DEPARTMENT OF HEALTI	HAND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDIC	CAID SERVICES	
					AND TRANSMITTAL		ID: EFPC	
	PART I -	TO BE COMPI	LETED BY 1	THE STA	TE SURVEY AGENCY		Facility ID: 00260	
1. MEDICARE/MEDICAID PROVIDE (L1) 245387	ER NO.	3. NAME AND AI (L3) ST OLAF R	ESIDENCE			 TYPE OF ACTIC Initial 	DN: <u>7 (</u> L8) 2. Recertification	
2.STATE VENDOR OR MEDICAID N (L2) 492242500	0.	(L4) 2912 FREM (L5) MINNEAPC		E NORTH	(L6) 55411	 Termination Validation On-Site Visit 	 CHOW Complaint Other 	
5. EFFECTIVE DATE CHANGE OF 0 (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEC 05 HHA	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	 8. Full Survey After 		
6. DATE OF SURVEY 09/1 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	8/2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDI 09/30	NG DATE: (L35)	
11LTC PERIOD OF CERTIFICATION	I	10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		X A. In Complia			And/Or Approved Waivers Of	The Following Requirem	ents:	
To (b):			equirements		2. Technical Personnel	6. Scope of Se	rvices Limit	
12. Total Facility Beds	80 (L18)	1	e Based On: cceptable POC		3. 24 Hour RN7. Medical Director 4. 7-Day RN (Rural SNF)8. Patient Room Size			
12.100011001109 2000	00 (E10)		eceptable i de		5. Life Safety Code	9. Beds/Room		
13.Total Certified Beds	80 (L17)		npliance with Pro ents and/or Appl		* Code: A *	(L12)		
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS			
18 SNF 18/19 SNF 80	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM.	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:	
Becky Wong, HFE NE II		(09/19/2014	(L19)	Anne Kleppe, Enforcement Specialist 09/24/2014			
PAI	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE S	TATE AGENCY		
 DETERMINATION OF ELIGIBIL <u>X</u> 1. Facility is Eligible to P 			IPLIANCE WIT HTS ACT:	H CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	:	(L30)	
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00	INVOLUN	NTARY	
12/01/1986					01-Merger, Closure	05-Fail to	Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse		Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	OTHER		
	A. Suspensio	n of Admissions:	7.10		04-Other Reason for Withdrawal	07-Provid 00-Active	er Status Change	
(L27)	B. Rescind S	uspension Date:	(L44)			00-Active		
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	L DATE				
	(L32)	08/27/2014		(L33)	DETERMINATION APPI	ROVAL		



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,

Are Klegese

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



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 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.

St Olaf Residence September 24, 2014 Page 2

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,

Ane Kleene

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

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245387	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/18/2014
Name of Facility		Street Address, City, State, Zip Code	
ST OLAF RESIDENCE		2912 FREMONT AVENUE NOR MINNEAPOLIS, MN 55411	TH

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	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
	F0225 483.13(c)(1)(ii)-(iii),	Correction Completed 09/11/2014 (c)(2) -		483.13(c)	Correction Completed 09/11/2014		483.20(d)(3), 483.10(Correction Completed 09/11/2014 (k)(2)
LSC			LSC		-	LSC		
	F0323 483.25(h)	Correction Completed 09/11/2014	Reg. #		Correction Completed	Dec. #		Correction Completed
ID Prefix Reg. # LSC			_		Correction Completed	Reg. #		
ID Prefix Reg. # LSC								
Reg. #			Dog #			D //		
Reviewed I State Agen Reviewed I CMS RO	cy GD/	wed By AK wed By	Date: 09/19/20 Date:	Signature of Sun 14 Signature of Sun	-	30951	Date: 09/1 Date:	8/2014
	o Survey Complete 6/27/2014			Check for any Unco Uncorrected Defic				NO

DEPARTMENT OF HEALTH	I AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVI	CES	
	MEDIC	ARE/MEDICAL	D CERTIFIC	CATION	AND TRANSMITTAL	ID: EFPC		
	PART I -	TO BE COMP	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 0026	0	
MEDICARE/MEDICAID PROVIDE (L1) 245387 2.STATE VENDOR OR MEDICAID N		3. NAME AND AI (L3) ST OLAF R (L4) 2912 FREM	ESIDENCE			4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertific: 3. Termination 4. CHOW	ation	
(L2) 492242500		(L5) MINNEAPO	DLIS, MN		(L6) 55411	5. Validation 6. Complaint	t	
5. EFFECTIVE DATE CHANGE OF C (L9)	WNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEC 05 HHA	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY 08/20 8. ACCREDITATION STATUS: 0 Unaccredited 0 Unaccredited 1 TJC 2 AOA 3 Other)/2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (09/30	L35)	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:		·		
From (a) : To (b) :			nce With equirements ce Based On:		And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN	<u>The Following Requirements:</u> <u>6</u> . Scope of Services Limit 7. Medical Director		
12.Total Facility Beds	80 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code			
13.Total Certified Beds	80 (L17)	X B. Not in Con Requirem	npliance with Prog ents and/or Appli		* Code: B *	(L12)		
14. LTC CERTIFIED BED BREAKDOW	VN	•			15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
80 (L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Becky Wong, HFE NE II		(09/17/2014	(L19)	Anne Kleppe, Enforcer	nent Specialist 09/18/	/2014 (L20)	
PAR	T II - TO BE	COMPLETED	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE S			
 DETERMINATION OF ELIGIBILI <u>X</u> 1. Facility is Eligible to Pa <u>2</u>. Facility is not Eligible 			IPLIANCE WITI HTS ACT:	H CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION 12/01/1986	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safe	ty	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse			
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	OTHER		
	A. Suspension	n of Admissions:	7.10		04-Other Reason for Withdrawal	07-Provider Status Change 00-Active		
(L27)	B. Rescind S	uspension Date:	(L44)			00-Active		
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVAL	L DATE				
	(L32)	08/27/2014		(L33)	DETERMINATION APPI	ROVAL		



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 deficiency 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)

St Olaf Residence September 2, 2014 Page 2

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 St Olaf Residence September 2, 2014 Page 3

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:

St Olaf Residence September 2, 2014 Page 5

> 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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

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

Feel free to contact me if you have questions.

Sincerely,

Ame Klagge

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



Protecting, maintaining and improving the health of all Minnesotans

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 noncompliance 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, 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 FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING R 245387 B. WING 08/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH ST OLAF RESIDENCE MINNEAPOLIS, MN 55411 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {F 000} **INITIAL COMMENTS** {F 000} An onsite resurvey was conducted by surveyors F 225- D of this department on August 19 and 20, 2014, to Corrective Action: determine compliance with Federal deficiencies A. Facility has provided directions issued during a recertification survey exited on and education for staff to June 27, 2014. immediately report {F 225} 483.13(c)(1)(ii)-(iii), (c)(2) - (4) {F 225} INVESTIGATE/REPORT mistreatment/neglect/abuse to SS=D ALLEGATIONS/INDIVIDUALS OHFC. The facility must not employ individuals who have Corrective Actions as it applies to other been found guilty of abusing, neglecting, or Residents: mistreating residents by a court of law; or have A. The Abuse Prevention Plan was had a finding entered into the State nurse aide reviewed and revised. Facility staff registry concerning abuse, neglect, mistreatment members were re-educated about of residents or misappropriation of their property; the Abuse Prevention Plan and the and report any knowledge it has of actions by a definition of Immediate Reporting court of law against an employee, which would to OHFC. They were also educated indicate unfitness for service as a nurse aide or on the requirement of filing other facility staff to the State nurse aide registry Investigative Reports within 5 or licensing authorities. working days of the Initial Report The facility must ensure that all alleged violations to OHFC. The education occurred involving mistreatment, neglect, or abuse, at the All Staff Meetings completed including injuries of unknown source and the week of 9-8-14. misappropriation of resident property are reported immediately to the administrator of the facility and Date of Completion: September 11, 2014 to other officials in accordance with State law through established procedures (including to the Recurrence will be prevented by: State survey and certification agency). A. Facility Staff received education related to the Abuse Prevention The facility must have evidence that all alleged Plan, the definition of Immediate violations are thoroughly investigated, and must Reporting and the Requirement to prevent further potential abuse while the file Investigative Reports within 5 investigation is in progress. working days of the Initial Report to OHFC at the All Staff Meetings The results of all investigations must be reported completed the week of 9-8-14. to the administrator or his designated LABORATORY DIRECTOR'S OR PROVIDER/S ITATIVE'S SIGNATURE (X6) DATE TITLE Executive Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			U	MB NO.	<u>0938-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				1	PLETED
		245387	B. WING	i		F 08/2	} 20/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		· · · · · · · · · · · · · · · · · · ·
ST OLAF	RESIDENCE				912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 225}	representative and with State law (inclu- certification agency incident, and if the appropriate correct This REQUIREMEI by: Based on interview facility failed to ens allegations of mistr agency in accordar residents for whom (R107). Findings include: A vulnerable adult i 8/8/14, indicated th campus by an off c off duty environment employee noted re Aldrich and Broadw (a large 4 lane stre R107's wheelchair resident had to tak back to the facility. Investigation report the facility premise had been called, an facility by paramed taken him to a loca Investigation docur provider had given versus electric pow assessment for sat	to other officials in accordance uding to the State survey and within 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced w and document review the ure timely reporting of eatment/neglect to the state nee with their policies for 4 of 5 allegations were reviewed incident report for R107, dated the resident had been found off luty employee on 8/7/14. "An ntal services (EVS)-A sident [R107] at the corner of vay, 1.1 miles from the facility et)." The report indicated had run out of power, and the e public transportation to get	{F 2		 B. Daily audits x 2 weeks, the weekly x 4 weeks then more months. Findings will be r to the QAPI/QA Committereview and follow up recommendations. The QA Committee will determine audits may be discontinued. Responsible Person: Administrator Designee RECEIVE SEP 1.5 2014 COMPLIANCE MONITORING LICENSE AND CERTIFIC 	nthly x 3 eported e for API/QA when the l. or ED	
L	occupational thera				j 		

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Facility ID: 00260

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	F PROVIDER OR SUPPLIER	L	I	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
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{F 225	regarding the 8/7/1 administrator had b 8/7/14, the docume the SA had not bee incident of elopeme documented on an added to the Verific the 8/7/14 incident to be determined w reported to either t timely manner. The nursing notes regarding the 8/9/1 NN, on 8/9/14 at 1 asked the nurse if to the bank and Bu the resident he wa facility alone. The understood and we the nurse could no initiating a grounds police had been ca 8/9/14 included: "If on but it did not ala An entry at 7:50 p. paramedics had bu following an asses emergency room t On 8/19/14, at 2:5 worker (LSW) was thought the facility SA) if no harm, bu reported within 2 h facility had reporte administrator imm piece to report to t	4 elopement indicated the been notified of the incident on entation indicated a report to en made until 8/8/14. The ent from 8/9/14 was not clearly incident report, but had been cation of Investigation report for . Consequently, it was not able whether the incident had been he administrator or the SA in a included additional detail 4 incident. According to the 0:30 a.m., the resident had he could leave the facility to go urger King. The nurse had told s not allowed to leave the resident had told nurse he build not leave. At 12:00 p.m., t locate the resident and after s search without results, the alled. An entry at 2:00 p.m. on Resident has his wander guard arm when he left the building." m. that evening indicated that rought R107 back to the facility sment in the hospital	{F 2	225}			

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Event ID: EFPC12

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OMB NO 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM	/CLIA (X2)		PLE CONSTRUCTION		(X3) DATE COM		ΞY
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	PROVIDER OR SUPPLIER	210001			STREET ADDRESS, CITY, STATE, ZI		08/2	20/201	4
	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411				
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{F 225}	8/9/14 left facility by was recorded on vi WanderGuard from assisted living facili and it was working, working; R107 had had agreed to work (OT) for safe outing initially (after first el wouldn't do it again verified the elopem On 8/19/14, at 3:11 R107 had gotten ou administrator furthe reporting to the SA at night, they wait for The Supervisors re (supervisors) have report to the SA); it for practice." On 8/20/14, at 9:35 been trained to sep them and call the s administrator and c interventions used. report, but the DON report (to SA). The facility's Abuse 9/20/13, identified r maltreatment. The as: "the failure to p necessary to avoid under the section F policy included: " receives the report	put on. He eloped ag ALF door and went of	ain on but, it y (to check it vas hair and erapy o do that aid he W ed late. or verified The ate d or late ext day. t. The bw to ve done e had protect N, and hd t do the o the o the addition, nent, the hal who tment is	{F 225	}				
FORM CMS-2	567(02-99) Previous Versions	Obsolete Ev	ent ID: EFPC12	F	acility ID: 00260	If continua	tion sheet	t Page	4 of 16

