaired and required extensive assist with toileting. During review of the facility Environmental Service Monthly Inspection logs dated 5/14/14, 5/27/14, and 5/30/14, it was revealed R17's room had been inspected on 5/14/14, and was indicated "Good with Grading: 1= Good 2= Fair 3= Poor" for bathroom door condition, edges, baseboards, walls, and floors. R43's room radiator was noted to be in ill repair. On 6/23/14, at 6:00 p.m. during room observation R43's radiator in room was noted to have multiple rusty patches and with chipped paint. On 6/27/14, ESD verified stated monthly room audits were done but had not identified the concerns. R43's quarterly MDS dated 6/16/14, indicated R43 required extensive assist with toileting and R43 had intact cognition.	F 253		

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R37's room was with ill repair.
On 6/23/14, 4:31 p.m. during R37's room observations the radiator was noted to have chipped paint, the wall was noted to have different color patches all around the room and the archway to the bathroom above the base board the sheet rock was exposed and had several gouged areas and was heavily scuffed with black marks.

On 6/27/14, ESD stated he was aware of some rooms having different paint but had not addressed R37's room and verified the concerns.

R37's quarterly MDS dated 4/20/14, indicated R37 required total to extensive assist with ADL's including transfers, R37 had intact cognition, had a functional limitation to both upper and lower extremities with an impairment and used a wheelchair for mobility.

R19's room was with ill repair.
On 6/24/14, 10:46 a.m. R19's room walls were observed to have multiple white paint patches marked around the south portion of room where R19 faced when lying in bed and the radiator was noted to have multiple rusty patches and with chipped paint.

On 6/27/14, ESD verified the concerns stated "Not all the time" when asked if he was aware R19's room had the patches and indicated was from nails on the wall from hanging pictures he thought. ESD was not to indicate when the holes had been painted.

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F 253	Continued From page 33 R19's quarterly MDS dated 6/17/14, indicated R19 required extensive to total assist with ADL's including toileting and had moderately impaired cognition. R11's room was with ill repair. On 6/23/14, at 5:31 p.m. R11's bathroom archway metal was noted to be heavily scuffed, scrapped and with chipped paint. In addition the left closet door had a dented hole and the lower portion of the bathroom door frame and room entry door were both observed to have gouges which created jagged edges and were scuffed with black marks. On 6/27/14, ESD verified concerns. R11's quarterly MDS indicated he had intact cognition and required limited to extensive assist with ADL's and R11 had a functional limitation on his both upper extremities. R84's room was with ill repair. On 6/23/14, at 3:57 p.m. R84's radiator under the window was observed with rusty patches, scraped and had chipped paint. In addition the bathroom door frame was noted to be scuffed and had gouges which created jagged edges. On 6/27/14, ESD verified. R84's quarterly MDS dated 4/18/14, indicated R84 was independent with toileting and had moderately impaired cognition. 2ND FLOOR RESIDENT RESTROOM	F 253		

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	245387	A. BUILDING ______ B. WING ______	

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ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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F 253	Continued From page 34 Ill repaired privacy covering: On 6/25/14, at 8:29 a.m. 2nd Floor Resident Restroom room 201 door was observed wide open and upon looking straight from the hallway it was noted the privacy translucent window covering was peeled off the glass, cracked and with jagged edges approximately 10 centimeter (cm) x 14 cm surveyor able to look outside to the parking lot and across the street. On 6/27/14, ESD and administrator both verified. The administrator stated, "We will get it fixed." Resident Room Cleaning (General) policy with review date 10/02/02, directed "Write any damaged items, such as drapes, electrical outlets, nurse call cords, etc., repairs needed, or unsafe condition, in the maintenance books at each nursing station."	F 253		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared 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, the participation of the resident, the resident's family or the resident's	F 280		

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F 280	Continued From page 35 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise care plans for 2 of 3 residents (R2, R71) reviewed for alcohol/drug consumption and accidents whose status had changed. Findings include: R2s care plan was not revised to reflect resident is independent with activities of daily living (ADL). R2's diagnoses included schizophrenia, lupus, epilepsy, chronic obstructive pulmonary disease, brain injury and muscle weakness obtained from the Resident Admission Record dated 1/16/13. The quarterly Minimum Data Set (MDS) dated 5/9/14, identified the resident was independent all ADLs except walking in the corridor. The care area assessment (CAA) dated 11/11/13 indicated R2 was at risk for decline in ADLs related to extensive assist needed. Staff was to assist with ADLs and monitor for changes with bed mobility, transfers and locomotion on unit, dressing and toileting. R2's care plan dated 11/25/13, identified R2 required "assistance with dressing, bathing, grooming...all ADL." The undated "Team 2 Assignment" sheet for nursing assistants	F 280	**F 280-D** Corrective Action: A. The care plan of R2 has been revised to reflect her current ADL, transfer and ambulation needs. B. The care plan of R71 has been revised to include the Risk/Benefit of missing meds and treatments and of consuming alcohol while on LOA. Corrective Action as it applies to other Residents: A. The Care Plan-Comprehensive policy has been implemented. Assessments of residents are on-going and care plans are revised as information about the resident and the residents condition changes. The care plans of current residents were reviewed and revised as appropriate. Date of Completion August 8, 2014 Recurrence will be prevented by: A. Facility Staff members were educated on the Care Plan-Comprehensive policy at the All	

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F 280	Continued From page 36 indicated R2 required assist of one for transfers and ADLs. During observation on 6/25/14, at 12:14 p.m. R2 independently transferred from her bed, used a four wheeled walker to ambulate over to her scooter and transferred into the scooter without difficulty. During an interview on 6/25/14, at 11:35 a.m. nursing assistant (NA)-E stated R2 gets up and will transfer by herself. Licensed practical nurse (LPN)-A stated, "It's OK for her to transfer by herself." During an interview on 6/26/14, at 4:55 p.m. trained medication assistant (TMA)-B stated R2 does not usually call for help, she self-transfers and does "most things by herself." TMA-B further stated she has never seen her call light on to get help when she is down on the floor. During an interview on 6/27/14, at 8:10 a.m. MDS coordinator stated she updated the care plans quarterly and annually, further stating "I am responsible for the updating the care plan, it has been a work in progress, the previous director of nursing used to do them, there was a mix, yes it should have been updated." Review of the facility "Care Planning IDT [interdisciplinary department team]" policy indicated "the care planning process begins during pre-admission /intake and continues on a regular and periodic basis throughout the resident/patient stay." Under section V [five] Change in Status Review" the policy indicated "the care plan is updated on an ongoing basis to meet the needs of the resident."	F 280	Staff meetings completed the week of 7-28-14. B. Daily audits x 2 weeks, then weekly x 4 weeks then monthly x 3 months. Findings will be reported to the QAPI/QA Committee for review and follow up recommendations. The QAPI/QA Committee will determine when the audits may be discontinued. Responsible Person: DON or Designee	

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F 280	Continued From page 37	F 280		

R71

R71's Minimum Data Set (MDS) dated 4/14/14, revealed a BIMS score of 15 which indicated intact cognition.

R71's physician progress notes dated 5/27/14, revealed diagnoses included alcohol abuse, COPD and chronic pain.

On 6/26/14, at 9:21 a.m. LPN-A stated R71 went out drinking nearly every night. Staff were aware when the resident had been drinking, and R71's medications were then held and the supervisor was notified. Incidents were documented in the progress notes and on the 24-hour status record. On the 6/12/14, 24-hour report it was noted R71 returned to facility smelling of alcohol. LPN-A explained that R71 had to return by a certain time, and had been informed of this policy.

At 9:55 a.m. the daytime receptionist (R)-K reported she had often witnessed R71 leave the facility.

Interdisciplinary (IDT) notes revealed the resident had returned to the facility after drinking alcohol, becoming intoxicated and/or very intoxicated while on LOA on 4/24/14, 5/6/14, 5/8/14, 6/9/14, and 6/12/14.

R71 reported on 6/26/14, at 5:35 p.m. she only drank three beers when on LOA, and did not bring any alcohol into the facility. R71 stated no one had talked to her about the risks versus benefits of consuming alcohol and missing nightly medications and treatments.

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F 280	Continued From page 38	F 280		

R71's medical record revealed inconsistencies and omissions in physician orders. The resident was frequently absent from the facility when medications were ordered, therefore, did not consistently receive her medications as ordered.

R71's care plan dated 4/8/14, did not include the problem of R71 becoming intoxicated and missing medication doses while on LOA, nor was there a goal statement or interventions to minimize risks to the resident. R71's careplan dated 4/8/14, did not include daily inhaler and neb treatments.

On 6/26/14, at 2:26 p.m. the interim director of nursing (IDON) stated he expected nursing to follow resident careplans and to implement and revise careplans as needed.

The facility's Care Planning IDT policy dated 5/11 noted, "The care planning process begins during pre-admission/intake and continues on a regular and periodic basis throughout the resident stay. The resident and/or their representative, along with the entire care team is involved in the care planning process. Care is planned to help attain or maintain the resident's highest practicable physical, mental and psychosocial well being. The comprehensive care plan is reviewed during the initial care conference and on an ongoing basis. The care plan is updated on an ongoing basis to meet the needs of the resident. The comprehensive care plan is used by all personnel involved in the care of the resident."

F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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NAME OF PROVIDER OR SUPPLIER: ST OLAF RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE: 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	

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F 282 Continued From page 39
The services provided or arranged by the facility must 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 provide services in accordance with the resident's written plan of care for 1 of 1 resident (R45) for dialysis dressing removal reviewed for dialysis; the facility failed to follow the revised plan of care for 1 of 3 residents (R31) observed for activities of daily living (ADls); the facility failed to offer psychiatric services for 1 of 5 residents (R2) according to the plan of care and the facility failed to ensure 2 of 2 residents (R83, R34) call lights were readily accessible according to the care plan.

Findings include:

Dialysis:
On 6/25/14, at 7:15 a.m. licensed practical nurse (LPN)-A was observed standing outside R45's door in front of the medication cart documenting.
-At 7:16 LPN-A was observed applying gloves and entered R45's room then came out briefly.
-At 7:18 a.m. nursing assistant (NA)-A was observed wheeling R45 to the dining room (DR).
-At 7:22 a.m. observed resident sitting on her wheelchair (W/C) at the DR appeared all dressed up looking around wearing a short sleeve shirt and was observed to have dressing to her upper left arm when she pulled her sleeve up.
-At 8:32 a.m. observed staff bring R45's breakfast tray and R45 was observed eating independently.
-At 9:10 a.m. NA-A was observed wheeling R45

F 282

F 282-D
Corrective Action:

A. R 45 now has the dressing removed from her dialysis site in the evening when she returns from dialysis. The area is monitored per protocol.
B. The care plan and group sheet of R45 now reflects the location of the dialysis fistula. The dialysis care plan has been updated to include monitoring for signs of infection of the fistula and what to do if there is bleeding at the site.
C. R31 had her nails trimmed and cleaned.
D. The care plan and group sheet of R31 has been updated to reflect the need to do routine nail care on bath day.
E. The care plan of R2 has been updated to include non-pharmacological interventions to treat behaviors in addition to her psychotropic medications. A referral has been made for her to receive psychiatric services.
F. The call light of R83 is now within reach when the resident is in his room. His care plan was reviewed and revised as appropriate.