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	PROVIDER OR SUPPLIER		1		TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/2	20/2014
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ST OLAF	RESIDENCE			1	IINNEAPOLIS, MN 55411		
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{F 225} {F 226} SS=D	Continued From pa maltreatment to the Administrator's des Department of Hea (common entry poi 483.13(c) DEVELC ABUSE/NEGLECT The facility must de policies and procee mistreatment, negl and misappropriati This REQUIREME by: Based on interview facility failed to ens allegations of mistr agency in accorda allegations reviewe Findings include: The facility's Abuse 9/20/13, identified maltreatment. The as: "the failure to I necessary to avoid under the section I policy included: " receives the report then responsible for maltreatment to th Administrator's des Department of Hea	age 4 e facility Administrator or the signee, the Minnesota alth (SA) and the CEP int) as describe" DP/IMPLMENT 7, ETC POLICIES evelop and implement written dures that prohibit fect, and abuse of residents on of resident property. NT is not met as evidenced w and document review the sure timely reporting of reatment/neglect to the state nce with their policies for 2 of 5 ed (R107). e Prevention Plan dated neglect as a form of e plan further defined Neglect provide goods and services d physical harm" In addition, Reporting of Maltreatment, the The facility professional who t of suspected maltreatment is or immediately reporting the e facility Administrator or the signee, the Minnesota alth (SA) and the CEP	{F 2	225}	 F 226- D Corrective Action: A. The Abuse Prevention P. reviewed and revised. Fa provided directions and e for supervisory staff to immediately report mistreatment/neglect/abu OHFC. Corrective Actions as it applies to o Residents:	lan was acility ha education set to other n was cility sta d about a and the eporting o educate g in 5 l Report occurred complete	i ff
	(common entry po				A. Facility Staff received edu related to the Abuse Preve		
					Plan, the definition of Imm		

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Facility ID: 00260

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE	SURVEY
AND FLAN OF OURNEOFION	DEATH OATON NOMBER.	A. BUILD	NG		F	
	245387	B. WING				0/2014
NAME OF PROVIDER OR SUPP	LIER		STREET ADDRESS, CI 2912 FREMONT AVE MINNEAPOLIS, M	NUE NORTH		
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
8/8/14, indicate campus by an off duty enviror employee note Aldrich and Bro (a large 4 lane R107's wheelc resident had to back to the fac lnvestigation re the facility pren had been calle facility by parar taken him to a lnvestigation d provider had g versus electric assessment fo occupational th regarding the 8 administrator h 8/7/14, the doc the SA had not incident of elop documented, b Verification of incident. Cons determined wh reported to eith timely mannerOn 8/19/14, at worker (LSW) thought the facility had rep	dult incident report for R107, dated dult incident report for R107, dated dothe resident had been found off off duty employee on 8/7/14. "An imental services (EVS)-A d resident [R107] at the corner of badway, 1.1 miles from the facility street)." The report indicated hair had run out of power, and the take public transportation to get ility. The Verification of eport indicated the resident had left nises again on 8/9/14, the police d, and R107 was returned to the medics because the police had local hospital. The Verification of ocument further indicated the iven R107 a manual wheelchair powered wheelchair until an r safety could be conducted by herapy. Although the report 3/7/14 elopement indicated the had been notified of the incident on cumentation indicated a report to been made until 8/8/14. The beenent from 8/9/14 was not clearly but had been added to the Investigation report for the 8/7/14 sequently, it was not able to be nether the incident had been her the administrator or the SA in a		file II work to OI comp B. Rand then mont be re Com up re QAP deter disco	rting and the Require nvestigative Reports v ing days of the Initial IFC at the All Staff M oleted the week of 9-8 om daily audits x 2 w weekly x 4 weeks the hly x 3 months. Find ported to the QAPI/Q mittee for review and commendations. The I/QA Committee will mine when the audits ntinued. Verson: Administrator	within 5 I Report Meetings 3-14. veeks, on lings will A follow e may be	

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245387	B. WING	1		R 20/2014	
	ROVIDER OR SUPPLIER	L	1	STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411			
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{F 226}	further stated R107 WanderGuard was 8/9/14 left facility b was recorded on vi WanderGuard from assisted living facil and it was working working; R107 had had agreed to work (OT) for safe outing initially (after first e wouldn't do it agair verified the eloper On 8/19/14, at 3:11 R107 had gotten o administrator further reporting to the SA at night, they wait f The Supervisors re (supervisors) have report to the SA); if for practice." On 8/20/14, at 9:33 been trained to sep them and call the s	he SA immediately. LSW 7 eloped on 8/7, and then a put on. He eloped again on y ALF door and went out, it	{F 2:	26}			
{F 280} SS=D	report, but the DOI report (to SA). 483.20(d)(3), 483. PARTICIPATE PLA The resident has t incompetent or oth	N and administrator do the	{F 2	280}			
			<u> </u>	i			

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	13 I UN MILUIUARL	A MEDICAID SERVICES	·			MD NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	····	240387				08/2	20/2014
	PROVIDER OR SUPPLIER			29	REET ADDRESS, CITY, STATE, ZIP CODE 012 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411		
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{F 280}	changes in care an A comprehensive of within 7 days after comprehensive ass interdisciplinary tea physician, a register for the resident, an disciplines as deter and, to the extent p the resident, the re legal representative	ing care and treatment or	{F 2	80}	 F 280-D Corrective Action: A. The care plan of R45 has be revised to reflect her curre and supervision needs. Corrective Action as it applies to of Residents: A. The Care Plan-Compreher policy has been implement Assessments of residents a going and care plans are reinformation about the residents condition chat The care plans of current to were reviewed and revised appropriate. 	ther nsive ted. are on- evised as dent and anges. residents 1 as	
	by: Based on observa review, the facility 1 of 3 residents (R accidents/supervis Findings include: On 8/19/14, at 12: seated on her whe table. R45 was cry told the surveyor s up since 5:00 a.m. When asked R45 y lunch and stated s wanted to go sleep	NT is not met as evidenced tion, interview and document failed to revise the care plan for 45) reviewed for ion including suicidal ideation. 33 p.m. R45 was observed elchair (w/c) at the dining room ing loudly. When asked, R45 he was tired as she had been and wanted to go to sleep. verfied she had not eaten her he was not hungry but just b. R45 was observed to say ed tears from her cheeks and			 Date of Completion: September 11 Recurrence will be prevented by: A. Facility Staff were educate Care Plan-Comprehensive the All Staff meetings con the week of 9-8-14. B. Daily audits x 2 weeks, th weekly x 4 weeks then mo months. Findings will be to the QAPI/QA Committ review and follow up recommendations. The Q Committee will determine audits may be discontinue Responsible Person: DON or Designation 	ed on the policy a npleted en onthly x : reported ee for API/QA when th d.	at 3

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	FUN MEDICANE	& MEDICAID SERVICES			\sim	<u>MB NO.</u>	0938-0391
STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY PLETED
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NAME OF PRC	VIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
ST OLAF RI	ESIDENCE	-			912 FREMONT AVENUE NORTH /INNEAPOLIS, MN 55411		
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R id di di di di di di di di di di di di	entified diagnoses sturbance, end sta ementia persisting nmunodeficiency v Resident Incident :00 p.m.) included irough the southw heelchair (w/c) (w esident stated, 'Am inute checks initia oplied. Daughter con couraged to call oot cause indicate then family visits d ansportation and co estings of lonelines greement with the hysician Orders 8. /anderGuard to rig /anderGuard proto of major depression of major depression included, "Will eeling down, depre- nterventions incluce redered encourage eelings, observe for epression includin	nission Record, dated 1/13/14, s of depression, sleep age renal disease (ESRD), g alcohol induced and human virus (HIV). Report dated 8/9/14, 1300 d, "R45 was noted to try to go est stairway with her hile sitting on w/c) when asked n trying to kill myself.' 15 ated and WanderGuard called and R45 was family to decrease loneliness. ed increased depressive mood lecreased (son did not have daughter was ill). Resident phone children when she had ss. Children were in plan." /9/14, included the use of a ght wrist and to utilize the pool for monitoring. dated 8/11/14, indicated R45 n Zoloft (an anti-depressant) by mouth every morning (AM)	{F 2	80}			

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

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		245387	B. WING				20/20	1/1
	PROVIDER OR SUPPLIER	<u>I</u>	L	STE	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/20	14
STOLAF	RESIDENCE				2 FREMONT AVENUE NORTH			
]				MI	NNEAPOLIS, MN 55411			
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					DEFICIENCY)			
{F 280}	Continued From pa	P end	{F 2	001				
(1 200)	1	-	{F 2	60 <u>]</u>				
ł		disorder and depression. The						
		been revised to include the use						
1	of the WanderGuar	rd, or the concern related to						
	the resident's suicion	dal ideations.		l L				
	On 8/19/14, at 1:27	⁷ p.m. director of nursing						
		suicidal ideation and use of a						
		not been added to the care						
	plan or the Team A							
	plan of the reality	long internet officiel.						
	On 8/10/14 at 3:04	p.m. DON acknowledged the		i			ļ	
ļ		rvention should have been						
				1				
		plan and further stated she had						
		censed social worker (LSW)						
		Ve were dropping the ball. I						
		e chart and the report will be		-				
	brought to the daily	/ stand up and this will make						
	sure everything is o	done right there then."						
		-						
	On 8/19/14, at 3:15	5 p.m. the LSW was						
		knowledged the WanderGuard						
		ave been added to the care						
		dal ideation. The LSW looked						
		care plan and verified the						
		not been added to the care		Ì				
		t it at that time under the						
	problem area of "m	100d".						
		on 8/19/14, at 3:40 p.m.						
		NA)-A, who was assigned to						
	R45 for the shift. st	tated she was not sure exactly	1					
		VanderGuard, "Usually when						
1		ander guard it's because they						
	wander."							
	On 8/19/14 at 2.44	5 p.m. when asked if she knew						
		anderGuard, NA-B stated she						
				1				
		old the surveyor she could find						
	out from one of the	e nurses at the desk. When			· · · · · · · · · · · · · · · · · · ·			
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: EFPC	12	Facil	lity ID: 00260 If continua	tion sheet	Page	10 of 16

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB_NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING R 245387 B. WING 08/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH ST OLAF RESIDENCE MINNEAPOLIS, MN 55411 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID IÐ (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {F 280} Continued From page 10 {F 280} 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. 483.25(h) FREE OF ACCIDENT {F 323} {F 323} HAZARDS/SUPERVISION/DEVICES SS=D 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 Facility ID: 00260 If continuation sheet Page 11 of 16 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: EFPC12

PRINTED: 09/02/2014

PRINTED: 09/02/2014 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVE COMPLETED A. BUILDING NAME OF PROVIDER OR SUPPLIER 245387 B. WING 08/20/201 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 08/20/201 ST OLAF RESIDENCE STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY EULI D PROVIDER'S PLAN OF CORRECTION (FACH DEFICIENCY MUST BE PRECEDED BY EULI)								
245387 B. WING 08/20/201 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ST OLAF RESIDENCE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES							Сом	PLETED
ST OLAF RESIDENCE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4)			245387	B. WING				
ST OLAF RESIDENCE MINNEAPOLIS, MN 55411 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4)	NAME OF PRO	OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF RESIDENCE MINNEAPOLIS, MN 55411 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4)					29	12 FREMONT AVENUE NORTH		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4)	ST OLAF R	AF RESIDENCE						
								(VC)
	PRÉFIX	IX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
 (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 verticed 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 persiting 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 structure called and R45 was encouraged to call family to decrease lonellness. 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 wree in agreement with the plan." Physician Orders 8/9/14, included the use of a WanderGuard to right wrist and to utilize the WanderGuard to right wrist and to utilize the WanderGuard to rotool 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. 	se ta to u W lu w tr w R icd d d ir A (^ tr w r e F w tr w f e a F V V A h 5	 seated on her whe table. R45 was cry told the surveyor si up since 5:00 a.m When asked R45 will unch and stated si wanted to go sleep this while she wiped her nose. R45's Resident Ad identified diagnose disturbance, end si dementia persistin immunodeficiency A Resident Incider (1:00 p.m.) include through the southwich wheelchair (w/c) (will resident stated, 'An minute checks initia applied. Daughter encouraged to call Root cause indicatives indicatives of loneline agreement with the Physician Orders & WanderGuard to rive WanderGuard to rive and the stated of the state of the s	elchair (w/c) at the dining room ing loudly. When asked, R45 he was tired as she had been and wanted to go to sleep. verfied she had not eaten her he was not hungry but just b. R45 was observed to say id tears from her cheeks and mission Record, dated 1/13/14, es of depression, sleep tage renal disease (ESRD), g alcohol induced and human virus (HIV). At Report dated 8/9/14, 1300 ed, "R45 was noted to try to go vest stairway with her vhile sitting on w/c) when asked m trying to kill myself." 15 ated and WanderGuard called and R45 was family to decrease loneliness. red increased depressive mood decreased (son did not have daughter was ill). Resident o phone children when she had ess. Children were in e plan." B/9/14, included the use of a ight wrist and to utilize the tocol for monitoring. r dated 8/11/14, indicated R45 on Zoloft (an anti-depressant)) by mouth every morning (AM)		23}	 Corrective Action: A. New interventions have be to the care plan and group R45 and R107. B. R107 working with Therag Department for community C. R45 has been referred to a visited psychiatric services Corrective Action as it applies to of Residents: A. Current residents and documentation have been a and care plans were update appropriate. Date of Correction: September 11, Recurrence will be prevented by: A. Facility staff members were educated on new intervent ongoing process for implet and communicating intervent All Staff Meetings comple week of 9-8-14. B. Daily audits x 2 weeks, the weekly x 4 weeks then mo months. Findings will be a to the QAPI/QA Committe review and follow up recommendations. The Qa Committee will determine audits may be discontinued 	sheet fo by y safety. nd s. her reviewed ed as , 2014 re ions and menting entions a ted the en mthly x 3 reported ee for API/QA when th	r 1 1

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00260

PRINTED:	09/02/2014
FORM	APPROVED
	0038-0301

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT	E SURVEY
		245387	B. WING				R 20/2014
	PROVIDER OR SUPPLIER	L		2912	EET ADDRESS, CITY, STATE, ZIP CODE P FREMONT AVENUE NORTH NEAPOLIS, MN 55411	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 323}	7/16/14, identified a goal included, "Will feeling down, depre Interventions include ordered encourag feelings, observe fr depression includir loss of appetite. Int treat primary mood care plan had not b of the WanderGuat the resident's suici On 8/19/14, at 1:27 (DON) verified the WanderGuard had plan or the Team A On 8/19/14, at 3:04 WanderGuard inte added to the care p just talked to the lic and had told her "W just told her that th brought to the daily sure everything is On 8/19/14, at 3:15 interviewed and act was supposed to h plan after the suici through the entire WanderGuard had plan, so she addec problem area of "m	ent's plan of care dated a problem of "depression". The discuss feelings that lead to essed or hopeless." ded, administer medications as ge resident to verbalize or signs and symptoms of ng tearfulness, hopelessness, erventions identified included: disorder and depression. The been revised to include the use rd, or the concern related to dal ideations. 7 p.m. director of nursing suicidal ideation and use of a not been added to the care ssignment sheet. 4 p.m. DON acknowledged the rvention should have been blan and further stated she had censed social worker (LSW) Ve were dropping the ball. I e chart and the report will be <i>r</i> stand up and this will make done right there then." 5 p.m. the LSW was knowledged the WanderGuard lave been added to the care dal ideation. The LSW looked care plan and verified the not been added to the care d it at that time under the	{F 3	23}			

Facility ID: 00260

If continuation sheet Page 13 of 16

	NO FUR MEDICARE		SERVICES				0	<u>MB NO.</u>	0938	<u>3-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SI IDENTIFICATI				CONSTRUCTION			IPLETE	
		245	387	B. WING					R 20/20)14
	PROVIDER OR SUPPLIER				29	REET ADDRESS, CITY, STATE, Z 12 FREMONT AVENUE NORT NNEAPOLIS, MN 55411		•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFIC Y MUST BE PRECED .SC IDENTIFYING IN	ED BY FULL	ID PREFI TAG	×	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ION SHOULD	BE	COM	(X5) PLETION DATE
{F 323}	Continued From pa nursing assistant (I R45 for the shift, st why R45 had the W residents have a w wander." On 8/19/14, at 3:45 why R45 had a Wa did not know and to out from one of the asked if she had w "Yes we get rotated got done working w NA-B also verified all the staff can hel On 8/19/14, at 3:47 aware why R45 had practical nurse (LP ideations and that i the WanderGuard attempt to get throut According to a vuln R107, dated 8/8/14 off campus by an o The report included services (EVS)-A e at the corner of Ald from the facility (a I indicated R107's w power, and the resi transportation to get Verification of Invest resident had left the 8/9/14, the police h returned to the faci police had taken hi	NA)-A, who was tated she was n VanderGuard, "l ander guard it's op.m. when ask inderGuard, NA old the surveyor e nurses at the c orked with R45 d every two wee vith her this last that when worki p any of the res 7 p.m. when ask d a WanderGua N)-B stated R45 t had been deci to alert staff if sl ugh the (stairwa herable adult inc 4, the resident h off duty employe d, "An off duty el mployee noted drich and Broad large 4 lane stree heelchair had ru ident had to tak et back to the fa stigation report i e facility premis- ad been called, lity by paramedi	ed if she knew B stated she she could find lesk. When NA-B stated, ks and I just weekend." ng on the floor idents. ed if she was rd on, licensed b had suicidal ded to put on he would y) door. ident report for iad been found e on 8/7/14. hvironmental resident [R107] way, 1.1 miles ret)." The report un out of e public cility. The ndicated the es again on and R107 was cs because the	{F 3:	23}					
FORM CMS-25	Verification of Inves		ent further Event ID: EFPC1	2	Facil	ity ID: 00260	If continuati	on sheet	Paga	14 of 16
	. ,					,	nooninuali		aye	1 1 1 1 1 0

	10 T OT MEDIOATE			<u> </u>	C	INB NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONST			E SURVEY IPLETED
		245387	B. WING				R 20/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET AD	DRESS, CITY, STATE, ZIP CODE	1 00/2	20/2014
ST OLAF	RESIDENCE				POLIS, MN 55411		
					······································		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC EACH CORRECTIVE ACTION SHOULI OSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 323}	wheelchair versus until an assessmer conducted by occu The nursing notes regarding the 8/9/1 NN, on 8/9/14 at 10 asked the nurse if to the bank and Bu the resident he was facility alone. The r understood and wo the nurse could no initiating a grounds police had been ca 8/9/14 included: "F on but it did not ala An entry at 7:50 p.1 paramedics had br following an assess emergency room th Although the reside updated on 8/8/14 Wanderguard for u seeking behaviors, able to exit the buil the alarm sounding no intervention cha motorized wheelch charged. On 8/19/14, at 2:57 worker (LSW) was had eloped on 8/7/ WanderGuard had	der had given R107 a manual electric powered wheelchair int for safety could be ipational therapy. included additional detail 4 incident. According to the 0:30 a.m., the resident had he could leave the facility to go urger King. The nurse had told s not allowed to leave the resident had told nurse he build not leave. At 12:00 p.m., it locate the resident and after is search without results, the alled. An entry at 2:00 p.m. on Resident has his wander guard arm when he left the building." m. that evening indicated that rought R107 back to the facility sment in the hospital		23}			
		by going through a door into					
FORM CMS-2	567(02-99) Previous Version	is Obsolete Event ID: EFPC	12	Facility ID: 00	1260 If continua	tion sheet	Page 15 of 16

		AND HUMAN SERVICES					FORM	09/02/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONST			(X3) DATE COMI	E SURVEY PLETED
		245387	B. WING				F 08/2	⊰ 20/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET AI	DDRESS, CITY, STATE, ZI	P CODE		
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI COSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD	BE	(X5) COMPLETION DATE
{F 323}	this by review of the The LSW stated the the kitchen to the A believe they did che According to the LS work with occupation safe use of the whe planned to do that i	She said they had determined air hallway video recording. ere was a WanderGuard from L hallway, and added "I eck it and it was working." SW, R107 had now agreed to onal Therapy (OT) to ensure belchair for outings. "We had nitially (after the first 107] said he wouldn't do it did."	{F 3	23}				
FORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID: EFPC1	2	Facility ID: 00	0260	If continuati	on sheet I	Page 16 of 16

DEPARTMENT OF HEA	LTH AND HUMAN SERVIC	ES			APPROVED
CENTERS FOR MEDIC	ARE & MEDICAID SERVIC	ES		OMB NO.	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB	- D. ' '	TIPLE CONSTRUCTION	COM	E SURVEY IPLETED
	245387	B. WING			R 20/2014
NAME OF PROVIDER OR SUPP	LIER		STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
ST OLAF RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FU OR LSC IDENTIFYING INFORMATIC		PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 000} INITIAL COMM	IENTS	{F 0	00}		
of this departm determine com issued during a June 27, 2014.	rvey was conducted by survient on August 19 and 20, 2 pliance with Federal deficie a recertification survey exite -(iii), (c)(2) - (4)	014, to encies	25}		
SS=D INVESTIGATE					
been found gui mistreating res had a finding er registry concer of residents or and report any court of law aga indicate unfitne	st not employ individuals whilty of abusing, neglecting, o idents by a court of law; or land ntered into the State nurse ning abuse, neglect, mistreat misappropriation of their pro- knowledge it has of actions ainst an employee, which we set for service as a nurse aid aff to the State nurse aide re- thorities.	r have aide atment operty; by a rould de or			
involving mistre including injurie misappropriatio immediately to to other officials through establis	st ensure that all alleged vic eatment, neglect, or abuse, es of unknown source and on of resident property are r the administrator of the fac s in accordance with State I shed procedures (including nd certification agency).	eported ility and aw			
violations are th	st have evidence that all alle horoughly investigated, and potential abuse while the in progress.				
to the administ	all investigations must be re rator or his designated		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 09/02/2014

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

		AND HUMAN SERVICES			FORM	09/02/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245387	B. WING			R 20/2014
NAME OF I	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 225}	representative and with State law (inclu- certification agency incident, and if the a appropriate correction by: Based on interview facility failed to ensi- allegations of mistre agency in accordan- residents for whom (R107). Findings include: A vulnerable adult in 8/8/14, indicated the campus by an off d off duty environmer employee noted res Aldrich and Broadw (a large 4 lane street R107's wheelchair resident had to take back to the facility. Investigation report the facility premises had been called, an facility by paramedi taken him to a local Investigation docum provider had given versus electric pow assessment for saf	to other officials in accordance uding to the State survey and v) within 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced v and document review the ure timely reporting of eatment/neglect to the state nce with their policies for 4 of 5 allegations were reviewed ncident report for R107, dated e resident had been found off uty employee on 8/7/14. "An ntal services (EVS)-A sident [R107] at the corner of vay, 1.1 miles from the facility et)." The report indicated had run out of power, and the e public transportation to get	{F 225}			

Facility ID: 00260

If continuation sheet Page 2 of 16

		AND HUMAN SERVICES				FORM	09/02/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245387	B. WING				R 20/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	F RESIDENCE				912 FREMONT AVENUE NORTH /INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 225}	regarding the 8/7/14 administrator had b 8/7/14, the docume the SA had not bee incident of elopeme documented on an added to the Verific the 8/7/14 incident. to be determined w reported to either the timely manner. The nursing notes i regarding the 8/9/14 NN, on 8/9/14 at 10 asked the nurse if h to the bank and But the resident he was facility alone. The ru understood and wo the nurse could not initiating a grounds police had been cal 8/9/14 included: "R on but it did not alar An entry at 7:50 p.m paramedics had bro following an assess emergency room th On 8/19/14, at 2:57 worker (LSW) was thought the facility h SA) if no harm, but reported within 2 ho facility had reported administrator imme piece to report to the	4 elopement indicated the been notified of the incident on entation indicated a report to n made until 8/8/14. The ent from 8/9/14 was not clearly incident report, but had been cation of Investigation report for Consequently, it was not able hether the incident had been he administrator or the SA in a ncluded additional detail 4 incident. According to the 0:30 a.m., the resident had he could leave the facility to go rger King. The nurse had told a not allowed to leave the esident had told nurse he uld not leave. At 12:00 p.m., locate the resident and after search without results, the lled. An entry at 2:00 p.m. on Resident has his wander guard rm when he left the building." n. that evening indicated that ought R107 back to the facility sment in the hospital	{F 2	25}			

Facility ID: 00260

If continuation sheet Page 3 of 16

DEPART CENTE	RINTED: 09/02/2014 FORM APPROVED MB NO. 0938-0391						
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
245387		B. WING _			R 08/20/2014		
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF RESIDENCE					912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 225}	WanderGuard was 8/9/14 left facility by was recorded on vie WanderGuard from assisted living facili and it was working. working; R107 had had agreed to work (OT) for safe outing initially (after first el wouldn't do it again verified the elopem On 8/19/14, at 3:11 R107 had gotten ou administrator further reporting to the SA: at night, they wait for The Supervisors re (supervisors) have report to the SA); it' for practice." On 8/20/14, at 9:35 been trained to sep them and call the se administrator and d interventions used. report, but the DON report (to SA). The facility's Abuse 9/20/13, identified r maltreatment. The as: "the failure to p necessary to avoid under the section R policy included: " receives the report	put on. He eloped again on /ALF door and went out, it deo. There was a the kitchen to hallway (to ty), I believe they did check it The WanderGuard was his motorized wheelchair and with occupational Therapy gs. "We had planned to do that opement) but R107 said he , and then he did." LSW ents had been reported late. p.m. the administrator verified ut the door on 8/7/14. The er stated in regard to late : "if it's on the weekend or late or us to report it the next day. port it to management. The been educated (on how to 's just not what we have done a.m. LPN-A stated he had harate the resident's, protect upervisor, ADON, DON, and locument the event and LPN-A stated I do not do the and administrator do the Prevention Plan dated	{F 22	!5}			