Corrective Actions as it applies to other Residents:

A. The Hemodialysis Policy has been reviewed and revised.

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F 282	Continued From page 40 back to her room then came out briefly. On 6/25/14, at 10:52 a.m. LPN-A and surveyor went to R45's room observed R45 lying in bed awake covered up. LPN-A pulled R45's left shirt sleeve up and verified R45's bandages from dialysis the previous day on 6/24/14, were still on. LPN-A stated "They are supposed to be removed by the evening shift when she returns to the facility." -At 10:53 a.m. LPN-A was observed removing gauze secured with white paper tape from R45's left upper arm noted area had no signs and symptoms of infection and a small amount of blood noted on the gauze. LPN-A also listened to for bruit using a stethoscope. R45's diagnoses included acute kidney disease, end stage renal disease (ESRD), diabetes mellitus (DM), proliferative retinopathy and alcohol induced persistent dementia obtained from the Diagnoses Report- Clinical dated 1/13/14. R45's Brief Interview for Mental Status (BIMS-tool used to measure cognition) indicated R45 had moderate impairment in cognition. The activities of daily living (ADL's) Minimum Data Set (MDS) indicated R45 required limited to extensive physical assistance of one staff with all cares. The care plan dated 3/14, identified R45 needed hemodialysis related to end stage renal disease. The care plan indicated R45 had an access site fistula but did not identify the location. The care plan directed "May remove dressing to shut site 4 hours after return from dialysis." Goal "Will be free of infection ..." Physician Orders dated 5/30/14, did not identify specific instructions for care and removal of the shunt site dressing.	F 282	B. The Care Plan policy has been reviewed and revised. C. The Nail Care policy has been reviewed and revised. D. The Call Light policy ~~was reviewed~~ was reviewed and revised. Date of Completion: August 8, 2014 Recurrence will be prevented by: A. Facility staff members were educated on the Hemodialysis, Care Plan, Nail Care and Call Light Policy at the All Staff meetings completed the week of 7-28-14. B. Random daily audits x 2 weeks, then weekly x 4 weeks then monthly x 3 months. Findings will be reported to the QAPI/QA Committee for review and follow up recommendations. The QAPI/QA Committee will determine when the audits may be discontinued. Responsible Person: DON or Designee	

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F 282	Continued From page 41 When interviewed on 6/25/14, at 10:46 a.m. registered nurse (RN)-A who was also the facility MDS coordinator verified the care plan did not address the location of R45's fistula. RN-A stated she usually did not indicate the location of the site in the care plan as it was in the Treatment Administration Record (TAR). When asked about how the nursing assistants and other staff who floated to the unit would know the location that were not familiar with R45's fistula site location, RN-A stated the floors were set up the same and the nurses would be able to know from the TAR and was not responsible for writing/updating the NA Team Assignment sheet. When interviewed on 6/25/14, at 11:21 a.m. interim director of nursing (IDON) stated "In reasonable professional practice" the care plan should address the location of the site and nursing assistant Team Assignment sheet should indicated the location." IDON further stated the care plan should address monitoring for signs and symptoms of infection, dressing removal after dialysis as directed and should be followed. IDON verified the NA Team Assignment sheet and care plan lacked the location of the fistula. When asked about his expectation for staff removing the bandages IDON stated "They are supposed to remove the dressing on the day of treatment and the night shift would in the morning before she leaves that's how I understand it." When interviewed on 6/25/14, at 11:25 a.m. dialysis registered nurse (DRN) stated R45's dialysis runs were going well and when asked about the dressing concerns addressed in the Dialysis/Nursing Facility Communication Forms dated 4/15,14, 4/19/14, 4/24/14, 5/8/14, 5/13/14, 5/31/14, 6/14/14, DRN stated "There had been	F 282		

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concerns about the bandages being left on until she returned back for dialysis and the nurse practitioner and the nephrologist had been involved and am still not sure why this is not clear to the facility." DRN further stated "The bandages are supposed to be removed the evening after dialysis like yesterday or latest this morning when she got up immediately. When the bandages are left in place they can cause the site to clot or cause an infection to the fistula." Surveyor indicated to DRN he needed to speak to a facility staff to clarify the dressing removal instruction and surveyor gave phone to LPN-A who after getting off the phone stated the dialysis nurse had told her the dressings was to be removed the evening after "Just as I had told you earlier."

When interviewed on 6/25/14, at approximately 11:40 a.m. NA-A stated "I know resident's dialysis site is on the left arm because there is always a dressing on the arm and the nurse had told me before." When asked if she knew what to do incase R45 had bleeding from the site or if she knew if she would take a blood pressure on that arm NA-A stated she would apply gloves and leave the room to go get the nurse then looked at surveyor and stated "I will ask the nurse now can I." as she pointed at LPN-A standing by the cart down the hallway.

ADLs:
On 6/23/14, at 7:21 p.m. during a stage 1 family interview, R31 ' s family member (F)-A stated "the staff did not always trim R31 ' s fingernails, and stated "sometimes I have to do it when I get there." The F-A further stated, at 98 years old, the resident really only likes to eat sweets. F-A stated he had not been there at meal times and did not know if staff assisted R31 to eat or not

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On 6/23/14, at 3:00 p.m. R31 was observed to be lying down in bed, and appeared asleep.
-At 5:55 p.m. R31 was in the dining room leaning far to the right in her wheelchair. When NA-C, talked with her she sat up straight without assistance, and smiled and had a simple conversation with NA-C, immediately after the conversation she leaned to the extreme right again. When supper arrived at 6:05 p.m. R31 sat up straight without assistance and fed herself, at times she used her fingers to scoop up sweet things. Staff was nearby in the kitchenette area, no one was observed to assist R31.

On 6/24/14, at 8:00 a.m. the resident was sitting in the 2nd floor dining room, sitting up straight in her wheelchair. R31 ate her toast, and then used her fingers to scoop the last of the jelly out of the jelly container.
- At 1:00 p.m. R31 was observed to eat lunch, scooping food up with her right hand and shoveling into her mouth.

R31 was admitted to the facility on 12/17/08, with admission diagnoses of dementia with behavioral disturbances, Alzheimer, chronic kidney disease, malnutrition, was given a regular diet with supplements for weight loss per the Admission Record.

A quarterly MDS dated 6/18/14, indicated R31 had short term and long term memory loss and severely impaired decision making skills. R31 was totally dependent on two staff for bed mobility, and transfers, and totally dependent on one staff for toileting and dressing. R31 required extensive assistance of one staff for personal hygiene and locomotion on the unit, and limited

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F 282	Continued From page 44 assistance of one staff for eating. The last annual Care Area Assessment (CAA) dated 12/20/13, lacked identification of ADL's. R31's care plan last revised 6/18/14, indicated R31 had a cognitive loss, and self-care ADL deficit, and directed the staff to provide total care for the resident, including passive range of motion to ensure the right hand can be opened well enough to be cleaned. On 6/27/14, at 2:14 p.m. NA-B stated the nurses trim the fingernails of R31, she then went to verify that with LPN-I and LPN-I returned and stated the NA trim the nails. -At 2:16 p.m. NA-B accompanied to observe the R31's fingernails, NA-B verified the fingernails were long and had a brown debris substance underneath the nails. NA-B stated "she just got done eating. " NA-B then proceeded to clean the debris from under the fingernails. NA-B stated she was not aware she was supposed to clean and trim the fingernails. On 6/27/14, at 2:35 the IDON verified the staff was expected to trim nails on bath day routinely, unless the resident was diabetic, then the nurse would trim the fingernails. The ADL policy dated 8/2013, directed the staff to provide assistance to residents as necessary, and described assisting a resident to complete daily personal cares. The policy lacked direction on providing cares to residents who are dependent for ADL functions. Staff was unclear who was to clean or trim the resident ' s nails; the undated NA care sheet did not direct staff to trim nails on bath day.	F 282		

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F 282	Continued From page 45	F 282		

Psych services:
R2 was observed and interviewed on 6/25/14, at 12:14 p.m.to independently transfer from her bed, used a four wheeled walker and ambulated over to the scooter and got in without difficulty. R2 was sitting in the scooter, right hand was shaking and called surveyor over and whispered "they have mold in the water and I am allergic to it, they are supposed to have the best ice and water here."

During observation and interview on 6/26/14, at 7:21 a.m. R2 was dressed, sitting in her scooter at the doorway of her room. R2 stated "I'm going to sue these people, and I have it all written down, I was up until 1:00 a.m. with a lot on my mind, I needed to sit and write, it's broken you know [referring to leg fracture]." R2 then got angry and loudly yelled "just say broken will you, I checked it for gangrene, I know what it looks like and I saw skin cancer too." R2 then apologized for the outburst.

R2's diagnoses included schizophrenia, brain injury, morbid obesity and muscle weakness obtained from the Resident Admission Record dated 1/16/13.

The care plan dated 10/16/13, identified potential for alteration in thought process due to schizophrenia. The staff was directed to allow R2 time when speaking, repeat questions if resident does not understand and be patient and social service to obtain order for in house psych to see as needed.

R2's medications obtained from physician orders dated 5/21/14, included ziprasidone (an

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F 282	Continued From page 46 antipsychotic medication), clonazepam (a medication used for anxiety) and paroxetine (a medication used for depression). Review of Behavior Monitoring Records dated June 2014 indicated R2 had increased behaviors averaging one to three times per day such as obsessive statements and anxiousness regarding treatments, health, appointments and staff, inability to calm, weepiness, paranoia - obsessive complaints regarding health concerns. The records however did not outline what alternative non pharmacological interventions were used and if they were effective. Additional Behavior Monitoring Records for the past three months were requested but not provided. During an interview on 6/27/14, at 7:52 p.m. social worker (SW) stated R2 was angry yesterday because she borrowed cigarettes and didn't get them back. "We have noticed when that happens she is angry and yells a lot, I checked with her and she started yelling, getting mad, so I said I would check back." During an interview on 6/27/14, at 8:07 a.m. LPN-F stated he saw R2 that morning and she immediately started yelling about the day she fell and got her leg fracture. LPN-F stated "I tried to talk with her and she went off and started yelling, she does fixate a lot and gets delusional." During an interview on 6/27/14, at 2:11 p.m. LPN-I stated R2 has not received psych services that "I know of, unless she saw in house psych services, I'm not sure."	F 282		

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F 282	Continued From page 47 During an interview on 6/27/14, at 3:37 p.m. SW stated to her knowledge R2 had not seen psychiatric services, "unless she went out to see one." SW stated she did contact the in house psych doctor to see her, but she needed an MD (medical doctor) order, "I don't see anything in her file that she has seen one in the past." The plan of care was not followed for social services obtaining psych services as R2 had increased behaviors averaging one to three times per day such as obsessive statements and anxiousness regarding treatments, health, appointments and staff, inability to calm, weepiness, paranoia - obsessive complaints regarding health concerns. Call Lights: R83's call light was not at reach. On 6/24/14, at 8:54 a.m. R83's both call lights were observed hanging on the wall around the call light button. On 6/24/14, at 2:15 p.m. R83 was observed lying in bed which was lowered to the floor and both call lights were observed still hanging on the wall not accessible for R83. On 6/26/14, at 3:15 p.m. R83 was again observed lying in his bed with call light hanging on the wall not accessible. R83's fall care plan dated 12/23/13, directed staff to "Keep call light in reach at all times." R34's call light was not kept at reach. On 6/23/14, at 4:01 p.m. R34 call light was observed hanging on the bedside pull table	F 282		

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F 282	Continued From page 48 across from resident seated on the recliner not at reach. Resident started she used the call light when she needed help. On 6/27/14, during the tour two call lights were observed on top of the bedside pull table by R34's foot of bed and R34 was observed sitting in her recliner across from the pull table which was not accessible. ESD reached over untwisted the call lights and gave R34 one of the call lights. R34's activities of daily living functional /rehabilitation care plan dated 3/11/14, identified R34 with an alteration in mobility and locomotion related to weakness. The Goal was "Will continue to ambulate safely." The care plan directed staff to keep "Call light within reach." On 6/27/14, the administrator stated resident call light needed to be at reach and accessible. When interviewed on 6/27/14, at 11:53 a.m. interim director of nursing (IDON) stated "Resident's call lights need to be within reach when in bed and when in wheelchair unless they are independent."	F 282		
F 283 SS=E	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.	F 283		

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F 283	Continued From page 49 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to complete a recapitulation of stay for 13 of 19 discharged residents (R99, R24, R64, R97, R16, R91, R98, R102, R64, R103, R32, R42, R38) reviewed for closed records. Findings include: During stage one closed record review the discharged resident records did not contain a recapitulation of the residents' stay, or summary of resident cares and treatments while in the facility. All records lacked recapitulation of stay or summary of resident cares and treatments. Discharges occurred between 1/21/14, through 6/9/14, were as follows: R99 was admitted to the facility 1/28/14, and discharged home on 2/4/14. R24 was admitted to the facility 2/4/14, was discharged home on 3/31/14. R97 was admitted to the facility 1/21/14, and discharged home on 2/8/14. R16 was admitted to the facility 2/25/14, and discharged to the hospital on 3/27/14, after making statements wanting to kill herself. R91 was discharged to the attached assisted living facility (ALF) on 2/27/14. A transfer discharge form indicated diagnoses of cocaine abuse and anxiety, vital signs at discharge and height and weight. R98 was discharged home on 2/11/14. It was unclear from the medical record if services were set up prior to discharge. R102 was admitted to the facility 3/5/14, was sent	F 283	**F 283-E** Corrective Action: A. Recapitulation of Stay/Discharge Summaries have been completed for R99, R24, R64, R97, R16, R91, R98, R102, R64, R103, R32, R42 and R38. Corrective Actions as it applies to other Residents: A. The Discharge Summary policy was reviewed and revised. B. The medical records of residents who have been discharged since August 2013 have been reviewed and Recapitulation of Stay/Discharge Summaries have been completed as necessary. Date of Completion: August 8, 2014 Recurrence will be prevented by: A. Facility staff members were educated about the Discharge Summary Policy at the All Staff meetings completed the week of 7-28-14.	

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F 283	Continued From page 50 to acute care hospital 4/8/14, for cellulitis of the trachea and chemotherapy treatment and did not want to go back to nursing home area. R64 was admitted to the facility 3/13/14, and discharged to the community 4/2/14. R103 was admitted to the facility 3/10/14, and discharged to the community 6/3/14, with hospice services. R32 was admitted to the facility 5/1/14, and discharged to the community 5/15/14. R42 was admitted to the facility on 5/21/14. A physician progress note dated 5/30/14, indicated R42 was unhappy with his care and wanted to leave. A nurses note on 5/30/14, indicated R42 was last seen at 8:00 a.m. and his belongings are noted to be missing from his room. A nursing recapitulation of stay was added to the medical record after the health information services (HIS) coordinator was interviewed on 6/25/14, after surveyor intervention. R38 was admitted to the facility on 4/16/14. The resident remained in the facility until 4/28/14, at 2:50 p.m. when she was sent to NMMC (North Memorial Medical Center) due to possible overdose of pill which got from other residents in the smoke room." On 4/29/14, the nurses notes revealed the R38 had been discharged home directly from the hospital. A nursing recapitulation of stay was added to the medical record after the HIS coordinator was interviewed on 6/25/14, and surveyor intervention. On 6/25/14, at 2:35 p.m. the HIS coordinator verified all the discharged medical records lacked summary of the recapitulation of stay she stated "The recapitulation of stay would be at the front and if they are not there then it's not been done. You know I work in medical records and you need to talk to nursing about that."	F 283	B. Ddaily audits x 2 weeks, then weekly x 4 weeks then monthly x 3 months. Findings will be reported to the QAPI/QA Committee for review and follow up recommendations. The QAPI/QA Committee will determine when the audits may be discontinued. Responsible Person: DON and Administrator or Designee.	

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F 283	Continued From page 51 Medical Records policy dated August 8, 2013, gave Retention Guidelines but lacked information on ensuring residents medical records were accurate, organized and complete. In addition the policy lacked who was responsible to oversee the residents medical records were complete and accurate.	F 283		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure dialysis site dressing was removed after dialysis to reduce the risk of access site infection or clotting for 1 of 1 resident (R45) reviewed for dialysis; the facility failed to offer psychiatric services for 1 of 5 residents (R2) reviewed for unnecessary medications; and the facility failed to provide care/services for the highest well being for 1 of 1 resident (R71). Findings include: On 6/25/14, at 7:15 a.m. licensed practical nurse (LPN)-A was observed standing outside R45's door in front of the medication cart documenting.	F 309	**F 309- D** Corrective Action: A. The dialysis dressing of R45 is now being removed in the evening upon return from dialysis. B. The care plan and group sheet of R45 has been updated to state the location of the dialysis fistula. There are specific instructions on care and removal of the dialysis dressing as well as what to do if there is bleeding. C. The care plan of R2 now addresses non-pharmacological interventions for behaviors in addition to medication. Behavior Monitoring sheets are in place and include non-pharmacological interventions. The resident is now receiving Psychiatric services. D. R71 has been re-assessed for pain. She was seen by the physician/nurse practitioner for treatment of pain.	

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Continued From page 52

-At 7:16 a licensed practical nurse (LPN)-A was observed applying gloves and entered R45's room then came out briefly.
-At 7:18 a.m. a nursing assistant (NA)-A was observed wheeling R45 to the dining room.
-At 7:22 a.m. observed resident sitting on her wheelchair (W/C) at the dining room appeared dressed in a short sleeve shirt and had a dressing to her upper left arm when she pulled her sleeve up.
-At 8:32 a.m. observed staff bring R45's breakfast tray and R45 was observed eating independently.
-At 9:10 a.m. NA-A was observed wheeling R45 back to her room then came out briefly.

On 6/25/14, at 10:52 a.m. LPN-A and surveyor went to R45's room where the resident was in bed. LPN-A lifted R45's left shirt sleeve up and verified the bandages from dialysis were from the previous day on 6/24/14, and were still in place. LPN-A stated "They are supposed to be removed by the evening shift when she returns to the facility."
-At 10:53 a.m. LPN-A was observed removing gauze secured with white paper tape from R45's left upper arm noted area had no signs and symptoms of infection and a small amount of blood noted on the gauze. LPN-A also listened to for bruit using a stethoscope.

R45's diagnoses included acute kidney disease, end stage renal disease (ESRD) obtained from the Diagnoses Report-Clinical dated 1/13/14.

The care plan dated 3/14, identified R45 needed hemodialysis related to end stage renal disease. The care plan indicated R45 had an access site fistula but did not identify the location. The care plan directed "May remove dressing to shut site 4

F 309

E. The care plan of R71 now addresses non-pharmacological interventions to treat pain.
F. The care plan of R71 addresses the need to educate the resident on the risks of missing medications while out on LOA and the risks of alcohol interacting with her medications.
G. R71 has been offered Chemical Dependency Counseling.
H. The Sliding Scale Insulin order of R71 has been clarified and it was discontinued.
I. The medication orders and times of administration for R71 have been reviewed by the physician/nurse practitioner and changes made as appropriate.

Corrective Actions as it applies to other Residents:

A. The Care Plan policy, Medication Utilization and Prescribing Policy, IDT Stand Up Policy, Medication Order Policy, Physician Service Policy, Hemodialysis Policy, Pain Assessment Policy, Physician Medication Orders and the Guidelines for Notifying Practitioners of Clinical Problems have been reviewed and revised as appropriate.

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F 309	Continued From page 53 hours after return from dialysis." Goal was "Will be free of infection ..." The activities of daily living (ADLs) Minimum Data Set (MDS) dated 4/15/14, indicated R45 required limited to extensive physical assistance of one staff with all cares. R45's Brief Interview for Mental Status (BIMS-tool used to measure cognition) indicated R45 had moderate impairment in cognition. Physician orders dated 5/30/14, did not identify specific instructions for care and removal of the shunt site dressing. When interviewed on 6/25/14, at 10:46 a.m. registered nurse (RN)-A (who was also the facility (MDS) coordinator) verified the care plan, did not address the location of R45's fistula. RN-A stated she usually did not indicate the location of the site in the care plan as it was in the Treatment Administration Record (TAR). When asked about how the nursing assistants and other staff who floated to the unit would know the location that were not familiar with R45's fistula site location, RN-A stated the floors were set up the same and the nurses would be able to know from the TAR and was not responsible for writing/updating the NA Team Assignment sheet. When interviewed on 6/25/14, at 11:21 a.m. interim director of nursing (IDON) stated "In reasonable professional practice" the care plan should address the location of the site and nursing assistant Team Assignment sheet should indicated the location. IDON further stated the care plan should address monitoring for signs and symptoms of infection, dressing removal after dialysis as directed and should be followed.	F 309	Date of Completion: August 8, 2014 Recurrence will be prevented by: A. Facility staff members were educated on the Care Plan policy, Medication Utilization and Prescribing Policy, IDT Stand Up Policy, Medication Order Policy, Physician Service Policy, Hemodialysis Policy, Pain Assessment Policy, Physician Medication Orders and the Guidelines for Notifying Practitioners of Clinical Problems at the All Staff Meetings completed the week of 7-28-14. B. Daily audits x 2 weeks, then weekly x 4 weeks then monthly x 3 months. Findings will be reported to the QAPI/QA Committee for review and follow up recommendations. The QAPI/QA Committee will determine when the audits may be discontinued. Responsible Person: DON and Administrator or Designee	

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IDON verified the NA Team Assignment sheet and care plan lacked the location of the fistula. When asked about his expectation for staff removing the bandages IDON stated "They are supposed to remove the dressing on the day of treatment and the night shift would in the morning before she leaves that's how I understand it."

When interviewed on 6/25/14, at 11:25 a.m. dialysis registered nurse (DRN) stated R45's dialysis runs were going well and when asked about the dressing concerns addressed in the Dialysis/Nursing Facility Communication Forms dated 4/15,14, 4/19/14, 4/24/14, 5/8/14, 5/13/14, 5/31/14, 6/14/14, DRN stated "There had been concerns about the bandages being left on until she returned back for dialysis and the nurse practitioner and the nephrologist had been involved and am still not sure why this is not clear to the facility." DRN further stated "The bandages are supposed to be removed the evening after dialysis like yesterday or latest this morning when she got up immediately. When the bandages are left in place they can cause the site to clot or cause an infection to the fistula." Surveyor indicated to DRN he needed to speak to a facility staff to clarify the dressing removal instruction and surveyor gave phone to LPN-A who after getting off the phone stated the dialysis nurse had told her the dressings was to be removed the evening after "Just as I had told you earlier."

When interviewed on 6/25/14, at approximately 11:40 a.m. NA-A stated "I know resident's dialysis site is on the left arm because there is always a dressing on the arm and the nurse had told me before." When asked if she knew what to do incase R45 had bleeding from the site or if she knew if she would take a blood pressure on that

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arm NA-A stated she would apply gloves and leave the room to go get the nurse then looked at surveyor and stated "I will ask the nurse now can I." as she pointed at LPN-A standing by the cart down the hallway.

Dialysis (Program Guidelines) policy reviewed 8/13/14, directed the care plan should address care of the access site, and to removing dressing "Band-Aids or gauze 4 hours after discharge from dialysis."

During observation and interview on 6/25/14, at 12:14 p.m. R2 was observed to independently transfer from her bed, used a four wheeled walker and ambulated over to the scooter and got in without difficulty. R2 was sitting in the scooter, right hand was shaking and called surveyor over and whispered "they have mold in the water and I am allergic to it, they are supposed to have the best ice and water here."

During observation and interview on 6/26/14, at 7:21 a.m. R2 was dressed, sitting in her scooter at the doorway of her room. R2 stated "I'm going to sue these people, and I have it all written down, I was up until 1:00 a.m. with a lot on my mind, I needed to sit and write, it's broken you know [referring to leg fracture]." R2 then got angry and loudly yelled "just say broken will you, I checked it for gangrene, I know what it looks like and I saw skin cancer too." R2 then apologized for the outburst.

R2's diagnoses included schizophrenia, brain injury, morbid obesity and muscle weakness obtained from the Resident Admission Record dated 1/16/13.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING ______ B. WING ______	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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The care plan dated 10/16/13, identified potential for alteration in thought process due to schizophrenia. The staff was directed to allow R2 time when speaking, repeat questions if resident does not understand and be patient and social service to obtain order for in house psych to see as needed. The lacked evidence of alternative non pharmacological interventions were used for behavior and if they were effective.

R2's quarterly MDS dated 5/9/14, indicated R2 had intact cognition, used a wheelchair and walker for mobility and was independent with transfers. The MDS also noted R2 displayed no behaviors in the last week.

R2's medications obtained from physician orders dated 5/21/14, included ziprasidone (an antipsychotic medication), clonazepam (a medication used for anxiety) and paroxetine (a medication used for depression).

Review of Behavior Monitoring Records dated June 2014 indicated R2 had increased behaviors averaging one to three times per day such as obsessive statements and anxiousness regarding treatments, health, appointments and staff, inability to calm, weepiness, paranoia - obsessive complaints regarding health concerns. The records however did not outline what alternative non pharmacological interventions were used and if they were effective.

Additional Behavior Monitoring Records for the past three months were requested but not provided.