Facility ID: 00260

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DEPART CENTER	RINTED: 09/02/2014 FORM APPROVED MB NO. 0938-0391						
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
245387		B. WING	i		R 08/20/2014		
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF RESIDENCE					2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 225} {F 226} SS=D	Administrator's des Department of Hea (common entry poin 483.13(c) DEVELO ABUSE/NEGLECT The facility must de policies and proced mistreatment, negle and misappropriatio This REQUIREMEN by: Based on interview facility failed to ens allegations of mistra agency in accordan allegations reviewe Findings include: The facility's Abuse 9/20/13, identified r maltreatment. The as: "the failure to p necessary to avoid under the section R policy included: "	A facility Administrator or the ignee, the Minnesota lith (SA) and the CEP ht) as describe" P/IMPLMENT, ETC POLICIES evelop and implement written lures that prohibit ect, and abuse of residents on of resident property.	{F 2	-	}		
	maltreatment to the Administrator's des	r immediately reporting the facility Administrator or the ignee, the Minnesota Ith (SA) and the CEP nt) as describe"					

If continuation sheet Page 5 of 16

DEPART CENTE	RINTED: 09/02/2014 FORM APPROVED MB NO. 0938-0391							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED R		
		245387	B. WING				20/2014	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
ST OLAF RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 226}	A vulnerable adult in 8/8/14, indicated the campus by an off d off duty environmer employee noted res Aldrich and Broadw (a large 4 lane stree R107's wheelchair l resident had to take back to the facility. Investigation report the facility premises had been called, ar facility by paramedi taken him to a local Investigation docum provider had given versus electric pow assessment for saf occupational therap regarding the 8/7/14 administrator had b 8/7/14, the docume the SA had not bee incident of elopeme documented, but ha Verification of Invest incident. Conseque determined whethe reported to either the timely manner.	ncident report for R107, dated e resident had been found off uty employee on 8/7/14. "An intal services (EVS)-A sident [R107] at the corner of vay, 1.1 miles from the facility et)." The report indicated had run out of power, and the e public transportation to get	{F 2:	26}				

Facility ID: 00260

If continuation sheet Page 6 of 16

DEPARTMENT OF HEALTH	PRINTED: 09/02/2014 FORM APPROVED MB NO. 0938-0391								
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		• •	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
245387		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						
PREFIX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE				
 piece to report to the further stated R107 WanderGuard was p 8/9/14 left facility by was recorded on vid WanderGuard from assisted living facilit and it was working; R107 had I had agreed to work (OT) for safe outing initially (after first eld wouldn't do it again, verified the elopemer On 8/19/14, at 3:11 R107 had gotten ou administrator further reporting to the SA: at night, they wait fo The Supervisors p (supervisors) have the report to the SA); it's for practice." On 8/20/14, at 9:35 been trained to sepathem and call the su administrator and do interventions used. I report, but the DON report (to SA). {F 280} {F 280} The resident has the 	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 (to SA). 483.20(d)(3), 483.10(k)(2) RIGHT TO		DEFICIENCY)						

Facility ID: 00260

If continuation sheet Page 7 of 16

		AND HUMAN SERVICES				FORM	09/02/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED R	
		245387	B. WING _			08/20/2014	
NAME OF F	PROVIDER OR SUPPLIER	-		ST	FREET ADDRESS, CITY, STATE, ZIP CODE	-	
ST OLAF	RESIDENCE				012 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 280}	participate in planni changes in care and A comprehensive car within 7 days after t comprehensive ass interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p the resident, the resi legal representative	ing care and treatment or	{F 28	;0}			
	by: Based on observat review, the facility fa 1 of 3 residents (R4 accidents/supervision Findings include: On 8/19/14, at 12:3 seated on her where table. R45 was cryin told the surveyor sh up since 5:00 a.m. a When asked R45 v lunch and stated sh wanted to go sleep.	NT is not met as evidenced tion, interview and document ailed to revise the care plan for 45) reviewed for on including suicidal ideation. (a3 p.m. R45 was observed elchair (w/c) at the dining room ng loudly. When asked, R45 he was tired as she had been and wanted to go to sleep. refied she had not eaten her he was not hungry but just . R45 was observed to say d tears from her cheeks and					

Facility ID: 00260

If continuation sheet Page 8 of 16

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/02/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245387	B. WING				R 20/2014
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 280}	identified diagnoses disturbance, end st dementia persisting immunodeficiency v A Resident Incident (1:00 p.m.) included through the southw wheelchair (w/c) (w resident stated, 'Am minute checks initia applied. Daughter of encouraged to call Root cause indicate when family visits d transportation and of was encouraged to feelings of lonelines agreement with the Physician Orders 8. WanderGuard to rig WanderGuard proto A physician's order had been started or 50 milligrams (mg) for major depression Although the reside 7/16/14, identified a goal included, "Will feeling down, depre- Interventions includ ordered encourage feelings, observe for depression includin	nission Record, dated 1/13/14, s of depression, sleep age renal disease (ESRD), g alcohol induced and human virus (HIV). Report dated 8/9/14, 1300 d, "R45 was noted to try to go est stairway with her hile sitting on w/c) when asked n trying to kill myself.' 15 ated and WanderGuard called and R45 was family to decrease loneliness. ed increased depressive mood ecreased (son did not have daughter was ill). Resident phone children when she had ss. Children were in plan." /9/14, included the use of a ght wrist and to utilize the bool for monitoring. dated 8/11/14, indicated R45 n Zoloft (an anti-depressant) by mouth every morning (AM) in.	{F 2	80}			

Facility ID: 00260

If continuation sheet Page 9 of 16

		AND HUMAN SERVICES			FORM	09/02/2014 APPROVED 0938-0391	
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COM	(X3) DATE SURVEY COMPLETED	
		245387	B. WING		R 08/20/2014		
NAME OF	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE			
ST OLAF	FRESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
{F 280}	treat primary mood care plan had not b of the WanderGuar the resident's suicid On 8/19/14, at 1:27 (DON) verified the s WanderGuard had plan or the Team As On 8/19/14, at 3:04 WanderGuard inter added to the care p just talked to the lic and had told her "W just told her that the brought to the daily sure everything is d On 8/19/14, at 3:15 interviewed and acl was supposed to ha plan after the suicid through the entire of WanderGuard had plan, so she added problem area of "m When interviewed on nursing assistant (N R45 for the shift, sta why R45 had the W residents have a wa wander." On 8/19/14, at 3:45 why R45 had a Wan did not know and to	disorder and depression. The been revised to include the use rd, or the concern related to dal ideations. 7 p.m. director of nursing suicidal ideation and use of a not been added to the care ssignment sheet. 9 p.m. DON acknowledged the rvention should have been blan and further stated she had censed social worker (LSW) Ve were dropping the ball. I e chart and the report will be r stand up and this will make done right there then." 5 p.m. the LSW was knowledged the WanderGuard ave been added to the care dal ideation. The LSW looked care plan and verified the not been added to the care it at that time under the	{F 280}				

Facility ID: 00260

If continuation sheet Page 10 of 16

		AND HUMAN SERVICES			FORM	09/02/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245387	B. WING		R 08/20/2014	
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE			912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 280}	"Yes we get rotated got done working w NA-B also verified t all the staff can help On 8/19/14, at 3:47 aware why R45 had practical nurse (LPI ideations and that it the WanderGuard t attempt to get throu	orked with R45 NA-B stated, d every two weeks and I just with her this last weekend." that when working on the floor p any of the residents. Y p.m. when asked if she was d a WanderGuard on, licensed N)-B stated R45 had suicidal t had been decided to put on to alert staff if she would ugh the (stairway) door.	{F 280}			
{F 323} SS=D	HAZARDS/SUPER The facility must en environment remain as is possible; and adequate supervision prevent accidents. This REQUIREMENT by: Based on observator review, the facility for suicidal ideation; ar adequate supervision		{F 323}			
	On 8/19/14, at 12:3	3 p.m. R45 was observed				

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		AND HUMAN SERVICES				FORM	09/02/2014 APPROVED 0938-0391	
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COM	(X3) DATE SURVEY COMPLETED	
		245387	B. WING			R 08/20/2014		
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ST OLA	FRESIDENCE				912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
{F 323}	seated on her whee table. R45 was cryin told the surveyor sh up since 5:00 a.m. When asked R45 v lunch and stated sh wanted to go sleep, this while she wiped wiped her nose. R45's Resident Adr identified diagnoses disturbance, end st dementia persisting immunodeficiency v A Resident Incident (1:00 p.m.) included through the southw wheelchair (w/c) (w resident stated, 'Am minute checks initia applied. Daughter of encouraged to call Root cause indicate when family visits d transportation and of was encouraged to feelings of lonelines agreement with the Physician Orders 8, WanderGuard proto A physician's order had been started of	elchair (w/c) at the dining room ng loudly. When asked, R45 he was tired as she had been and wanted to go to sleep. verfied she had not eaten her he was not hungry but just . R45 was observed to say d tears from her cheeks and mission Record, dated 1/13/14, s of depression, sleep rage renal disease (ESRD), g alcohol induced and human virus (HIV). t Report dated 8/9/14, 1300 d, "R45 was noted to try to go vest stairway with her while sitting on w/c) when asked n trying to kill myself.' 15 ated and WanderGuard called and R45 was family to decrease loneliness. ed increased depressive mood decreased (son did not have daughter was ill). Resident ophone children when she had ss. Children were in e plan." /9/14, included the use of a ght wrist and to utilize the ocol for monitoring. dated 8/11/14, indicated R45 n Zoloft (an anti-depressant) by mouth every morning (AM)	{F 32	23}				

If continuation sheet Page 12 of 16

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	09/02/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245387	B. WING			R 08/20/2014	
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLA	F RESIDENCE				912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 323}	Continued From pa	age 12	{F 32	23}			
	7/16/14, identified a goal included, "Will feeling down, depre- Interventions includ ordered encourage feelings, observe for depression includin loss of appetite. Inter- treat primary mood care plan had not b of the WanderGuar the resident's suicion On 8/19/14, at 1:27 (DON) verified the s WanderGuard had plan or the Team As On 8/19/14, at 3:04 WanderGuard inter- added to the care p just talked to the lic and had told her "W just told her that the brought to the daily sure everything is d On 8/19/14, at 3:15 interviewed and act was supposed to ha plan after the suicion through the entire of WanderGuard had plan, so she added problem area of "m	ded, administer medications as ge resident to verbalize or signs and symptoms of ng tearfulness, hopelessness, terventions identified included: I disorder and depression. The been revised to include the use rd, or the concern related to dal ideations. 7 p.m. director of nursing suicidal ideation and use of a not been added to the care ssignment sheet. 4 p.m. DON acknowledged the rvention should have been blan and further stated she had censed social worker (LSW) Ve were dropping the ball. I e chart and the report will be y stand up and this will make done right there then." 5 p.m. the LSW was knowledged the WanderGuard ave been added to the care dal ideation. The LSW looked care plan and verified the not been added to the care I it at that time under the					

		AND HUMAN SERVICES				FORM	09/02/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245387	B. WING				R 20/2014
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
				2	912 FREMONT AVENUE NORTH		
ST OLAF	RESIDENCE			N	/INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 323}	nursing assistant (N R45 for the shift, st why R45 had the W residents have a wa wander." On 8/19/14, at 3:45 why R45 had a Wa did not know and to out from one of the asked if she had wa "Yes we get rotated got done working w NA-B also verified t all the staff can help On 8/19/14, at 3:47 aware why R45 had practical nurse (LPI ideations and that if the WanderGuard t attempt to get throu According to a vuln R107, dated 8/8/14 off campus by an o The report included services (EVS)-A e at the corner of Alc from the facility (a I indicated R107's wi power, and the resi transportation to get Verification of Inves resident had left the 8/9/14, the police h returned to the facili police had taken hit	age 13 NA)-A, who was assigned to ated she was not sure exactly /anderGuard, "Usually when ander guard it's because they be p.m. when asked if she knew nderGuard, NA-B stated she old the surveyor she could find nurses at the desk. When orked with R45 NA-B stated, l every two weeks and I just with her this last weekend." that when working on the floor p any of the residents. T p.m. when asked if she was d a WanderGuard on, licensed N)-B stated R45 had suicidal t had been decided to put on to alert staff if she would ugh the (stairway) door. erable adult incident report for , the resident had been found ff duty employee on 8/7/14. I, "An off duty environmental mployee noted resident [R107] drich and Broadway, 1.1 miles arge 4 lane street)." The report heelchair had run out of dent had to take public et back to the facility. The stigation report indicated the e facility premises again on ad been called, and R107 was lity by paramedics because the m to a local hospital. The stigation document further	{F 3	23}			

Facility ID: 00260

If continuation sheet Page 14 of 16

		AND HUMAN SERVICES				FORM	09/02/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245387	B. WING				R 20/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				912 FREMONT AVENUE NORTH /INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 323}	wheelchair versus e until an assessment conducted by occup The nursing notes if regarding the 8/9/14 NN, on 8/9/14 at 10 asked the nurse if h to the bank and But the resident he was facility alone. The re- understood and wo the nurse could not initiating a grounds police had been cal 8/9/14 included: "R on but it did not ala An entry at 7:50 p.r paramedics had bro following an assess emergency room the Although the reside updated on 8/8/14 to Wanderguard for up seeking behaviors, able to exit the builit the alarm sounding no intervention cha motorized wheelcha charged. On 8/19/14, at 2:57 worker (LSW) was had eloped on 8/7/ WanderGuard had had eloped again o	der had given R107 a manual electric powered wheelchair at for safety could be pational therapy. Included additional detail 4 incident. According to the 0:30 a.m., the resident had ne could leave the facility to go rger King. The nurse had told a not allowed to leave the esident had told nurse he uld not leave. At 12:00 p.m., clocate the resident and after search without results, the lled. An entry at 2:00 p.m. on Resident has his wander guard rm when he left the building." n. that evening indicated that pught R107 back to the facility senent in the hospital	{F 3	23}			

Facility ID: 00260

If continuation sheet Page 15 of 16

		AND HUMAN SERVICES				FORM	09/02/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245387	B. WING	i			२ 20/2014
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 323}	this by review of the The LSW stated the the kitchen to the A believe they did che According to the LS work with occupation safe use of the whe planned to do that in	She said they had determined eir hallway video recording. ere was a WanderGuard from L hallway, and added "I eck it and it was working." SW, R107 had now agreed to onal Therapy (OT) to ensure eelchair for outings. "We had initially (after the first 107] said he wouldn't do it	{F 3.	23}			

Facility ID: 00260

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245387	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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		(Y5) Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
	50455	Correction Complete	d	50044		Correction Completed		ID Drofin	50240		Correction Completed 08/08/2014
	483.10(b)(4)	08/08/201	Reg. #	F0244 483.15(c)(6)		08/08/2014			483.15(e)(1)		_
ID Prefix Reg. #		Correctior Complete 08/08/201	d 4 ID Prefix Reg. #	_F0250 483.15(g)(1)		Correction Completed 08/08/2014		ID Prefix Reg. #			Correction Completed 08/08/2014
ID Prefix Reg. # LSC	483.20(k)(3)(d ID Prefix	F0283 483.20(l)(1)&(2)		Correction Completed 08/08/2014		ID Prefix Reg. # LSC	F0309 483.25		Correction Completed 08/08/2014
	F0312 483.25(a)(3)	Correctior Complete 08/08/201	d 4 ID Prefix Reg. #	F0329 483.25(I)		Correction Completed 08/01/2014		ID Prefix Reg. # LSC	483.60(b), (d)	, (e)	Correction Completed 08/08/2014
ID Prefix Reg. # LSC	<u>F0441</u> 483.65	Correctior Complete 08/01/201	d 4 ID Prefix Reg. #	F0514 483.75(I)(1)		Correction Completed 08/08/2014					
State Agen	-	Reviewed By GD/AK Reviewed By	Date: 09/02/20 Date:	014 Signature Signature		•		30	951	Date: 08/22 Date:	2/2014
Followup	to Survey Cor 6/27/	npleted on: /2014		Check for any Uncorrecte					Summary of the Facility?	YES	NO

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245387	(Y2) Multiple Construction A. Building B. Wing 01 - MA	(Y3) Date of Revisit 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	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 08/08/2014	ID Prefix		Correction Completed	ID Prefix		Correction Completed
	NFPA 101 K0020							
Reg. #		Correction Completed	Rea. #		Correction Completed	Dog #		
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed	Reg. #		Correction Completed
ID Prefix Reg. # LSC		Correction Completed			Correction Completed	ID Prefix Reg. # LSC		
Reg. #			D "			Dag. #		
Reviewed E	By Reviewed	Ву	Date:	Signature of Sur	veyor:		Date	:
State Agen	cy PS/AK		09/02/2014			281	20 08/	11/2014
Reviewed E CMS RO	By Reviewed	Ву	Date:	Signature of Sur	veyor:		Date	:
Followup t	o Survey Completed or 6/30/2014	1:	0	Check for any Uncor Uncorrected Defic				S NO

DEPARTMENT OF H						DICARE & MEDICAID SERVICES
					AND TRANSMITTAL TE SURVEY AGENCY	ID: EFPC
					IE SURVEI AGENCI	Facility ID: 00260
1. MEDICARE/MEDICAID I (L1) 245387	PROVIDER NO.	3. NAME AND AI (L3) ST OLAF R				4. TYPE OF ACTION: $2(L8)$
2.STATE VENDOR OR MED	DICAID NO.	(L4) 2912 FREM	ONT AVENUI	E NORTH		1. Initial2. Recertification3. Termination4. CHOW
(L2) 492242500		(L5) MINNEAPOLIS, MN			(L6) 55411	5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHAN	NGE OF OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEG	ORY	<u>02</u> (L7)	8. Full Survey After Complaint
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	6. Fun Survey After Complaint
 6. DATE OF SURVEY 8. ACCREDITATION STATE 	06/26/2014 (L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/III	14 CORF D 15 ASC	FISCAL YEAR ENDING DATE: (L35)
	US: (L10)	03 SNF/NF/Distillet	07 A-Kay 08 OPT/SP	12 RHC	16 HOSPICE	09/30
2 AOA	3 Other					
11LTC PERIOD OF CERTIF	FICATION	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		X A. In Complia			And/Or Approved Waivers Of	
To (b):			equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds	80 (L18)	<u>X</u> 1. A	cceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code	
13.Total Certified Beds	80 (L17)	B. Not in Con Requirem	npliance with Prog ents and/or Appli	gram ed Waivers:	* Code: B	(L12)
14. LTC CERTIFIED BED BI	REAKDOWN				15. FACILITY MEETS	
18 SNF 18/	/19 SNF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
	80					
(L37)	(L38) (L39)	(L42)	(L43)			
16. STATE SURVEY AGEN	CY REMARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION	DATE):		
17. SURVEYOR SIGNATUR	RE	Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Becky Wong, HFE	E NE II		07/30/2014	(L19)	Anne Kleppe, Enforce	ment Specialist 08/26/2014 (L20)
	PART II - TO BE	COMPLETED I	BY HCFA RE	EGIONA	L OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF I	ELIGIBILITY		IPLIANCE WITH	H CIVIL		ncial Solvency (HCFA-2572)
1. Facility is El	igible to Participate	RIGI	ITS ACT:		 Ownership/Control Both of the Above 	ol Interest Disclosure Stmt (HCFA-1513)
2. Facility is no	ot Eligible (L21)					
	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	6 DATE	ENDING DA	ТЕ	VOLUNTARY 00	INVOLUNTARY
12/01/1986					01-Merger, Closure 02-Dissatisfaction W/ Reimburse	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction w/ Reimburse 03-Risk of Involuntary Terminatio	······································
25. LTC EXTENSION DAT					04-Other Reason for Withdrawal	07-Provider Status Change
	A. Suspension	n of Admissions:	(L44)			00-Active
((L27) B. Rescind Su	spension Date:	~ /			
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS	
		03001			Dested 09/27/2014	
	(L28)			(L31)	Posted 08/27/2014 (
	520 22	DETEDMOLATION		DATE		
31. RO RECEIPT OF CMS-1	559 <u>32</u>	. DETERMINATION	UF APPROVAL	DAIE		
	(L32)			(L33)	DETERMINATION APPI	ROVAL



Protecting, Maintaining and Improving the Health of Minnesotans 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; <u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

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

St Olaf Residence July 15, 2014 Page 4

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

St Olaf Residence July 15, 2014 Page 5

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.

St Olaf Residence July 15, 2014 Page 6

Sincerely,

Ame Klegge

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

Enclosure

cc: Licensing and Certification File

officer allocation of the second	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		E SURVEY PLETED
D PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG		1
		245387	B. WING	······································	1	5/27/14 pe 26/2014
IAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CO	DE	
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	TS	F(J. J.	
	as your allegation of Department's acce enrolled in ePOC, at the bottom of the form. Your electro	of correction (POC) will serve of compliance upon the optance. Because you are your signature is not required e first page of the CMS-2567 nic submission of the POC will ation of compliance.		Ruces.	24-17 Z	
F 155 SS=D	Upon receipt of an on-site revisit of yo validate that subst regulations has be your verification. 483.10(b)(4) RiGH	in acceptable electronic POC, an your facility may be conducted to stantial compliance with the been attained in accordance with HT TO REFUSE; FORMULATE		F 155- D Corrective Action: A. R71 has been educa risk/benefit of consu and missing medicat treatments while bei LOA. B. R71 has been offered	ming alcohol ions and ng out on d Chemical	
	refuse to participa and to formulate a specified in parage	he right to refuse treatment, to te in experimental research, n advance directive as raph (8) of this section. comply with the requirements rt I of part 489 of this chapter	26-0	C. The care plan of R 7 updated to include g interventions to min from missing medica becoming intoxicate LOA.	'l has been oals and imize her risks ations and	
	related to maintain procedures regard requirements inclu provide written inf concerning the rig or surgical treatme	hing written policies and ding advance directives. These ude provisions to inform and ormation to all adult residents ht to accept or refuse medical ent and, at the individual's an advance directive. This	NCOL	Corrective Action as it applie Residents: A. The Care Plan policy reviewed and revised appropriate. B. The Alcohol Consur	y has been d as	
	includes a written	description of the facility's ent advance directives and		has been reviewed a appropriate. Date of Completion: August	5	
		A. M. H.		Recurrence will be prevented	Hby:	(X6) DATE,

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

FORM CMS-2567(02-99) Previous Versions Obsolete

1 Facility ID: 00260

TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED			
		245387	B. WING _						
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETK DATE			
F 155	This REQUIREME by: Based on observa review, the facility it to the risk and ben missing physician- treatments for 1 of were reviewed. Findings include: R71 was consumir absence (LOAs) fr under-treated pain medication, blood treatments due to reported and evide regarding staff disc the risk/benefit rati and not following p R71 was observed 11:55 a.m. As the arm, she reported out of 10" on her le neck, left shoulder stated, "My head is serious headache week." R71 said sl with the physician following day at 7:: mid-abdominal pai in her head and ne addition, her abdo couple of days and nurse. On 6/27/14 had neuropathy ar	NT is not met as evidenced tion, interview and document failed to provide education as efit of consuming alcohol and ordered medications and 2 residents (R71) whose LOAs and missed prescribed sugar testing, and breathing her absences. The resident ence in the record was lacking cussion with the resident as to o of both alcohol consumption	F 15	 A. Staff education was p the revised Alcohol a policy at the All Staff completed the week of B. Daily audits x 2 weel weekly x 4 weeks the months. Findings wi to the QAPI/QA Con review and follow up recommendations. T Committee will deter audits may be discon Responsible Person: DON and Administrator or Do 	nd Care Plan f meetings of 7-28-14. is, then in monthly x 3 ll be reported imittee for the QAPI/QA mine when the tinued.				

Event ID: EFPC11

Facility ID: 00260

If continuation sheet Page 2 of 101

		AND HUMAN SERVICES				FORM	07/15/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		e survey IPleted
		245387	B. WING	i			
NAME OF F	PROVIDER OR SUPPLIER		d		TREET ADDRESS, CITY, STATE, ZIP CO	DE	5/27/14
ST OLAF	RESIDENCE	·			912 FREMONT AVENUE NORTH		0/2//14
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F 155	pain radiated on the Physician progress revealed diagnoses notes revealed the facility after drinking intoxicated and/or v on 4/24/14, 5/6/14, Although R71's phy Neurontin 8:00 a.m Tylenol every 6 hou including at night fo Robaxin every 8 hot the 6/14 Medication showed R71 did no medications eight t due to LOAs. LSW-A explained of she had only worke facility, and was un R71's drinking had meetings or in com LSW-A thought R7 but she did not ask was unable to find been offered chem treatment or couns At 9:21 a.m. LPN- nearly every night, were aware when t and her medication	an her left foot was touched e entire left side of her body. notes for R71 dated 5/27/14, including alcohol abuse. IDT resident had returned to the g alcohol, becoming /ery intoxicated while on LOA 5/8/14, 6/9/14, and 6/12/14. visician orders included ., 12:00 p.m. and 8:00 p.m., urs as needed for pain, or gout pain, as well as burs as needed for pain in feet, n Administration Record (MAR) treceive her 8:00 p.m. imes including Tylenol 500 mg on 6/26/14, at 8:30 a.m. that ed for a couple weeks at the aware R71 had been drinking. never come up in IDT versations with the resident. 1 seemed rather frail and ill, her about her LOAs. LSW-A any documentation R71 had ical dependency (CD) eling. A stated R71 went out drinking and returned "bubbly." Staff he resident had been drinking, is were then held and the	F	155			
		Marganian		F	clity ID: 00260	ntinuation sheet	Deep 0 =(110

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) NAME OF PROVIDER OR SUPPLIER 245387 B. WING	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ST OLAF RESIDENCE 2912 FREMONT AVENUE NORTH (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	DATE SURVEY COMPLETED
ST OLAF RESIDENCE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
ST OLAF RESIDENCE MINNEAPOLIS, MN 55411 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIAT	
	(X5) COMPLETION DATE
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's orders specified alcoholic beverages were not allowed. At 12:50 p.m. R71 was standing near the elevator and announced, I'm leavingchecking on an apartment." At 1:31 p.m. LPN-A stated regarding R71, "That's our party gif. Everybody knows she likes to party." LPN-A stated R71 if mearly 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:	