During an interview on 6/26/14, at 7:42 a.m. LPN-A stated R2 "wants things immediately and if

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F 309	Continued From page 57 you don't do it immediately she gets worked up, she will borrow cigarettes in the smoking room and will get very angry when she is out and doesn't get them back." During an interview on 6/27/14, at 7:52 p.m. social worker (SW) stated R2 was angry yesterday because she borrowed cigarettes and didn't get them back. "We have noticed when that happens she is angry and yells a lot, I checked with her and she started yelling, getting mad, so I said I would check back." During an interview on 6/27/14, at 8:07 a.m. LPN-F stated he saw R2 that morning and she immediately started yelling about the day she fell and got her leg fracture. LPN-F stated "I tried to talk with her and she went off and started yelling, she does fixate a lot and gets delusional." During an interview on 6/27/14, at 2:11 p.m. LPN-I stated R2 has not received psych services that "I know of, unless she saw in house psych services, I'm not sure." During an interview on 6/27/14, at 3:37 p.m. SW stated to her knowledge R2 had not seen psychiatric services, "unless she went out to see one." SW stated she did contact the in house psych doctor to see her, but she needed an MD (medical doctor) order, "I don't see anything in her file that she has seen one in the past." R71 reported under-treated pain, physician orders for pain medication were not followed, and the resident had frequent leaves of absence (LOAs) from the facility during medication administration times.	F 309		

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R71 was observed in her room on 6/24/14, at 11:55 a.m. As the resident rubbed her upper left arm, she reported experiencing some pain "20 out of 10" on her left forehead, back of head, neck, left shoulder and upper left arm. She explained that the Tylenol she had received earlier had not helped. Although she had reported this to the nurse, she stated they had not obtained other pain medication for her pain. R71 stated, "My head is killing me. I've been having a serious headache the same way for about a week." R71 said she had a follow up appointment with the physician and would like pain relief.

On 6/25/14, at 7:50 a.m. R71 reported having mid-abdominal pain of an "8 or 9" as well as pain in her head and neck had pain on the left side. In addition, her abdomen had been tender the last couple of days and she planned to inform the nurse. She reportedly slept well the previous evening. Later at 10:09 a.m. R71 was observed walking in the hallway and reported she was feeling a little better.

On 6/27/14, at 3:35 p.m. R71 reported she had neuropathy and always experienced pain on the bottoms of her feet. R71 rated her pain 20 out of 10, and said when her left foot was touched pain radiated on the entire left side of her body. The resident said she had told the staff "over and over" that Tylenol was ineffective, and wished she could get better pain relief. She had tried to do different things to take her mind off the pain, but now because of the pain she was not even listening to music as she previously enjoyed. The resident explained that in the past she had been prescribed Neurontin 800 mg (commonly used to treat neuropathic pain).

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On 6/26/14, at 9:16 a.m. trained medication assistant (TMA)-A stated R71 had reported a headache that morning. If a resident was routinely prescribed pain medication, TMA-A stated they did not use the 0-10 pain scale, but most of the time she did ask R71 to rate her pain. If the resident had pain, she was to report it to the nurse.

R71's Minimum Data Set (MDS) dated 4/14/14, revealed a BIMS score of 15 which indicated intact cognition.

R71's physician progress notes dated 5/27/14 revealed diagnoses including chronic pain. A nurse practitioner (NP) note on 4/15/14 the resident had been seen for an evaluation of pain. The resident reported to the NP, "'I am in too much pain--you need to increase my Neurontin back to 800s'...."

Although R71's physician orders included Neurontin 8:00 a.m., 12:00 p.m. and 8:00 p.m., Tylenol every 6 hours as needed for pain, including at night for gout pain, as well as Robaxin every 8 hours as needed for pain in feet, the 6/14 Medication Administration Record (MAR) showed R71 did not receive her 8:00 p.m. medications eight times including Tylenol 500 mg due to LOAs. A telephone order dated 5/12/14, revealed changes to "medications" to 8:00 a.m. and noon, add Tylenol 1000 mg at night as needed and increase Neurontin to 600 mg twice daily. On 6/27/14, R71's original unsigned physician orders were noted in the primary physician's binder located at the nursing station.

R71 was observed in the smoke room on

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F 309	Continued From page 60 6/25/14, at 7:50 a.m. She stated she sometimes just went to the smoke room because it was boring on the unit. She was planning to meet with her "worker" today to look at apartments and added, "It's okay here, but I wouldn't want to live here." At 10:36 a.m. a licensed practical nurse (LPN)-F explained that when a resident left on a LOA, they were to sign out at the reception area. LPN-F reported residents were not evaluated regarding LOAs, rather it was based on whether the resident had a physician's orders for LOA either with or without medications. "If there is an order, the resident can leave." At 10:53 a.m. a licensed social worker (LSW)-A stated she did not know if the facility had a policy or assessed residents related to LOAs, but there would be a physician order regarding this in a resident's record. LSW-A explained that the interdisciplinary team (IDT) met weekly on Thursdays to talk about residents whose MDS assessments were due. No meeting notes were kept, but if an individual resident was mentioned a note would be written in the resident's record. Other IDT meetings were held on an as needed basis, and she had not attended or been aware of any such meetings for R71. At 11.05 a.m. LPN-L stated he did not know which residents had approval for a LOA. At 11:07 a.m. LSW-A verified that R71 had no orders in either 5/14 or 6/14 for LOA from the facility included in the physician's orders. In addition, R71's physician orders specified alcoholic beverages were not allowed. At 12:11 p.m. the administrator also said resident LOAs were specified on their physician orders.	F 309		

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F 309	Continued From page 61 On 6/26/14, at 9:21 a.m. LPN-A stated R71 went out drinking nearly every night, and returned "bubbly." Staff were aware when the resident had been drinking, and her medications were then held and the supervisor was notified. Incidents were documented in the progress notes and on the 24-hour status record. LPN-A explained that R71 had to return by a certain time, and had been informed of this policy. At 9:55 a.m. the daytime receptionist (R)-K reported she had often witnessed R71 leave the facility. At 12:50 p.m. R71 was standing near the elevator and announced, I'm leaving...checking on an apartment." At 1:31 p.m. LPN-A stated regarding R71, "That's our party girl. Everybody knows she likes to party." LPN-A stated R71 left nearly everyday after lunch, arranging her own taxi transportation, and sometimes returning with alcohol. The day nurse passed on information to the oncoming shift where R71 went and what time she left. R71 arranged her own taxi cab transportation. If the resident did not return, her family was called to see if they knew of her whereabouts. At 1:43 p.m. LPN-F explained that when a resident became intoxicated or smelled of alcohol use, they usually notified the doctor and documented it in the progress notes. At 1:46 p.m. LPN-A reported staff was aware R71 was not to have alcohol, "but what can you do when [R71] drinks on the street?" Although staff tried to encourage her not to drink, the resident also denied drinking. At 1:47 p.m. LPN-F stated the facility documented incidents on the 24-hour report and on 6/12/14, it was noted R71 returned smelling of alcohol.	F 309		

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R71's care plan dated 4/8/14, indicated the resident had intact cognition. The plan did not include the problem of R71 becoming intoxicated and missing medication doses while on LOA, nor was there a goal statement or interventions to minimize risks to the resident.

Physician progress notes for R71 dated 5/27/14, revealed diagnoses including alcohol abuse. IDT notes revealed the resident had returned to the facility after drinking alcohol, becoming intoxicated and/or very intoxicated while on LOA on 4/24/14, 5/6/14, 5/8/14, 6/9/14, and 6/12/14.

On 6/26/14, at 3:17 p.m. RN-B who worked for R71's primary physician was interviewed via telephone. RN-B stated R71 had told a physician at the clinic that she consumed 1-2 beers per night, and there was no documentation in the resident's medical file that the facility had reported the resident had returned from LOAs intoxicated. R71's physician was then interviewed at 3:35 p.m. and stated that in fact a staff person from the facility had reported the resident had a headache last week, and "yes" he was aware she was drinking, wished she would stop, but legally he could not prevent her from drinking. The physician reported R71 made poor choices, but the facility was not a jail, therefore, she was free to take LOAs.

On 6/26/14, at 4:23 p.m. R71 reported she had not been informed of the risks versus benefit of drinking alcohol while on LOA and with medication use. R71's medical record lacked documentation showing this had been discussed with the resident. A note dated 4/18/14, revealed R71 had a "reaction" where she was itching all

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over after drinking, and as needed and as needed Benadryl 25 mg (allergy medication) was administered and was "effective." The physician and director of nursing were updated.

LSW-A explained on 6/26/14, at 8:30 a.m. that she had only worked for a couple weeks at the facility, and was unaware R71 had been drinking. R71's drinking had never come up in IDT meetings or in conversations with the resident. LSW-A thought R71 seemed rather frail and ill, but she did not ask her about her LOAs. LSW-A was unable to find any documentation R71 had been offered chemical dependency (CD) treatment or counseling.

R71 reported on 6/26/14, at 5:35 p.m. she only drank three beers when on LOA, and did not bring any alcohol into the facility. She stated no one had talked to her about the risks versus benefit of consuming alcohol.

The facility's Care Planning IDT policy dated 5/11 noted, "The care planning process begins during pre-admission/intake and continues on a regular and periodic basis throughout the resident stay. The resident and/or their representative, along with the entire care team is involved in the care planning process. Care is planned to help attain or maintain the resident's highest practicable physical, mental and psychosocial well being. The comprehensive care plan is reviewed during the initial care conference and on an ongoing basis. The care plan is updated on an ongoing basis to meet the needs of the resident. The comprehensive care plan is used by all personnel involved in the care of the resident."

R71's medical record revealed inconsistencies

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F 309	Continued From page 64 and omissions in physician orders. The resident was frequently absent from the facility when medications were prescribed, therefore, did not consistently receive her medications as ordered. The primary physician for R71 was interviewed via telephone on 6/26/14, at 3:17 p.m. He verified if the resident had elevated blood pressure, he would want her to receive sliding scale insulin. He was unaware the sliding scale insulin had been discontinued. The 6/14 MAR showed the sliding scale insulin had been discontinued on 6/6/14, however, on 6/26/14, at 5:30 p.m. LPN-M verified there was no physician order in the resident's record to show it had actually been discontinued. LPN-E then informed the surveyor that on a consultation sheet dated 5/20/14, the insulin was not noted. LPN-E said at that point, the transcribing nurse should have called the physician to clarify whether the sliding scale insulin should have been continued or discontinued. LPN-E also verified orders written on the consultation sheet were considered to be current (whether they remained the same or changes were made) as of the date of the physician's signature on the consultation sheet. In an interview with R71 on 6/26/14, at 5:35 p.m. she stated had been prescribed sliding scale insulin, but it had had been discontinued. She was aware when her blood sugar was elevated, as the bottoms of her feet became very cold and her fingertips numb. The following morning at 8:03 a.m. LPN-F explained that "whoever has time" transcribed orders around the 25th of each month. The staff	F 309		

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F 309	Continued From page 65 was to check new orders with the pre-printed MARs printed by the pharmacy on the 22nd of each month. The staff person "must have been in a hurry" and missed the consult order dated 5/20/14. The order still appeared on the 6/14 MAR, however, a line had been drawn and a date of 6/6/14 had been added. LPN-F stated it was not the correct way to discontinue an order. The previous director of nursing (DON) had instructed staff to file consult orders under the consultation tab in a resident's record which LPN-F said it may have been the reason the order change had been missed. On 6/27/14, at 8:10 a.m. LPN-H reported she had called R71's primary physician the previous day to clarify the 5/20/14 insulin order. LPN-H verified no insulin had been administered to the resident between 6/1/14 and 6/4/14. At 1:18 p.m. LPN-H explained that on 5/12/14, R71's medication administration times had all been changed to to 8:00 a.m. and noon, due to her LOAs and missing evening medications and treatments. A telephone order signed by a LPN, but not yet signed by the physician read, "[Change] meds to 8 AM et. [and] noon. The order did not specify the names of the medications, doses, and the times they were to be administered according to standards of practice. On 6/27/14, at 1:50 p.m. after reviewing the telephone order, LPN-F stated he would have expected the nurse who wrote the telephone order to clarify each medication order with the physician to determine the appropriateness of changing each medication, and which medications should have remained the same. LPN-F also verified that as of 5/21/14 R71's medication orders had been re-written to be	F 309		

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administered at 8:00 a.m. 12:00 p.m. and 4:00 p.m. and some medications were left at 8:00 p.m. on the 5/14 MAR. LPN-F also verified R71's monthly June orders had reverted back to the medication times previous to the 5/14 order. LPN-F could not offer an explanation, but said perhaps it could have happened when she returned from the hospital at the end of May. Although LPN-F verified he would have expected a progress note regarding the change, there was no note by the transcribing nurse to that effect.