STATEMEN	OF DEFICIENCIES OF CORRECTION	A MEDICAID SERVICES		E CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
		245387	B. WING			
	PROVIDER OR SUPPLIER		29	TREET ADDRESS, CITY, STATE, ZIP COD 912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		brow
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMFLETIO DATE
F 155		-	F 155			
F 225 SS=D	resident had intact include the problem and missing medic was there a goal si minimize risks to the The facility's Care noted, "The care p pre-admission/inta and periodic basis The resident and/c with the entire care planning process." 483.13(c)(1)(ii)-(iii) INVESTIGATE/RE ALLEGATIONS/IN The facility must n been found guilty of mistreating residen had a finding enter registry concerning of residents or mis and report any kno court of law agains indicate unfitness other facility staff to or licensing author The facility must e involving mistreatr including injuries of misappropriation of immediately to the to other officials in	Planning IDT policy dated 5/11 lanning process begins during ke and continues on a regular throughout the resident stay. or their representative, along a team is involved in the care , (c)(2) - (4) PORT DIVIDUALS of employ individuals who have of abusing, neglecting, or hts by a court of law; or have red into the State nurse aide g abuse, neglect, mistreatment appropriation of their property; weldge it has of actions by a st an employee, which would for service as a nurse aide or o the State nurse aide registry		 F 225- D Corrective Action: A. R10 and R 71 have b to Psychiatric Service of both residents has I B. OHFC was notified o on 6/24/14. C. The Social Services I been visiting with R1 assure safety. D. LPN-J was terminated of reporting abuse at i incident. E. The Investigative Rep was submitted late to the 2567 statement. F. The Investigative Rep was submitted late to the 2567 statement. Corrective Actions as it applie Residents:	s. The safety been assured f the incident Director has 0 and R71 to d due to lack the time of th port from R 9 OHFC as pe port from R 7 OHFC as pe	e 8

ENTER	<u>AS FOR MEDICARE</u>	& MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	• •	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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T OLAP	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	
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F 225	State survey and c The facility must haviolations are thoroprevent further pote investigation is in p The results of all in to the administrato representative and with State law (incl certification agency incident, and if the appropriate correct This REQUIREME by: Based on interview facility failed to imm for 1 of 4 residents failed to file the inw manner for 2 of 4 r (R98, R76) review Findings include: R71	ertification agency). ave evidence that all alleged bughly investigated, and must ential abuse while the progress.	F 2:	 A. The Abuse Prevention 1 reviewed. Facility staff were re-educated about Prevention Plan and the of Immediate Reporting They were also educate requirement of filing In Reports within 5 worki the Initial Report to OF education occurred at th Meetings completed th 28-14. Date of Completion August 8, Recurrence will be prevented by A. Facility Staff received related to the Abuse Pr Plan, the definition of 1 Reporting and the Requ file Investigative Repo working days of the Im to OHFC at the All Sta completed the week of B. Daily audits x 2 weeks weekly x 4 weeks then months. Findings will 	f members the Abuse e definition g to OHFC. d on the investigative ng days of HFC. The he All Staff e week of 7- 2014 ceducation evention mmediate direment to rts within 5 itial Report ff Meetings 7-28-14. , then monthly x 3
	1:03 p.m. At 3:55 p new incident had b a recent resident a slapped by anothe	ports for R71 on 6/24/14, at o.m. the administrator stated a been reported to him regarding altercation with R71 being r resident and that the nurse old the supervisor or him about ation on 6/13/14. R10 had been struck four times		to the QAPI/QA Comm review and follow up recommendations. The Committee will determ audits may be discontin Responsible Person: Administr Designee	e QAPI/QA ine when the nued.

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ST OLAP					912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411			
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F 225	in the face by R71 social services dire visits to both reside days to assure the referred to psychia consultation. A poli 6/24/14. The admin R10 and R71's saf The report stated II (LPN)-J had been abuse. It also state terminate employe suspected and/or a educated on 12/20 the Vulnerable Adu procedures. The report stated I started re-education reporting policy an not be allowed to v received education On 6/24/14, at 3:55 the LPN-J who had not reported the all reporting. The admin report to the Office (OHFC) for the 6/1 2:35 p.m. R98 On 1/29/14, R98 r bands and a police	on 6/13/14. It also stated the ector (SSD) would perform ents involved for the next two ir safety. Both residents were tric services 6/24/14, for ice report was also filed histrator and the SSD assured ety. icensed practical nurse suspended for failure to report ed that it was facility practice to es for failure to report abuse. LPN-J had been //13, and again in May 2014 on ult (VA) policies and Human Resources (HR) had on to all staff of the abuse d procedure and staff would work a shift until they had	F	225				
	had mostly likely t	nvestigation that R98's sister aken the rings to sell for drugs						(1919) - Marine Marine
FORM CMS-2	2567(02-99) Previous Version	ns Obsolete Event ID: EFPC	11	Fa	cility ID: 00260 If continu	ation sh	ieet Pa	ge 7 of 10 ⁻

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F 225	submitted untimely	age 7 The investigation report was / to OHFC on 3/13/14, 38 days le time frame for reporting.	F 225			
	report was submitt that allegations of The investigation r	d fallen on 2/14/14. Incident ted on 2/14/14. It was found a fall were not substantiated. eport was submitted untimely 14, 22 days after the acceptable orting.				
F 226 SS=D	and their Vulnerab procedure states t be reported IMME as soon as possib knowledge that the received. The polii Vulnerable Adult Ir must be complete incident. And the if must be reported t health (MDH) and Administrator's de of the initial report 483.13(c) DEVEL0 ABUSE/NEGLEC The facility must d policies and proce	OP/IMPLMENT T, ETC POLICIES levelop and implement written dures that prohibit	F 226			
÷	and misappropriat	lect, and abuse of residents ion of resident property. ENT is not met as evidenced				

TATEMEN	T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.1		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
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ST OLA	F RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	
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F 226	by: The facility failed to immediate reporting administrator and s residents (R71). In timely submit intern SA for 2 of 4 reside for abuse prohibitio Findings include: The facility Abuse F and their Vulnerabil procedure states th be reported IMMED as soon as possible knowledge that the received. The polic Vulnerable Adult In must be completed incident. And the in must be reported to health (MDH) and f Administrator's des of the initial report. R71 The administrator v incidents and/or rej 1:03 p.m. At 3:55 p new incident had b a recent resident a slapped by another working had not tol the resident alterca	o operationalize the policies for g of resident abuse to tate agency (SA) for 1 of 4 addition, the facility failed to hal investigation reports to the ents (R98, R76) when reviewed n. Prevention Plan dated 9/20/13, e Adult Law/Abuse Reporting hat suspected abuse or abuse DIATELY. "Immediately" means e from the time initial incident occurred has been y also states that the ternal investigation Procedure within five days of the ternal investigation results the Minnesota Department of facility Administrator or signee within five working days was asked to provide any ports for R71 on 6/24/14, at on, the administrator stated a een reported to him regarding itercation with R71 being resident and that the nurse d the supervisor or him about	F 2	 F 226-D Corrective Action: G. R10 and R 71 have bee to Psychiatric Services. of both residents has bee H. OHFC was notified of the on 6/24/14. I. The Social Services Diffusion been visiting with R10 assure safety. J. LPN-J was terminated confrequenting abuse at the incident. K. The Investigative Report was submitted late to O the 2567 statement. L. The Investigative Report was submitted late to O the 2567 statement. Corrective Actions as it applies the Residents: B. The Abuse Prevention I reviewed. Facility staff were re-educated about Prevention Plan and the of Immediate Reporting They were also educate requirement of filing Im Reports within 5 working the Initial Report to OH education occurred at the Meetings completed the 28-14. 	The safety en assured he incident rector has und R71 to lue to lack e time of the t from R 98 HFC as per t from R 76 HFC as per o other Plan was members the Abuse definition to OHFC. d on the vestigative og days of FC. The the All Staff

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F 226 F 226 SS=D	visits to both reside days to assure thei referred to psychial consultation. A poli 6/24/14. The admir R10 and R71's safe On 6/24/14, at 3:55 the LPN-J who had not reported the ab reporting. The adm report to the Office (OHFC) for the 6/1 days later), at 2:35 R98 On 1/29/14, R98 re bands and a police was submitted to th determined after in had mostly likely ta after visiting R98. T submitted untimely after the acceptable R76 R76 stated that she incident report was found that allegatio substantiated. The submitted untimely after the acceptable 483,15(c)(6) LISTE GRIEVANCE/RECO When a resident of must listen to the v	ents involved for the next two r safety. Both residents were tric services 6/24/14, for ce report was also filed histrator and the SSD assured ety. 6 p.m. the administrator stated worked on 6/13/14, and had use would be fired for lack of inistrator submitted the first of Health Facility Complaints 3/14, incident on 6/24/14 (11 p.m. eported missing her wedding report was filed. The incident he OHFC on 1/29/14. It was vestigation that R98's sister ken the rings to sell for drugs The investigation report was to OHFC on 3/13/14, 38 days e time frame for reporting. e had fallen on 2/14/14. It was ns of a fall were not investigation report was to OHFC on 3/13/14, 22 days e time frame for reporting. EN/ACT ON GROUP	F 2 F 2	Date of Recum C	of Completion: August 8, 2 rence will be prevented by 2. Facility Staff received related to the Abuse Pre Plan, the definition of h Reporting and the Requ file Investigative Repor working days of the Init to OHFC at the All Staf completed the week of 2. Random daily audits x 2 then weekly x 4 weeks monthly x 3 months. Fi be reported to the QAPI Committee for review a up recommendations. T QAPI/QA Committee v determine when the aud discontinued.	educat evention irremed is with that Rec f Mee f Mee 7-28-1 2 weel then inding I/QA nd fol The vill lits ma	on iate nt to hin 5 port otings 14. ks, gs will llow ay be

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	245387 DF PROVIDER OR SUPPLIER AF RESIDENCE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 14 Continued From page 10 and families concerning proposed policy and operational decisions affecting resident care a life in the facility. This REQUIREMENT is not met as evidence by: Based on interview and document review, the facility failed to ensure prompt responses rela to grievances of missing laundry for 9 of 10 monthly resident council meeting minutes (September 2013 through June 2014) and nu statfing concerns for five of 10 monthly reside council meeting minutes (October 2013 throu May 2014). Findings include: Resident council meeting minutes from September 2013 through June 2014 were	245387	B. WING			
(X4) ID PREFIX	RESIDENCE SUMMARY STA (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	iD PREFIX	STREET ADDRESS, CITY, STATE, ZIP COL 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S)	ECTION HOULD BE	(X5) COMPLETIO
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F 244	and families concer operational decision life in the facility. This REQUIREMEID by: Based on interview facility failed to ensite to grievances of mi monthly resident co (September 2013 this staffing concerns for council meeting mi May 2014). Findings include: Resident council m September 2013 the reviewed and reveat Review of the reside dated September 1 related to missing 1 minutes did not refil responded to the co addressing the ider Review of the reside dated October 10, 3 related to nursing a facility. The old bus indicated "there wa minutes did not refil responded to the co	Aning proposed policy and ns affecting resident care and NT is not met as evidenced and document review, the ure prompt responses related ssing laundry for 9 of 10 puncil meeting minutes hrough June 2014) and nurse or five of 10 monthly resident nutes (October 2013 through eeting minutes from rough June 2014 were aled the following: ent council meeting minutes 9, 2013, revealed concerns aundry within the facility. The ect if the facility had oncern or discussed a plan for	F 244	 F 244-D Corrective Action: A. Missing laundry, calnurse staffing conceraddressed at the Resimeeting. B. The follow up to the addressed in the min Resident Council meeting. B. The follow up to the addressed in the min Resident Council meeting. C. Bed and mattress requires a state of the Resident Council minutes. Corrective Actions as it applications application of the Resident Council minutes. Corrective Actions as it applications and the follow up is the Resident Council minutes. Corrective Actions as it applications. A. The Missing Items and Grievance Policy has be and revised. B. The Resident Council previewed and revised. C. The Resident Council previewed and revised. C. The Resident Council previewed and revised. Date of Completion: August Recurrence will be prevented A. Facility staff receive related to the Complipic, the Complaint/Grievance Items form, the Resident form, the Resident form has been revised. 	ns have been ident Council se concerns is utes from the etting. uests have at this meeting ddressed in meeting lies to other r Resident en reviewed olicy has been lissing Items 8, 2014 by: d education aint/Grievance e/Missing dent Council	3