On 6/27/14, at 2:13 p.m. the nurse manager, LPN-D stated after a resident hospitalization, nurses accepted hospital discharge orders as current even though they may have differed at the time the resident had been sent to the hospital. At the time of the next scheduled visit with the resident, the primary physician was to note any changes. LPN-D confirmed she had written the telephone order dated 5/12/14, changing R71's medication times to 8:00 and noon. She verified some of the medications had in fact been changed to 8:00 a.m., noon, and 4:00 p.m., with some remaining at 8:00 p.m. inconsistent with the telephone order. LPN-D said the change was requested due to R71's LOAs "nearly every night" and because she was missing her evening medications and treatments. She was unable to provide documentation showing the why the medications were inconsistent with the telephone order.

A nurse practitioner note dated 4/15/14, revealed R71 requested an evaluation of her pain, sleep, and diabetes. "I am in too much pain you need to increase my Neurontin back to 800s...I cant sleep I need my Trazodone...My blood sugar is too high. I need to be back on insulin."

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F 309	Continued From page 67 An email thread was provided to the surveyor dated 5/9/14 between the former DON and physician. The DON wrote, "...came in on 300 mg Neurontin tid [three times daily] and took 800 mg prior to admission. Thinking 600 mg (06, 12 [times]) and ES Tylenol at noc? [night] With option to increase after evaluation further. Can we look into that? Also would like most or all meds in morning and noonish/before dinner, as she comes back from sisters every night intoxicated. No change to her TID, ER, or Statins, [three times daily, unknown--possibly extended release, cholesterol medication] we will hold these if necessary. States 2 beers only but she is a little thing and who knows (plus beer aggravates gout Haha). I am not concerned with her drinking she bothers no one and makes it back by curfew just that staff don't give her some meds and others they hold d/t [due to] safety with intoxication." The medications held were not specified by the DON, nor were there specific physician orders directing staff to hold certain medications. The physician's response read, "...I did take a look at her and agree that is likely gout made worse by her drinking. I think that your increase in neurontin idea is fine, as well as tylenol. Its okay to give those meds at AM/noon." No further direction regarding the staffs' practice of arbitrarily holding medications and/or changing medication administration times was addressed by the physician in his response. A consultation sheet dated 5/20/14, read R71's insulin should be discontinued, however, the order was not specific, and did not indicate whether this was regularly scheduled insulin or sliding scale insulin.	F 309		

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F 309	Continued From page 68 On 6/26/14, at 2:26 p.m. the interim director of nursing (IDON) stated he expected nursing to follow the policy regarding physician orders and the nurse who wrote the orders should be talking to the physician. The IDON said the 5/12/14 order was not properly written and should have specified the medication changes. In addition, the nurse who transcribed R71's orders had not followed their policy, and upon return to the facility from hospitalization, the primary physician should have been notified of changes to determine whether he agreed or wanted any orders changed. The IDON said it was "not okay" to just wait until the physician's next visit. R71's medications and their times for administration were as follows: 1) At 8:00 a.m. aspirin, Celexa, folic acid, Prilosec, Miralax, Spiriva inhaler, vitamin C, vitamin D3, Cozaar, and ferrous gluconate 2) At 8:00 p.m. Simvastatin and Trazodone 3) At 8:00 a.m. and 8:00 p.m.Neurontin and Glucophage, Advair, and Detrol 4) At 8:00 a.m. 12:00 p.m. and 8:00 p.m. Albuterol, ferrous sulfate, ibuprofen 5) PRN medications of Tylenol every six hours, Robaxin every 8 hours as needed for pain in feet 6) Insulin orders of Lantus 10 units at bedtime started 5/19/14, Check blood sugar 2 times daily at alternating times 8/12/4/8 starting 4/19/14, Novolog injection 120-149=2 units, 150-199=3 units, 200-249=6 units, 250-299=9 units, 300-349=12 units, >350=15 units starting 5/19/14. R71's 6/14 MAR showed R71 missed medications and treatments due to absence from the facility and returning having consumed alcohol. Missed medications included	F 309		

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F 309	Continued From page 69 Glucophage 1000 mg, Simvastatin 10 mg, Detrol 2 mg, Trazodone 100 mg, Tylenol 500 mg, and Robaxin 500 mg, six times. Treatment Administration Record (TAR) showed 15 missed accuchecks. The 5/14 MAR showed 14 missed Ventolin nebulizer treatments and Lantus 10 units, and the TAR showed six missed blood sugar tests. On 6/27/14, R71's original unsigned physician orders were found in R71's primary physician's white binder at the nursing station and verified by supervisor LPN-F included: 4/25/14--discontinue Trazodone, 5/12/14--change medications to 8 a.m. and noon, add Tylenol and increase Neurontin, 5/22/14--order for CPAP [for sleep apnea] setting at 12, 6/3/14--discontinue ted stocking, 6/25/14--ok to send resident to ER [emergency room], and 6/14 and unsigned monthly orders awaiting the primary physician's signature. The facility's Interdisciplinary Stand Up Meeting policy dated 5/11 noted, "The facility promotes communication between the interdisciplinary team to positively affect outcomes for the residents, and to provide an ongoing process of interdisciplinary communication with a focus on positive outcomes for the residents. The IDT will review residents and make changes necessary to assessments or care plan interventions to help improve outcomes for residents."	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312		

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F 312	Continued From page 70 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide nail care for 1 of 3 residents (R31) observed for activities of daily living (ADLs). Findings include: On 6/23/14, at 7:21 p.m. during a stage 1 family interview, R31's family member (F)-A stated "the staff did not always trim R31 ' s fingernails, and stated "sometimes I have to do it when I get there." The family member further stated, at 98 years old, the resident really only likes to eat sweats. The family member stated he had not been there at meal times and did not know if staff assisted R31 to eat or not. On 6/23/14, at 3:00 p.m. R31 was observed to be lying down in bed, and appeared asleep. -At 5:55 p.m. R31 was in the dining room leaning far to the right in her wheelchair. When nursing assistant (NA)-C, talked with her she sat up straight without assistance, and smiled and had a simple conversation with NA-C, immediately after the conversation she leaned to the extreme right again. When supper arrived at 6:05 p.m. R31 sat up straight without assistance and fed herself, at times she used her fingers to scoop up sweet things. Staff was nearby in the kitchenette area, no one was observed to assist R31. On 6/24/14 at 8:00 a.m. the resident was sitting in the 2nd floor dining room, sitting up straight in her	F 312	**F 312-D** Corrective Action: A. R 31 has received nail care. Her care plan and group sheet reflect the need to complete nail care on bath day and PRN. Corrective Action as it applies to other Residents: A. The Nail Care Policy ~~has been~~ reviewed and revised. Date of Completion: August 8, 2014 Recurrence will be prevented by: A. Facility Staff was educated on the revised Nail Care Policy at the All Staff Meetings completed the week of 7-28-14. B. Daily audits x 2 weeks, then weekly x 4 weeks then monthly x 3 months. Findings will be reported to the QAPI/QA Committee for review and follow up recommendations. The QAPI/QA Committee will determine when the audits may be discontinued. Responsible Person: DON and Administrator or Designee	

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F 312	Continued From page 71	F 312		

wheelchair. R31 ate her toast, and then used her fingers to scoop the last of the jelly out of the jelly container.

On 6/26/14, at 1:00 p.m. R31 was observed to eat lunch, scooping food up with her right hand and shoveling into her mouth.

R31 was admitted to the facility on 12/17/08, with current admission diagnoses of dementia with behavioral disturbances, Alzheimer, chronic kidney disease, malnutrition, was given a regular diet with supplements for weight loss.

A quarterly Minimum Data Set (MDS) dated 6/18/14, indicated R31 had short term and long term memory loss and severely impaired decision making skills. R31 was totally dependent on two staff for bed mobility, and transfers, and totally dependent on one staff for toileting and dressing. R31 required extensive assistance of one staff for personal hygiene and locomotion on the unit, and limited assistance of 1 staff for eating. The last annual Care Area Assessment (CAA) lacked identification of ADL's.

R31's care plan last revised 6/18/14, indicated R31 had a cognitive loss, and self-care ADL (activities of daily living) deficit, and directed the staff to provide total care for the resident, including passive range of motion to ensure the right hand can be opened well enough to be cleaned.

On 6/27/14, at 2:14 p.m. NA-B stated that the nurses trim the fingernails of R31, she then went to verify that with licensed practical nurse (LPN)-I and returned and said that the NA trim the nails.
-At 216 p.m. NA-B accompanied to observe the

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F 312	Continued From page 72 R31's fingernails, NA-B verified the fingernails were long and had a brown debris substance underneath the nails. NA-B stated "she just got done eating. " NA-B then proceeded to clean the debris from under the fingernails. On 6/27/14, at 2:35 the interim director of nursing (IDON) verified staff was expected to trim nails on bath day routinely, unless the resident was diabetic, then the nurse would trim the fingernails. The ADL policy dated 8/13, directed the staff to provide assistance to residents as necessary, and described assisting a resident to complete daily personal cares. The policy lacked direction on providing cares to residents who are dependent for ADL functions. Staff was unclear who was to trim the resident ' s nails, the undated NA care sheet did not direct staff to trim nails on bath day.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure post fall investigations were completed to identify the root cause of the falls for 1 of 3 residents (R58)	F 323		

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F 323	Continued From page 73 reviewed for accidents. Findings include: On 6/27/14, at 2:13 p.m. resident was observed sitting on his wheelchair (W/C) outside his room looking and saying "Hi" to staff and other residents as they went by. -At 2:20 p.m. R58 was observed dozing on and off as he sat on his W/C and staff were observed walking past him. -At 2:30 p.m. R58 continued dozing in his W/C then woke up looked down the hallway wheeled himself back to the room observed the call light clipped on the edge of the bed and R58 again was observed to doze off with his eyes closed, and her head jerking up and down facing the door. -At 2:42 p.m. R58 was observed standing up abruptly after he woke up from his W/C for approximately five seconds and sat on his bed then again stood up and transferred himself back to his W/C. R58 was observed to be unsteady and was grabbing the armrests of the W/C and bedding's when self-transferring and legs were shaky as he transferred. R58's diagnoses included congestive heart failure, glaucoma, diabetes mellitus, hypertension, muscle weakness, osteopenia, vascular dementia with delirium, peripheral vascular disease and psychosis obtained from the Resident Admission Record dated 10/24/13. R58's quarterly Minimum Data Set (MDS) dated 5/20/14, indicated R58 had moderately impaired cognition and had both short and long term memory concerns. In addition the MDS indicated R58 required extensive assistance of two staff	F 323	**F323- D** Corrective Action: A. A Fall Risk Assessment has been completed for R58 and new interventions have been added to the care plan and group sheet. B. R58 had a medication review completed by the physician/nurse practitioner. Corrective Action as it applies to other Residents: A. The Falls Clinical Protocol and Policy has been revised. B. Current residents have been reviewed and care plans were updated as appropriate. Date of Correction: August 8, 2014 Recurrence will be prevented by: A. Facility staff members were educated on the Falls Clinical Protocol and Policy at the All Staff Meetings completed the week of 7-28-14.	

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F 323	Continued From page 74 with transfers, was occasionally incontinent of bowel and bladder and had moderately impaired vision. Falls Care Area Assessment dated 11/25/13, identified R58 was at risk for falls related to impaired mobility. Falls care plan dated 11/6/13, identified R58 was at risk for falling related to vascular dementia. Goal "Will remain free from injury." Care plan directed "Keep bed in lowest position with brakes locked, place resident in a fall prevention program, keep call light at reach at all times, provide environment free of clutter and staff to assist 1-2 resident with all transfers/mobility/toileting." Fall Risk assessment dated 5/14/14, indicated R58 had falls since his last assessment but did not indicate how many, had history of falls, used a wheelchair for mobility, weak gait and his total score was "35 Moderate Risk." Physician Orders dated 5/29/14, indicated R58 was receiving the following medications: -Coreg (used to treat blood pressure) 6.25 Milligrams (mg) orally daily for hypertension. -Imdur extended release (ER- used to prevent angina attacks) 90 mg orally every morning for angina. -Lisinopril (Used to treat blood pressure and congestive heart failure) 5 mg orally every morning. -Trazodone (anti-depressant and used also to treat insomnia) 50 mg orally at bedtime -Risperidone 0.5 mg orally two times daily as needed for agitation/Paranoia Review of Nurse's Notes from 1/3/13, through 6/27/13, revealed R58 had six falls within the	F 323	B. Daily audits x 2 weeks, then weekly x 4 weeks then monthly x 3 months. Findings will be reported to the QAPI/QA Committee for review and follow up recommendations. The QAPI/QA Committee will determine when the audits may be discontinued. Responsible Person: DON and Administrator or Designee	

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F 323	Continued From page 75 facility: -On 1/31/14, at 1:40 a.m. another resident had summoned staff at the nursing station of R58 was calling for help in the stairway. Upon arrival staff indicated R58 was found on the Northwest stairway and had fallen the first flight of stairs. R58 neurological checks were within normal limit but he had "A small abrasion noted on (L) back of forearm, redness noted on (R) cheek by (R) eye." -On 2/14/14, at 1:30 p.m. "Patient [pt] attempting to self- transfer from bathroom to w/c and sat on the floor on his buttocks." R58 reported he was trying to sit in his w/c. -On 5/5/14, at 1:40 a.m. "Resident was yelling out for help. NAR went to room to help and found resident sitting on the floor." when asked why he was sitting on the floor R58 reported he had fallen on the floor, had sat hard to the floor and was complaining of right hip pain. Staff asked R58 to move his extremities which was normal, gave pain medication and called the on-call and received an order for x-ray which was negative. -On 5/17/14, at 5:00 a.m. "Write heard resident calling for help at 5 a.m. writer checked to see what was going on. Writer found resident sitting on the floor. He said that he slide off the bed and sat on the floor." -On 6/21/14, at 12:10 a.m. "Writer heard resident yelling- door room was closed. Upon investigation, writer noted wheelchair upside down & resident sitting on his buttocks with back against dresser (TV stand)." When interviewed R58 stated he was on his w/c and had slipped and staff indicated R58 self-transferred without assistance. -On 6/21/14, at 2:00 a.m. "When writer was assisting another resident, writer came out of room and noticed that resident wheelchair was empty. Resident had been sitting in his	F 323		

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F 323	Continued From page 76 wheelchair prior to full dozing. Writer noted resident to be "scooting" on his buttocks into room 218." When interviewed R58 stated "I was looking for a ladder." Although R58 had six falls in his room and around the unit during the evening and night hours, from 1:30 p.m. to 5:00 a.m. there was no indication the facility had compressively re-assessed R58's falls, to determine appropriate interventions to help decrease his risk of falls besides leaving his door open to frequently monitor, w/c being placed near bed at all times and monitor for trends which were repeated and had not been added to the fall care plan. On 6/27/14, at 3:22 p.m. Interim director of nursing (IDON) after reviewing the incident reports from February to June verified no new interventions were put into place and there was no evidence medications were reviewed to determine if they had any bearing on the falls. IDON further stated "I have not been able to address the anti-psychotropic yet, which is what I would want to see installed." Incident Reporting policy revised May 2011, Sept 2013, directed "All staff are expected to monitor resident and the incident for appropriate follow up. The 24 hour follow up will be completed and changes to care plan will be initiated."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329		

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F 329	Continued From page 77 without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic 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 interview and document review, the facility failed to ensure 1 of 5 residents (R6) had indication for continued use reviewed for unnecessary medications and the facility failed to ensure parameters were outlined for a pain medication, a gradual dose reduction (GDR) was attempted for antipsychotic medications and non-pharmacological interventions were implemented and monitored for 1 of 5 residents (R2) who were reviewed for unnecessary medications. Findings include: Physician and nurse practitioner notes dated	F 329	**F329-D** Corrective Action: A. The use of Restoril and Ambien for R6 has been reviewed and orders were obtained to implement GDR for Ambien. The care plan has been reviewed and revised as appropriate. B. R2 had the Percocet regimen reviewed and the Percocet has been discontinued. The Geodon was reviewed for GDR by consultant pharmacist on 7-17-14. The care plan has been revised to include target behaviors and non-pharmacological interventions. Corrective Actions as it applies to other Residents: A. The Antipsychotic Medication Use Policy has been revised. B. The Sleep Disorders-Clinical Protocol has been implemented. C. The policy for Administration of Pain Medications has been implemented. Date of Completion: August 8, 2014 Recurrence will be prevented by: A. Facility staff members were educated on the Antipsychotic Medication Use Policy, the Sleep Disorders- Clinical Protocol and the Policy for Administration of Pain Medications at the All Staff	

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F 329	Continued From page 78 8/15/13, 10/17/13, 10/22/13, 11/20/13, 11/22/13, 12/2/13, 1/22/14, 4/17/14, 4/18/14, and 6/18/14, were reviewed and lacked a clinical justification for its extended use as directed by the manufacturer's recommendations. Prescription Order dated 9/4/13, indicated R6 received Ambien 10 milligrams (mg) by mouth every bedtime (a hypnotic medication commonly used short term, less than 14 days, for insomnia) from 9/4/13 to 6/27/14, without clinical justification for its extended use as directed by the manufacturer's recommendations. R6's diagnoses included but were not limited to insomnia, manic depression, schizophrenia, and affective personality disorder obtained from annual Minimum Data Set (MDS) dated 1/10/14. The Psychotropic Drug Use Care Area Assessment (CAA) dated 1/10/14, indicated R6 was receiving a sedative/hypnotic and directed staff to monitor for side effects and effectiveness of medications in use. Review of R6's Physician Telephone orders signed by the nurse practitioner (NP) of 1/22/14 and 4/23/14, revealed NP had authorized to dispense ninety tablets on both times however, lacked to indicated justification for continued use. R6's Record of Medication Regimen Review by CP monthly revealed recommendations had been made on 2/19/14, 5/14/14, and 6/17/14, "1. Please review and document ongoing need for multiple hypnotic agents. Could a reduction of temazepam [Restoril- also used to treat insomnia] or Zolpidem [Ambien] be tried?" R6's quarterly MDS dated 4/9/14, indicated R6	F 329	Meetings completed the week of 7-28-14. B. Daily audits x 2 weeks, then weekly x 4 weeks then monthly x 3 months. Findings will be reported to the QAPI/QA Committee for review and follow up recommendations. The QAPI/QA Committee will determine when the audits may be discontinued. Responsible Person: DON and Administrator or their Designee	

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F 329	Continued From page 79	F 329		

was not able to be interviewed on her mood and instead a Staff Assessment Of Resident Mood indicated "No" for trouble falling or staying asleep or sleeping too much but indicated "Yes" for feeling tired or having little energy.

During interview on 6/25/14, at 8:05 a.m. R6 appeared sleep and was dozing as she made brief breaks as she propelled her wheelchair down the hallway as he body was slammed to the back. When asked how she sleeps at night R6 stated "I don't sleep well at night at all because the staff come and wake me up all night and am never rested at all." R6 further stated "I have never slept well."

When interviewed on 6/26/14, at 10:12 a.m. the NP stated when asked if he saw R6 for her psych issues NP stated "Yes and No am new in this provider setting and resident has long history of mental issues and I have not changed her medications since I started seeing her." When asked if R6 required documentation for continued use Ambien despite the manufacturer recommendation, NP stated "I really can't tell you that because I don't know."

When interviewed on 6/26/14, at 10:27 a.m. consultant pharmacist (CP) stated she had recommended facility/provider to provide continued indication for use for the Ambien on 2/19/14, but had requested the indication on subsequent reviews but had not gotten any information back and on her last review 6/17/14, she decided to write to nursing to address the recommendation. CP further stated she was not even clear why R6 was taking both Ambien and temazepam 15 mg daily and will continue to ask for indication.

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On 6/27/14, at 11:46 a.m. the interim director of nursing (IDON) stated "I would like to see a GDR or a minimum affective dose by the NP and a clear indication for use."

Pain:
R2's diagnoses included schizophrenia, lupus, epilepsy, chronic obstructive pulmonary disease, brain injury obtained from the Resident Admission Record dated 1/16/13. R2 was currently on Percocet a pain medication but with no parameters outlined for use.

R2's quarterly MDS dated 5/9/14, indicated R2 had intact cognition, used a wheelchair and walker for mobility and was independent with transfers. The MDS also noted R2 displayed no behaviors in the last week.

R2's physician orders dated 5/21/14, included:
- Oxycodone/apap 5/325 mg (Roxicet or Percocet) one to two tablets orally every six hours as needed for pain
- ziprasidone (Geodon -used to treat schizophrenia and the manic symptoms of bipolar disorder) 60 mg capsule (one capsule orally two times daily with meals).
- clonazepam (Klonopin - used to control seizures in epilepsy and for the treatment of panic disorder) 1 mg tablet (one tablet orally two times daily).
- paroxetine (Paxil - an antidepressant) 25 mg tablet (two tablets (50 mg) orally daily).

Review of the Medication Administration Record (MAR) for June 2014, indicated R1 had received Percocet:
- Two tablets, one time on 6/18/14, for pain level

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of 10 on a one to 10 pain level scale with 10 being worst
- One tablet, one time on 6/19/14, for pain level of 10 on a one to 10 pain level scale with 10 being worst
- Three tablets on 6/21/14; two tablets for pain level of nine and one tablet for pain level of eight on a one to 10 pain level scale with 10 being worst.
- Two tablets on 6/23/14; one tablet for pain level of seven and one tablet for pain level of 10 on a one to 10 pain level scale with 10 being worst.
- One tablet on 6/24/14 for pain level of nine on a one to 10 pain level scale with 10 being worst.
- One tablet on 6/25/14 for pain level of 10 on a one to 10 pain level scale with 10 being worst.
- Two tablets on 6/26/14; one tablet for pain level of eight/nine and one tablet for pain level of 10 on a one to 10 pain level scale with 10 being worst.

During an interview on 6/27/14, at 2:53 p.m. licensed practical nurse (LPN)-K verified the Percocet order had ranges and all residents with ranges for medications used the facility protocol that indicated pain level of one thru five would get one tablet and pain level six thru ten would get two tablets.

During an interview on 6/27/14, at 3:48 p.m. IDON acknowledged the order needed to be "tweaked." When asked about the facility pain protocol that LPN-K referenced, he stated it was only for the assessment of pain and that there was no facility protocol. Although R2 received Percocet pain medication per physician orders, the orders lacked parameters for staff to follow to determine how many pain medications to receive depending on the severity/level of pain.

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F 329	Continued From page 82 GDR/non-pharmacological interventions: R2 was on Geodon an antipsychotic medication that had insufficient justification for not attempting a gradual dose reduction and no non-pharmacological interventions that were implemented and monitored for their effectiveness. Review of R2's care plan with admit date of 1/16/13, did not outline or address target behaviors and non-pharmacological monitoring. Review of NP progress notes dated 2/4/14, indicated "schizophrenia - mood stable." Review of NP progress notes dated 6/6/14, indicated "schizophrenia - in supportive environment. Stable with current management." Review of NP progress notes dated 6/18/14, indicated "schizophrenia, stable presentation - psychiatric disease may impaired [sic] judgment." Review of medical doctor (MD) progress notes dated 2/6/14, did not address R2's schizophrenia. During review of the MD/NP progress notes it was revealed they lacked a clear justification for not attempting a GDR. Review of the CP monthly record of medication regimen review dated 2/19/14 thru 6/17/14, indicated "check GDR doc." Review of Behavior Monitoring Records dated June 2014 indicated R2 had increased behaviors averaging one to three times per day such as obsessive statements and anxiousness regarding treatments, health, appointments and staff, inability to calm, weepiness, paranoia - obsessive complaints regarding health concerns. The records however did not outline what alternative	F 329		

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non pharmacological interventions were used and if they were effective. During document review of the behavior monitoring records and care plan, it was revealed both lacked non-pharmacological interventions and monitoring used for R2 prior to administering psychotropic medication.

During interview on 6/26/14, at 10:36 a.m. the CP stated she indicated "check GDR doc" because she wanted more of a reason why the GDR was not being attempted and more than "in supportive environment, stable with current management." CP stated she expected an explanation, such as why or what happens when a GDR has been attempted.

During an interview on 6/27/14, at 8:25 a.m., LPN-I acknowledged no specific non pharmacological interventions were outlined, "When we work with them we get to know them so we know what works." LPN-I stated no dose reduction had been completed "that I know of."