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F 244	dated November 1 of the minutes indid business." The min facility had respond discussed a plan for the previous month clothing). Review of the resid dated December 1 related to nursing a facility. The old bus indicated "there wa minutes did not ref responded to the c for addressing the Review of the resid dated January 9, 2 to missing clothing written in the old bus The minutes did not responded to the c addressing the issu Review of the resid dated February 13, related to call lights timely manner and facility. The old bus indicated "there wa minutes did not ref responded to the c for addressing the Review of the resid dated February 13, related to call lights timely manner and facility. The old bus indicated "there wa minutes did not ref responded to the c for addressing the	dent council meeting minutes 4, 2013, old business section cated "there was no old butes did not reflect if the ded to the concerns or or addressing the issues from a (nursing and missing dent council meeting minutes 2, 2013, revealed concerns and missing clothing within the siness section of the minutes is no old business." The lect if the facility had oncerns or discussed a plan identified issues. dent council meeting minutes 014, revealed concerns related within the facility. Nothing was usiness section of the minutes. ot reflect if the facility had oncern or discussed a plan for ue. dent council meeting minutes a not being answered in a missing clothing within the siness section of the minutes as no old business." The lect if the facility had oncerns or discussed a plan	F 24	 44 Staff Meetings com of 7-28-14. B. Random daily audit then weekly x 4 we monthly x 3 months be reported to the Q Committee for revia up recommendation QAPI/QA Committ determine when the discontinued. Responsible Person: Admin Services Director, Activities or their Designee. 	s x 2 weeks, eks then S. Findings will API/QA ew and follow is. The ee will audits may be istrator, Social	

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F 244	manner and missir The old business s "there was no old b reflect if the facility concerns or discus issues. Review of the resid dated April 10, 201 minutes indicated from the previous reflect if the facility or discussed a pla Review of the resid dated May 8, 2014 a request for a new maintenance on a concerns and miss The old business s the clothing was s month. The minute had responded to plan for addressin Review of the resid dated June 12, 20 to missing clothing business section of request for a new but the mattress h did not reflect if th previous month ' s for addressing the During an interviet activities director of was registered du	ing clothing within the facility. section of the minutes indicated business." The minutes did not thad responded to the seed a plan for addressing the dent council meeting minutes 4, old business section of the the clothing was still missing month. The minutes did not thad responded to the concern n for addressing this issue. dent council meeting minutes t, revealed concerns related to w bed, a new mattress, n existing bed, nursing sing clothing within the facility. section of the minutes indicated till missing from the previous es did not reflect if the facility the concerns or discussed a g the issues. dent council meeting minutes 14, revealed concerns related g within the facility. The old of the minutes indicated the bed had not been addressed, ad been replaced. The minutes e facility had responded to the	F 24			

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F 244	council minutes an Response Form" a heads. AD stated s response form bac the response forms sometimes I just ve clothing you go dow them and most offe she had not followe departments to see shouldn't have put stated "the action r cracks, the last one probably haven't fo should." AD stated minutes for the qua assurance meeting During an interview AD stated she wer residents that regis August 2013 thru clothing and noted still missing or repl	d tape it on an "Action nd give it to the department she would typically get the k, but "I have not been giving s to the departments lately, erbally tell them, if it 's missing wn to the laundry and look for en they are found." AD stated ed up with any of the e if they addressed the issue, "I 'no old business' in there." AD response forms fell thru the e I got returned was in 2012, I she did summarize the arter and bring them to quality	F 244			
	administrator state resident council m interdisciplinary tea remember that a c address nursing co the AD had used th but lately I review t missing clothing, th services director (f Administrator state again we would no	v on 6/26/14, at 1:20 p.m., the d the AD will talk about eeting concerns at am meetings (IDT) and "I all light audit tool was used to oncerns." Administrator stated he response form in the past, " he meeting minutes and if it 's he AD or environmental ESD) will look for them. " The ed "unless the resident asks t know if it's been addressed, them on the grievance form				

Event ID: EFPC11

Facility ID: 00260

If continuation sheet Page 14 of 101

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F 244 F 246 SS=D	that they fill out. " During an interview ESD stated they de never gets an action the council meeting the AD or nursing a for lost items and S found, further station issue." A resident council requested but was unable to produce identify whether the addressed. 483.15(e)(1) REAS OF NEEDS/PREF A resident has the services in the fact accommodations of preferences, except the individual or ot endangered. This REQUIREME by: Based on observa- review, the facility (R83, R34) call light	w on 6/26/14, at 11:35 a.m. the o have a lost and found; he on response form but reviews g minutes. ESD stated laundry, aides come down here to look 80% of the missing items are ng "this has been an ongoing procedure policy was not provided. The facility was documentation that would e above grievances had been SONABLE ACCOMMODATION ERENCES right to reside and receive lity with reasonable of individual needs and ot when the health or safety of her residents would be ENT is not met as evidenced atton, interview and document failed to ensure 2 of 2 residents ints were readily accessible	F 2-			
	Findings include:	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SING CROSS-REFERENCED TO THE APP DEFICIENCY) F 244 (CROSS-REFERENCED TO THE APP DEFICIENCY) F 246 (CROSS-REFERENCED TO THE APP DEFICIENCY (CROSS-REFERENCED TO THE APP DEFICIENCY) F 246 (CROSS-REFERENCED TO THE APP DEFICIENCY (CROSS-REFERENCED TO THE APP (CROSS-REFERENC				

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	a. MEDICAID SERVICES OMB NO. 0538-0391 XI) PHOUTDERRUPPLENCUA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED 245387 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMIONT AVENUE NORTH MINNEAPOLIS, MN 55411 EMENT OF DEFICIENCIES MUST BE PRECEDED BYLUL DENTIFICATION INTERPROPHATION) D PREFX TAE STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMIONT AVENUE NORTH MINNEAPOLIS, MN 55411 EMENT OF DEFICIENCIES MUST BE PRECEDED BYLUL DENTIFICATION INFORMATION) D PREFX TAE PROVERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION BATOLD BE CROSS-REFERENCED TO THE APPROPHATE DEFICENCY) COMMETON DEFICIENCY ie 15 F 246 F 246-D Corrective Action as it applies to other Residents: A. The call lights of R83 and R34 have been placed within reach of the residents: a.m. R83 was again observed all light hanging on the wall a3. F 246 Corrective Action as it applies to other Residents: A set (MDS) dated 6/9/14, inctical light and ays. A. The Call Light policy has been revised to include that staff ensure the call light sare within reach of the residents: Date of Completion Agys. 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 weekty x 4 weeks then monthly x 3 monts. Findings will be reported to the QAPI/QA Committee for review and follow up recommendations. The QAPI/QA Committee will determine when the audits ma			
F 246	On 6/24/14, at 8:54 were observed han call light button. On 6/24/14, at 2:15 in bed which was lo call lights were obs not accessible for f On 6/26/14, at 3:15 lying in his bed with not accessible. R83's fall care plan to "Keep call light in R83's Minimum Da noted R83 to have of motion (ROM) o a wheelchair. The falls in the last 180 R34's call light was On 6/23/14, at 4:0° observed hanging across from reside reach. Resident sta when she needed On 6/27/14, during a.m. two call lights bedside pull table which reached over untw	a.m. R83's both call lights aging on the wall around the b.p.m. R83 was observed lying owered to the floor and both erved still hanging on the wall R83. b.p.m. R83 was again observed a call light hanging on the wall a dated 12/23/13, directed staff in reach at all times." ata Set (MDS) dated 6/9/14, functional limitations of range ne side of the body and utilized MDS further noted R83 had no days. a not kept at reach. I p.m. R34 call light was on the bedside pull table nt seated on the recliner not at arted she used the call light help. the environmental tour at 9:00 were observed on top of the by R34's foot of bed and R34 ng in her recliner across from a was not accessible. ESD isted the call lights and gave I lights. On 6/27/14, the		 Corrective Action: A. The call lights of R83 and R34 have been placed within reach the residents. Corrective Action as it applies to other Residents: A. The Call Light policy has been revised to include that staff ensithe call lights are within reach the resident when they are in the 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 meetic completed the week of 7-28-14 B. Daily audits x 2 weeks, then weekly x 4 weeks then monthly months. Findings will be report to the QAPI/QA Committee for review and follow up recommendations. The QAPI/Committee will determine whe audits may be discontinued. 	of ure of eeir mgs y x 3 rted r QA n the

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F 246	be at reach and ac R34's activities of o /rehabilitation care R34 with an alterat related to weaknes to ambulate safely.	d resident call light needed to cessible. Haily living functional plan dated 3/11/14, identified ion in mobility and locomotion s. The Goal was "Will continue " The care plan directed staff	F	246			
	functional limitation supervison and cur utilized a walker. T no falls in the last	6/4/14, noted R34 to have no as of range of motion, needed es for decision making, and he MDS further noted R34 had 80 days. However, R34 sistance to steady during					
	interim director of r "Resident's call ligh	on 6/27/14, at 11:53 a.m. hursing (IDON) stated hts need to be within reach hen in wheelchair unless they					
F 247 SS=D	7/14, lacked inform residents call lights	ty Call Light policy revised nation on staff ensuring s were within reach. T TO NOTICE BEFORE FE CHANGE	F	247			
		right to receive notice before 1 or roommate in the facility is					
	by:	NT is not met as evidenced w and document review, the					
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: EFPC		Fa	l cility ID: 00260 If contin	uation sheet P	age 17 of 101

ES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Lin í				
	245387	B. WING				
	<u>L</u>	I	29	912 FREMONT AVENUE NORTH		
FICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	x	(EACH CORRECTIVE ACTION SHO	ULD BE	() COMP D,
to pro- changes ot new transfer clude: new roc viewed ago "N R17's r us (BIM btained 1DS) da g intact es date Progres ked do new roc y on 4/i (S) veril umenta ommate had bee ceiving ntroduc ervice j	vide the appropriate notices of s for 2 of 4 residents (R17, roommates reviewed for r and discharge. mmate and was not provided on 6/24/14, at 10:10 a.m. R17 ten a new roommate about a lew roommate just showed up eccent Brief Inventory for 15-tool used to measure d from the quarterly Minimum ated 6/17/14, noted a score of cognition. d 1/3/7/14, through 6/18/14, as Notes dated 8/2/13, through cumentation on R17 being bommate R2 who was admitted B/14. 16 a.m. the licensed social ided R17's medical record tion R17 had been informed of e and no follow up after new een documented either. LSW expectation was to notify the the new roommate prior and be residents and write a note in progress notes.			 interviewed R17 and R ascertain any adjustme they may have related roommates. B. The Social Services Di documented the results interview in the medic: R17 and R19. C. The care plans of R17 were reviewed and rev appropriate. Corrective Actions as it applies Residents: A. The Room Change/Ro Assignment Policy has revised. B. All future Room chang assignments will be do the medical records an plans of the residents i be reviewed and revise appropriate. Date of Completion: August 8, Recurrence will be prevented b A. Facility staff member educated on the Room Change/Roommate po All Staff meetings com 	19 to nt issues to their rector of the al records o and R19 ised as to other commate been ge/Roomma currented if d the care nvolved will d as 2014 y have been licy at the	e
	ES WPPLIER MARY ST/ EFICIENC ORY OR L From pad d to pro- changes ot new transfer clude: new roc viewed had got s ago "N R17's r tus (BIM obtained ADS) da inter tas date Progres cked do f new roc ty on 4/i US) veril ummate had be c ceiving introduc service j	ES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245387 UPPLIER MARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION) From page 17 d to provide the appropriate notices of changes for 2 of 4 residents (R17, jot new roommates reviewed for transfer and discharge. clude: new roommate and was not provided viewed on 6/24/14, at 10:10 a.m. R17 had gotten a new roommate about a s ago "New roommate just showed up R17's recent Brief Inventory for tus (BIMS-tool used to measure obtained from the quarterly Minimum ADS) dated 6/17/14, noted a score of ng intact cognition. tes dated 1/3/7/14, through 6/18/14, Progress Notes dated 8/2/13, through cked documentation on R17 being	ES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILDI 245387 IUPPLIER 245387 B. WING IUPPLIER IDENTIFICATION NUMBER: PREFI PREFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION) PREFICENCY PREFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION) PREFICENCY PREFICIENCY TAG From page 17 F 2 d to provide the appropriate notices of changes for 2 of 4 residents (R17, jot new roommates reviewed for transfer and discharge. F 2 clude: new roommate and was not provided . viewed on 6/24/14, at 10:10 a.m. R17 had gotten a new roommate about a s ago "New roommate just showed up R17's recent Brief Inventory for tus (BIMS-tool used to measure obtained from the quarterly Minimum ADS) dated 6/17/14, noted a score of ng intact cognition. R17's nectent Brief Inventory for tus (BIMS-tool used to measure obtained from the quarterly Minimum ADS) dated 6/17/14, noted a score of ng intact cognition. tes dated 1/3/7/14, through 6/18/14, Progress Notes dated 8/2/13, through cked documentation on R17 being f new roommate R2 who was admitted ty on 4/8/14. R. at 11:16 a.m. the licensed social /S) verified R17's medical record umentation R17 had been informed of commate and no follow up after new had been documented either. LSW ed her expectation was to notify the ceiving the new roommate prior and introduce residents and write a note in service progress notes.	ES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPL A. BUILDING 245387 B. WING	ES (X1) PROVIDER/SUPPLER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 245387 STREET ADDRESS, GITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 WARY STATEMENT OF DEFICIENCIES FORM PAGE 12 CONSTRUCTION CORVOR LSC IDENTIFYING INFORMATION) STREET ADDRESS, GITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 WARY STATEMENT OF DEFICIENCIES FORM PAGE 12 CONSTRUCTION CORVOR LSC IDENTIFYING INFORMATION) IP From page 17 d to provide the appropriate notices of changes for 2 of 4 residents (R17, not new roommates reviewed for transfer and discharge. F 247 From page 17 did option and discharge. F 247 Find Social Services D documented and was not provided . F 247. New roommate and was not provided . F 247. New roommate and was not provided . F 247. R17's recent Brief Inventory for tus (BIMS-tool used to measure obtained from the quarterly Minimum ADS) dated 6/17/14, through 6/18/14, Progress Notes dated 8/2/13, through cked documentation on R17 being f new roommate R2 who was admitted ty on 4/8/14. Corrective Actions as it applies Residents: A. The Room Change/Ro Assignment Policy has revised. B. All future Room chang assignments will be de the medical records an plans of the residents i be reviewed and revise appropriate. Date of Completion: August 8, A that he exident write a note in service progress notes. Date of Completion: August 8, A. Facility Staff meetings con usels of 7.28.14	ES (X1) PROVIDENCIPALERICLA DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATL A. BUILDING 245367 B. WING