Additional Behavior Monitoring Records for the past three months were requested but not provided.

The facility "Review of Psychopharmacological Medication" policy dated 12/01/27, indicated at the time of monthly medical review the medical record would be reviewed for appropriate indications for use and diagnosis for use of medication, documentation of specific, measurable target behaviors and if a physician refused to address the recommendation provided by the pharmacy, or does not provide sufficient documentation for declining the pharmacy recommendations, the IDON would initiate the "Psychopharmacological Review Request Form."

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F 329	Continued From page 84 The policy however did not address implementing non-pharmacological interventions and monitoring.	F 329	**F 431- D** Corrective Action: A. The medication carts, treatment carts and medication rooms have been checked for expired medications. Replacement medications have been ordered as appropriate. B. Internal and External medications are now stored separately on the medication carts, treatment carts and in the medication rooms and medication refrigerators. C. Multi-use Insulin pens have been labeled appropriately by the pharmacy. D. The Insulin Pens of R45 and R81 were replaced and properly labeled. E. Medication room refrigerators have been cleaned and defrosted. F. The Advair Diskus of R4 has been replaced. G. The expired stock anti-diarrheal medications have been replaced. H. The rectal suppositories of R15, R51, R86 and R101 are now stored separately from internal medications. I. The nasal medication of R15 is stored separately. J. The liquid oral medications of R15 are also stored separately. K. The expired medications from R63 have been discarded from the 3rd floor refrigerator.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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 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.	F 431		

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F 431	Continued From page 85 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 3 of 6 TMA (trained medication aide) medication carts and nurse carts (2nd Floor Nurses cart, 2nd Floor TMA cart and 3rd Floor Nurse cart) had kept free of expired medications, rectal, nasal medications were stored separately from oral medications and the facility failed to properly ensure multi-use insulin pens were properly labeled for 9 of 9 residents (R45, R81, R4, R15, R51, R86, R101, R63, R95). In addition, the facility lacked a system to ensure the medication storage refrigerators were cleaned, defrosted and expired medications were not stored in the refrigerator. These practices had the potential to affect 36 of 67 residents who resided at the facility. Findings include: 2ND FLOOR REFRIGERATOR FREEZER On 6/26/14, at 3:09 p.m. during medication storage tour with licensed practical nurse (LPN)-B the freezer was observed to have a two-three inch thick build up frost. A glass thermometer was observed to be encased in the frost. LPN-B was unclear when the refrigerator was last cleaned or defrosted and was unclear on the schedule for cleaning and defrosting of the medication storage refrigerator stated she would have the supervisor find out. On 6/27/14, at 8:11 a.m. when asked if the facility had a system for cleaning the refrigerators/freezers and who was responsible	F 431	L. Rectal medications are now stored separately in the Medication Room refrigerators. Corrective Actions as it applies to other Residents: A. The Medication Storage Policy has been revised. B. The Labeling of Medications Policy has been revised. Date of Completion: August 8, 2014 Recurrence will be prevented by: A. Facility staff members were educated on the revised Medication Storage and Labeling of Medications Policy at the All Staff Meetings completed the week of 7-28-14. B. Daily audits x 2 weeks, then weekly x 4 weeks then monthly x 3 months. Findings will be reported to the QAPI/QA Committee for review and follow up recommendations. The QAPI/QA Committee will determine when the audits may be discontinued. Responsible Person- DON or Administrator	

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F 431	Continued From page 86 interim director of nursing (IDON) stated "I have not seen a cleaning log here I updated the temperature logs." When asked who was responsible IDON stated "I believe it's the night shift am not sure." 2ND FLOOR NURSE CART On 6/25/14, at 3:11 p.m. two Novolog Flex Pens for R45 and R81 dated 6/16/14, and 6/13/14, with names hand written on a bright green sticky. -At 3:15 p.m. LPN-D who was the supervisor verified both pens lacked pharmacy labels but stated the pens came from the pharmacy and that was how they were labeled and indicated he was going to show surveyor other pens stored in the refrigerator. -At 3:20 p.m. LPN-D came back to the cart with a box of Novolog Flex Pens and each one of them had a pharmacy label then stated "I guess they come with a pharmacy label. I am going to replace them with new ones." R45's Minimum Data Set (MDS) dated 4/15/14, indicated R45 had diabetes. R81's MDS dated 5/19/14, indicated R45 had diabetes. When interviewed on 6/27/14, at 11:32 a.m. IDON stated the labels were supposed to be reordered from pharmacy if medication had a missing label. IDON further stated "If medication has no label it needs to make it my office and expired medications should have been discarded and each nurse has to take responsibility to make sure all the carts are clean and not having expired medication. I was told night shift is responsible."	F 431		

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2ND FLOOR TMA CART
On 6/26/14, at 3:13 p.m. during medication storage tour with LPN-B R4's Advair Diskus (used for breathing) 250/50 microgram (mcg) dated opened 5/2/14, with instructions printed in red "Discard 30 days after opening" on plastic bag used to store the inhaler and a box of house stock supply SM anti-diarrheal 2 milligram (mg) tablets dispensed 10/21/12, with expiration date 4/14, on the box.
-At 3:19 p.m. LPN-B verified the inhale was outdated stated "It was opened 5/2/14." LPN-B further stated "Expired medications were not supposed to be stored in the cart."

R4's Minimum Data Set (MDS) dated 11/19/13, revealed R4 had pulmonary disease and MDS dated 5/16/14, revealed R4 had moderate cognition impairment.

The Advair Diskus Package Insert and Label Information by GlaxoSmithKline LLC last revised 5/19/14, noted to store the "Advair Diskus at room temperature between 68°F and 77°F (20°C and 25°C). Keep in a dry place away from heat and sunlight, store in the unopened foil pouch and only open when ready for use and to safely throw away Advair Diskus in the trash one month after you open the foil pouch or when the counter reads 0 , whichever comes first."

3RD Floor NURSE CART
On 6/26/14, at 3:42 p.m. during medication storage tour with LPN-C on the second drawer of the medication cart to the back were four different clear plastic bags of suppositories for R15's

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Canasa 1000 mg suppositories (used to treat mild to moderately active ulcerative proctitis - an idiopathic mucosal inflammatory disease involving only the rectum and is therefore an anatomically limited form of ulcerative colitis), R51's Bisac-Evac suppositories 10 mg (used to treat constipation), R86's Bisac-Evac suppositories 10 mg, R101's Bisac-Evac suppositories 10 mg, nasal ointment for R15 Bactroban 2% Nasal Ointment (an antibiotic ointment. It is used to kill a group of bacteria in the nose called 'Staphylococci') stored together with two bottles of oral liquid medications for R15's Citalopram sol 10 mg/5ml (anti-depressant) and Certavite-antioxidant (a multivitamin).

R15's MDS 5/25/14, revealed R15 had restrictive lung disease, an ostomy and had depression.
R51's MDS dated 5/16/14, R51 was incontinent of bowel and had no constipation.
R86's MDS dated 9/19/13, indicated R86 had expired 9/4/13, and the medications were still being stored in the refrigerator.
R101's MDS dated 5/28/14, indicated R101 had bowel incontinence and had no constipation.

On 6/26/14, at 3:44 p.m. when asked if the medication were supposed to be separated LPN-C stated "I don't know but will find my supervisor to answer that I just started to work here and today is my fifth day."

When interviewed on 6/26/14, at 3:48 p.m. IDON stated "I don't know if they can't be stored together as long as they are sealed I will ask my consultant pharmacist."

3RD FLOOR REFRIGERATOR

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F 431	Continued From page 89 On 6/26/14, at 4:07 p.m. LPN-C assisted the surveyor with access to the locked medication storage room directly behind the nursing station. In the refrigerator crisper drawer was observed R63's one infusion ball device of Vancomycin 500 mg (an antibiotic) with a discard date after "06/22/14" and two Ceftriaxone 1 gram (gm) infusion ball devices with a discard date after "6/6/14" for both stored together with R95's two boxes of Bisac-Evac suppositories. R63's MDS dated 6/24/14, had no current infections but did have intravenous therapy while at the facility. R95's MDS dated 6/10/14, noted R95 to be continent of bowel and have no constipation. On 6/26/14, at approximately 5:36 p.m. LPN-F nurse manager approached surveyor stated R63 had order for both antibiotics but was currently in the hospital. When asked what the expectation was with discarding medications LPN-F acknowledged medications should have been discarded and removed from the refrigerator. O 6/27/14, at 11:38 a.m. when asked about storing medications together IDON stated "I don't have a distinct objection on that and I was not aware of that being stored in the same area and the policy does not address that about separating medications." When asked if the infusion device antibiotics should have been discarded IDON stated "Yes they should have been discarded or removed." Medications: Storage of policy revised May 2011, directed "2. Drug containers having soiled, illegible, worn, makeshift, incomplete, damaged, or missing labels are returned to the pharmacy	F 431		

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F 431	Continued From page 90 for proper labeling before storing. 3. No discontinued, outdated, or deteriorated medications are available for use in this facility. All such medications are destroyed. 4. Medications for external use are clearly marked as such and are stored separately from other medications."	F 431	**F 441- F** Corrective Action: A. Resident Infections and Employee Illness are now being logged for trending purposes.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441	Corrective Action as it applies to other Residents: A. The Infection Control Surveillance Policy has been revised. B. An Employee Illness Log has been implemented. The Resident Infection Log was reviewed. Date of Completion: August 8, 2014 Recurrence will be prevented by: A. Facility Staff received education on the Infection Control Surveillance Policy, the Resident Infection Log and the Employee Illness log at the All Staff meetings completed the week of 7-28-14. B. Daily audits x 2 weeks, then weekly x 4 weeks then monthly x 3 months. Findings will be reported to the QAPI/QA Committee for review and follow up recommendations. The QAPI/QA Committee will determine when the audits may be discontinued. Responsible Person: DON and Administrator or their Designee	

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F 441	Continued From page 91 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure the infection control program included tracking and trending of employee infections and illness to determine if there was any correlation with resident infections. This had the potential to affect all 67 residents residing in the facility. Findings include: The interim director of nursing (IDON) was identified as the infection control contact. During review of the facility Resident Infection Log(s) from August 2013 through May 2014, the log revealed the facility did not track or trend employee infections/illness as part of the infection control program. The IDON stated on 6/27/14, at 10:23 a.m. that he was not told how they do it. Review of the facility Infection Control and Prevention Program policy dated November 2009 and the Infection Control Surveillance policy dated May 2011 were reviewed and lacked direction for tracking employee infection/illness. During an interview on 6/27/14, at 10:29 a.m. licensed practical nurse (LPN)-E stated that in morning standup meetings the employee call-in's	F 441		

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F 441	Continued From page 92 are discussed and any infections or illness would be addressed. During an interview on 6/27/14, at 10:31 a.m. the administrator stated human resources (HR) tracks employee infections. During an interview on 6/27/14, at 10:55 a.m. the human resources director (HRD) stated she does track employee absences but the former director of nursing (DON) was tracking the illness/infections. HRD stated the DON would get the attendance information related to illness in stand up morning meetings and she was tracking it by floor. During an interview on 6/27/14, at 11:10 a.m. the IDON stated the HRD was "not aware of the infection summary employee infection surveillance form", further stating that it was not currently being used "but it will be." During an interview on 6/27/14, at 11:48 a.m. the HRD stated "I make out the absentee report and bring it to standup; the employee absentee report shows what they called in for. HRD gave the surveyor a June 2013 absentee report stating "this June report was all we found, we didn't find any others." There was no indication employee infections/illness were reviewed to determine if employee and resident infections/illness were or could be related to each other.	F 441		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE	F 514		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING ______ B. WING ______	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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F 514	Continued From page 93 The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to maintain complete and accurate medical records for 1 of 1 resident (R71) who had inconsistencies and omissions in physician orders, as well as a recapitulation of stay for 11 of 19 discharged residents (R99, R24, R64, R97, R16, R91, R98, R102, R64, R103, R32). Findings include: R71's medical record revealed inconsistencies and omissions in physician orders. The resident was frequently absent from the facility when medications were prescribed, therefore, did not consistently receive her medications as ordered. The primary physician for R71 was interviewed via telephone on 6/26/14, at 3:17 p.m. He verified if the resident had elevated blood pressure, he would want her to receive sliding scale insulin. He was unaware the sliding scale insulin had been discontinued.	F 514	**F 514-E** Corrective Action: A. R71 had her medication regimen reviewed by the physician/nurse practitioner and changes were made as appropriate. B. Discharge Summaries have been completed for R99, R24, R97, R16, R91, R98, R102, R64, R103, R32, R42 and R38. Corrective Action as it applies to other Residents: A. The Discharge Summary policy has been revised. B. The Medication Orders Policy has been revised. C. The Physician Services Policy has been revised. D. The Physician Orders Policy has been revised. E. The Medication Utilization Policy has been revised. Date of Completion: August 8, 2014 Recurrence will be prevented by: A. Facility staff members were educated on the Discharge Summary, Medication Orders, Physician Services, Physician Order and Medication Utilization Policies at the All Staff meetings completed the week of 7-28-14.	

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F 514	Continued From page 94 The 6/14 MAR showed the sliding scale insulin had been discontinued on 6/6/14, however, on 6/26/14, at 5:30 p.m. LPN-M verified there was no physician order in the resident's record to show it had actually been discontinued. LPN-E then informed the surveyor that on a consultation sheet dated 5/20/14, the insulin was not noted. LPN-E said at that point, the transcribing nurse should have called the physician to clarify whether the sliding scale insulin should have been continued or discontinued. LPN-E also verified orders written on the consultation sheet were considered to be current (whether they remained the same or changes were made) as of the date of the physician's signature on the consultation sheet. In an interview with R71 on 6/26/14, at 5:35 p.m. she stated had been prescribed sliding scale insulin, but it had had been discontinued. She was aware when her blood sugar was elevated, as the bottoms of her feet became very cold and her fingertips numb. The following morning at 8:03 a.m. LPN-F explained that "whoever has time" transcribed orders around the 25th of each month. The staff was to check new orders with the pre-printed MARs printed by the pharmacy on the 22nd of each month. The staff person "must have been in a hurry" and missed the consult order dated 5/20/14. The order still appeared on the 6/14 MAR, however, a line had been drawn and a date of 6/6/14 had been added. LPN-F stated it was not the correct way to discontinue an order. The previous director of nursing (DON) had instructed staff to file consult orders under the consultation tab in a resident's record which LPN-F said it may have been the reason the order change had been	F 514	B. Random daily audits x 2 weeks, then weekly x 4 weeks then monthly x 3 months. Findings will be reported to the QAPI/QA Committee for review and follow up recommendations. The QAPI/QA Committee will determine when the audits may be discontinued. Responsible Person: DON and Administrator or their Designee	

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F 514	Continued From page 95 missed.	F 514		

On 6/27/14, at 8:10 a.m. LPN-H reported she had called R71's primary physician the previous day to clarify the 5/20/14 insulin order. LPN-H verified no insulin had been administered to the resident between 6/1/14 and 6/4/14. At 1:18 p.m. LPN-H explained that on 5/12/14, R71's medication administration times had all been changed to to 8:00 a.m. and noon, due to her LOAs and missing evening medications and treatments. A telephone order signed by a LPN, but not yet signed by the physician read, "[Change] meds to 8 AM et. [and] noon. The order did not specify the names of the medications, doses, and the times they were to be administered according to standards of practice.

On 6/27/14, at 1:50 p.m. after reviewing the telephone order, LPN-F stated he would have expected the nurse who wrote the telephone order to clarify each medication order with the physician to determine the appropriateness of changing each medication, and which medications should have remained the same. LPN-F also verified that as of 5/21/14 R71's medication orders had been re-written to be administered at 8:00 a.m. 12:00 p.m. and 4:00 p.m. and some medications were left at 8:00 p.m. on the 5/14 MAR. LPN-F also verified R71's monthly June orders had reverted back to the medication times previous to the 5/14 order. LPN-F could not offer an explanation, but said perhaps it could have happened when she returned from the hospital at the end of May. Although LPN-F verified he would have expected a progress note regarding the change, there was no note by the transcribing nurse to that effect.

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F 514	Continued From page 96 On 6/27/14, at 2:13 p.m. the nurse manager, LPN-D stated after a resident hospitalization, nurses accepted hospital discharge orders as current even though they may have differed at the time the resident had been sent to the hospital. At the time of the next scheduled visit with the resident, the primary physician was to note any changes. LPN-D confirmed she had written the telephone order dated 5/12/14, changing R71's medication times to 8:00 and noon. She verified some of the medications had in fact been changed to 8:00 a.m., noon, and 4:00 p.m., with some remaining at 8:00 p.m. inconsistent with the telephone order. LPN-D said the change was requested due to R71's LOAs "nearly every night" and because she was missing her evening medications and treatments. She was unable to provide documentation showing the why the medications were inconsistent with the telephone order. An email thread was provided to the surveyor dated 5/9/14 between the former DON and physician. The DON wrote, "...came in on 300 mg Neurontin tid [three times daily] and took 800 mg prior to admission. Thinking 600 mg (06, 12 [times]) and ES Tylenol at noc? [night] With option to increase after evaluation further. Can we look into that? Also would like most or all meds in morning and noonish/before dinner, as she comes back from sisters every night intoxicated. No change to her TID, ER, or Statins, [three times daily, unknown--possibly extended release, cholesterol medication] we will hold these if necessary. States 2 beers only but she is a little thing and who knows (plus beer aggravates gout Haha). I am not concerned with her drinking she bothers no one and makes it back by curfew just that staff don't give her some	F 514		

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F 514	Continued From page 97 meds and others they hold d/t [due to] safety with intoxication." The medications held were not specified by the DON, nor were there specific physician orders directing staff to hold certain medications. The physician's response read, "...I did take a look at her and agree that is likely gout made worse by her drinking. I think that your increase in neurontin idea is fine, as well as tylenol. Its okay to give those meds at AM/noon." No further direction regarding the staffs' practice of arbitrarily holding medications and/or changing medication administration times was addressed by the physician in his response. A consultation sheet dated 5/20/14, read R71's insulin should be discontinued, however, the order was not specific, and did not indicate whether this was regularly scheduled insulin or sliding scale insulin. On 6/26/14, at 2:26 p.m. the interim director of nursing (IDON) stated he expected nursing to follow the policy regarding physician orders and the nurse who wrote the orders should be talking to the physician. The IDON said the 5/12/14 order was not properly written and should have specified the medication changes. In addition, the nurse who transcribed R71's orders had not followed their policy, and upon return to the facility from hospitalization, the primary physician should have been notified of changes to determine whether he agreed or wanted any orders changed. The IDON said it was "not okay" to just wait until the physician's next visit. R71's medications and their times for administration were as follows: 1) At 8:00 a.m. aspirin, Celexa, folic acid,	F 514		

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F 514	Continued From page 98 Prilosec, Miralax, Spiriva inhaler, vitamin C, vitamin D3, Cozaar, and ferrous gluconate 2) At 8:00 p.m. Simvastatin and Trazodone 3) At 8:00 a.m. and 8:00 p.m.Neurontin and Glucophage, Advair, and Detrol 4) At 8:00 a.m. 12:00 p.m. and 8:00 p.m. Albuterol, ferrous sulfate, ibuprofen 5) PRN medications of Tylenol every six hours, Robaxin every 8 hours as needed for pain in feet 6) Insulin orders of Lantus 10 units at bedtime started 5/19/14, Check blood sugar 2 times daily at alternating times 8/12/4/8 starting 4/19/14, Novolog injection 120-149=2 units, 150-199=3 units, 200-249=6 units, 250-299=9 units, 300-349=12 units, >350=15 units starting 5/19/14. On 6/27/14, R71's original unsigned physician orders were found in R71's primary physician's white binder at the nursing station and verified by supervisor LPN-F included: 4/25/14--discontinue Trazodone, 5/12/14--change medications to 8 a.m. and noon, add Tylenol and increase Neurontin, 5/22/14--order for CPAP [for sleep apnea] setting at 12, 6/3/14--discontinue ted stocking, 6/25/14--ok to send resident to ER [emergency room], and 6/14 and unsigned monthly orders awaiting the primary physician's signature. The facility's Interdisciplinary Stand Up Meeting policy dated 5/11 noted, "The facility promotes communication between the interdisciplinary team to positively affect outcomes for the residents, and to provide an ongoing process of interdisciplinary communication with a focus on positive outcomes for the residents. The IDT will review residents and make changes necessary to assessments or care plan interventions to help improve outcomes for residents."	F 514		

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F 514	Continued From page 99	F 514		

Continued From page 99

During stage one closed record review the discharged resident records did not contain a recapitulation of the residents' stay, or summary of resident cares and treatments while in the facility. All records lacked recapitulation of stay or summary of resident cares and treatments.

Discharges occurred between 1/21/14, through 6/9/14, were as follows:

R99 was admitted to the facility 1/28/14, and discharged home on 2/4/14.
R24 was admitted to the facility 2/4/14, was discharged home on 3/31/14.
R97 was admitted to the facility 1/21/14, and discharged home on 2/8/14.
R16 was admitted to the facility 2/25/14, and discharged to the hospital on 3/27/14, after making statements wanting to kill herself.
R91 was discharged to the attached assisted living facility (ALF) on 2/27/14. A transfer discharge form indicated diagnoses of cocaine abuse and anxiety, vital signs at discharge and height and weight.
R98 was discharged home on 2/11/14. It was unclear from the medical record if services were set up prior to discharge.
R102 was admitted to the facility 3/5/14, was sent to acute care hospital 4/8/14, for cellulitis of the trachea and chemotherapy treatment and did not want to go back to nursing home area.
R64 was admitted to the facility 3/13/14, and discharged to the community 4/2/14.
R103 was admitted to the facility 3/10/14, and discharged to the community 6/3/14, with hospice services.
R32 was admitted to the facility 5/1/14, and discharged to the community 5/15/14.

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F 514	Continued From page 100	F 514		

R42 was admitted to the facility on 5/21/14. A physician progress note dated 5/30/14, indicated R42 was unhappy with his care and wanted to leave. A nurses note on 5/30/14, indicated R42 was last seen at 8:00 a.m. and his belongings are noted to be missing from his room. A nursing recapitulation of stay was added to the medical record after the health information services (HIS) coordinator was interviewed on 6/25/14, after surveyor intervention.
R38 was admitted to the facility on 4/16/14. The resident remained in the facility until 4/28/14 at 2:50 p.m. when she was sent to NMMC (North Memorial Medical Center) due to possible overdose of pill which got from other residents in the smoke room." On 4/29/14, the nurses notes revealed the R38 had been discharged home directly from the hospital. A nursing recapitulation of stay was added to the medical record after the HIS coordinator was interviewed on 6/25/14, and surveyor intervention.

On 6/25/14, at 2:35 p.m. the HIS coordinator verified all the discharged medical records lacked summary of the recapitulation of stay she stated "The recapitulation of stay would be at the front and if they are not there then it's not been done. You know I work in medical records and you need to talk to nursing about that."

Medical Records policy dated 8/8/13, gave Retention Guidelines but lacked information on ensuring residents medical records were accurate, organized and complete. In addition, the policy lacked who was responsible to oversee the residents medical records for completeness and accuracy.

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

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PRINTED: 07/15/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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, St Olaf Residence was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 482.41 (b), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, "The 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 St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	POC ok FB 7-29-14 RECEIVED JUL 28 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dc: 8-9-14

Exit: 6-26-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Executive Director | (X6) DATE 7/25/14

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 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. St Olaf Residence is a 4-story building with a basement. The original building was constructed in 1964, is separated from a church with a 2 hour fire rated barrier and was determined to be of Type I (332) construction. The facility is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection throughout the corridor system, in common areas and areas open to the corridor system and is monitored for automatic fire department notification. The facility has a capacity of 80 beds and had a census of 66 at the time of the survey. The requirement at 42 CFR, Subpart 482.41 (b), is NOT MET as evidenced by:	K 000	**K 020** Corrective Action: A. Facility will install a new door with the proper fire rating specifications Date of Completion: August 8, 2014 Responsible Person: Director of Environmental Services	
K 020 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with	K 020		

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K 020	Continued From page 2 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain vertical openings as required by LSC(00) Section 19.3.1.1. This deficient practice could affect all residents. Findings include: On facility tour between 9:15 AM and 10:45 AM on 06/30/2014, observation revealed that the mechanical room door in the third floor southeast stairwell is not fire rated. This deficient practice was verified by the Maintenance Director at the time of the inspection.	K 020		