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION IG	(X3) DATE SURVE COMPLETED
	······································	245387	B. WING_		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLE
F 247	prior notice. On 6/23/14, at 5:09 been moved to a di roommate change stated "Yes third ro given notice before roommate R19 stat second time I got a surprised, did not k A review of R19's ri quarterly MDS date indicated moderate Nurses Notes date Social Progress No R17 being informed was admitted to the Review of Notificati 10/29/13, revealed 330 to 127-1 with F When interviewed of health unit coordina had been moved fri but was not sure if same room. When interviewed of licensed practical in stated R90 had bee R19 who later requi room because R90 On 6/26/14, at 11:3 lacked documentat	P.m. when asked if he had ifferent room or had a in the last nine months R19 om" when asked if he was a room change or a change in ted "No notice was given, new roommate and was now ahead of time." ecent BIMS obtained from the ed 4/22/14, noted a score of 11 impaired cognition. d 9/3/14 through 6/17/14, and otes lacked documentation on d of new roommate R2 who e facility on 4/8/14. ion of Room Change dated R90 had been moved from	F 24	 B. Daily audits x 2 weeks, weekly x 4 weeks then months. Findings will b to the QAPI/QA Commireview and follow up recommendations. The Committee will determine audits may be discontine. Responsible Person: Social Serve Director or Designee 	nonthly x 3 e reported ittee for QAPI/QA ne when the ied.

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER	â,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH		
	- NEGILENCE		L	MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETI DATE
F 247 F 250 SS=D	LSW stated she wa chart to see if there -At 11:48 a.m. LSW more documentation Ecumen Room Chi- directed "6. All room in the patient's cha- include: a. The reason's b. The patient's c. The patient's c. The patient's d. Follow up or adjustment to the of 483.15(g)(1) PROV RELATED SOCIAL The facility must pr services to attain of practicable physica well-being of each This REQUIREME by: Based on interview facility failed to pro services to attain of practicable, physic well-being for 1 of behavioral outburs determine interven interventions for m and pursue the pro-	as going to look in the thinned a was any information. / returned stated there was no on. anges policy revised May 2011, m changes will be documented rt. The documentation will s for the change. s reaction. is notified of new roommate in patient and roommate change. /ISION OF MEDICALLY . SERVICE rovide medically-related social m maintain the highest al, mental, and psychosocial	F 24	F250- D Corrective Action: A. The care plan of R2 ha updated to include non- pharmacological interva	entions to be ors. A been ehavior 2 were abers were rentions the g her blood ulizer, her d her pain n LOA. hemical g. Her care to include and misses becomes and ct the need	

Event ID: EFPC11

Facility ID: 00260

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ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		245387	B. WING			
IAME OF	PROVIDER OR SUPPLIER		1	IREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLA	RESIDENCE			INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(XS) COMPLETIC DATE
F 250	12:14 p.m. R2 was transfer from her b walker and ambula in without difficulty. right hand was sha and whispered "the am allergic to it, the best ice and water During observation 7:21 a.m. R2 was of at the doorway of h to sue these peopli down, I was up unt mind, I needed to s know [referring to I angry and loudly you checked it for gang and I saw skin can for the outburst. R2's diagnoses ind injury, morbid obes obtained from the dated 1/16/13. The care plan date for alteration in tho schizophrenia. The time when speakin does not understa service to obtain o (psych) to see as a evidence of non-plane	and interview on 6/25/14, at observed to independently ed, used a four wheeled ted over to the scooter and got R2 was sitting in the scooter, king and called surveyor over by have mold in the water and I ey are supposed to have the	F 250	 Corrective Actions as it applies Residents: A. The Care Plan-Compression policy has been implement policy includes the neer incorporate risk factors with identified problem B. Care Plans of current resident of the care Plans of current resident of the care properties. Date of Completion: August 8, Recurrence will be prevented by A. Facility staff members educated on the Care Plans of the care policy Staff Meetings complete of 7-28-14. B. Daily audits x 2 weeks weekly x 4 weeks then months. Findings will to the QAPI/QA Compression of the care preview and follow up recommendations. The Committee will determ audits may be disconting Responsible Person: DON or Date of the care person of the care person. 	ehensive hented. This d to associated is. esidents ised as 2014 were lan- at the All ted the week , then monthly x 3 be reported nittee for e QAPI/QA ine when th nued.	

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		AND HUMAN SERVICES & MEDICAID SERVICES					07/15/2014 PPROVED 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		245387	B. WING _]
NAME OF I	PROVIDER OR SUPPLIER	ξ			EET ADDRESS, CITY, STATE, ZIP CODE		
STOLAF	RESIDENCE				2 FREMONT AVENUE NORTH		
	OLUN (ADV DTA	TEMENT OF DEFICIENCIES		1111	PROVIDER'S PLAN OF CORREC		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	COMPLETION OATE
F 250	Continued From pa	age 21	F 25	50			
	evidence of social s consult for the incre behavioral outburst	services obtaining a pyschiatric eased for one to two times ts.					
	5/9/14, indicated R wheelchair and wa independent with tr	mum Data Set (MDS) dated 2 had intact cognition, used a lker for mobility and was ransfers. The MDS also noted shaviors in the last week.					
	dated 5/21/14, inclu antipsychotic medi	obtained from physician orders uded ziprasidone (an cation), clonazepam (a or anxiety) and paroxetine (a or depression).					
	June 2014 indicate averaging one to the obsessive statement treatments, health, inability to calm, we complaints regard though the Behavio alternative non-pha	r Monitoring Records dated ad R2 had increased behaviors aree times per day such as ents and anxiousness regarding , appointments and staff, eepiness, paranoia - obsessive ng health concerns. Even or Monitoring Records had armacological interventions, the ze the interventions to eness.					
	Additional Behavio past three months provided.	or Monitoring Records for the were requested but not					
	licensed practical things immediately immediately she g cigarettes in the si	w on 6/26/14, at 7:42 a.m. nurse (LPN)-A stated R2 "wants y and if you don't do it ets worked up, she will borrow moking room and will get very out and doesn't get them					
FORM CMS-	2567(02-99) Previous Version	s Obsolete Event ID:EFPC	11	Facil	lity ID: 00260 If contin	uation sheet P	age 22 of 101

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/15/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1). PROVIDER/SUPPLIEF/CLIA IDENTIFICATION NUMBER:				(X3) DATI	E SURVEY PLETED
		245387	B. WING	i			
NAME OF F	PROVIDER OR SUPPLIER		L	5	STREET ADDRESS, CITY, STATE, ZIP CODE		<mark>-***=</mark> ,
	RESIDENCE			1	2912 FREMONT AVENUE NORTH		
			T		MINNEAPOLIS, MN 55411		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	JD PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 250	Continued From pa	lge 22	F	250			
	licensed social word angry yesterday be and didn't get them that happens she is checked with her at mad, so I said I word During an interview LPN-F stated he sa immediately started and got her leg fract talk with her and sh she does fixate a lo During an interview LPN-I stated R2 ha that "I know of, unle services, I'm not su During an interview stated to her knowl psychiatric services one." LSW stated s psych doctor to see medical doctor ord file that she has se Alcohol Use: R71 reported on 6/ from the facility had versus benefit of m diabetes as well as scale insulin, oral g diabetes for blood	 a on 6/27/14, at 8:07 a.m. a w R2 that morning and she d yelling about the day she fell cture. LPN-F stated "I tried to ne went off and started yelling, of and gets delusional." a on 6/27/14, at 2:11 p.m. as not received psych services ess she saw in house psych ure." a on 6/27/14, at 3:37 p.m. LSW ledge R2 had not seen s, "unless she went out to see she did contact the in house e her, but she needed an er, "I don't see anything in her en one in the past." /26/14, at 5:35 p.m. that no one d talked to her about the risk hissing her accuchecks for sugar control), and pain 					
	(LOAs) from the fa	n frequent leave of absences cility during medication es. R71 reported she only drank					

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Facility ID: 00260

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		AND HUMAN SERVICES				FORM	07/15/201 APPROVEI 0938-039
STATEMENT AND PLAN C	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1				E SURVEY PLETED
		245387	B. WING	i			
NAME OF F	PROVIDER OR SUPPLIER		J	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE			1	2912 FREMONT AVENUE NORTH		
				<u> </u>	MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 250	alcohol into the fac want to argue with stated she would lii (anti-depressant) to stated she takes si to control blood sug scheduled insulin a feel when her blood the bottom of her fo fingertips get numb talked to her about drinking alcohol, m accuchecks check: with her diagnoses was on pills for dia she took an evenin her diabetes. R71 beers when on LO alcohol into the fac talked to her about from facility nightly /treatments or getti dependency. R71's care plan da accuchecks as oro ordered. The care problem of R71's b missing medication there a goal statem minimize risks to th R71 had a Minimu 4/14/14, R71's Brie (BIMS) score of 15 cognition.	on LOA, and did not bring any sility, R71 stated she did not staff upon her return but R71 ke her evening Trazodone o help her sleep at night. R71 liding scale insulin (medication gars), but did not take anymore. R71 stated she can d sugars are elevated because eet get real, real cold and her o. R71 stated no one has ever the risks/benefits regarding lissing medications, missing s, and/or sliding scale insulin a. R71 stated she knew she betes but was unaware that ng dosage of Glucophage for reported she only drank three A, and did not bring any sility. She stated no one had t consuming alcohol while gone and missing medications ing with the chemical	F	250			
ORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: EFPC	11	Fa	acility ID: 00260 If contin	uation sheet P	200 24 of

		AND HUMAN SERVI				FORM	: 07/15/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM	/CLIA (X2) N		E CONSTRUCTION		E SURVEY
		245387	B. WI	NG			
NAME OF F	PROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP	CODE	t
ST OLAF	RESIDENCE			1	912 FREMONT AVENUE NORTH		
					IINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL PR	ID EFIX AG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IN SHOULD BE	(X5) COMPLETION DATE
F 250	going forward, reve facility after drinking intoxicated, and/or of absence (LOA) of 6/9/14, and 6/12/14 R71's May Medicat (MAR) showed R7 Ventolin nebulizer (treatment 14 times units (used to contri- returning from LOA had drank alcohol with showing R71 had h her. R71's May Treatmet (TAR) showed R71 blood sugar accuel returning from LOA had drank alcohol with showing R71 had h her. The June 2014 MA her 8:00 p.m. medi (medication used ff 500 mg eight times R71's June 2014 T missed 8:00 p.m. a June because of re	aled R71 had returne g alcohol, becoming very intoxicated while on 4/24/14, 5/6/14, 5/6 tion Administration Re 1 did not get her 8:00 (medication assist in b , her nightly insulin La rol blood sugar), beca tin the community wit with no documentation ad risks/benefits expl ent Administration Rec did not get her 8:00 hecks six times becau to the community wit with no documentation had risks/benefits expl and risks/benefits expl AR showed R71 did no ications including Gluc or blood sugar control	d to the on leave /14, cord p.m. reathing) ntus 10 use of h having ained to cord p.m. se of h having ained to t receive cophage), Tylenol had 5 times in he	F 250			
	documentation sho risks/benefits expla R71's Physician O the evening medic	owing R71 had had	dicated included				
FORM CMS-2	567(02-99) Previous Version		ent ID:EFPC11	Fa	cility ID: 00260	continuation sheet	Page 25 of 10

		AND HUMAN SERVICES				FORM	07/15/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. 1.				E SURVEY PLETED
		245387	B. WING	<u></u>			
NAME OF I	PROVIDER OR SUPPLIER			1 5	STREET ADDRESS, CITY, STATE, ZIP COD	E	
				2	2912 FREMONT AVENUE NORTH		
ST OLAF	RESIDENCE			1	MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 250	Detrol, Trazodone, twice daily at altern 12:00 p.m., 4:00 p. sliding scale injecti 120-149=2 units, 1 units, 250-299=9 u >350=15 units, Ibu as needed for pain needed for gout pa as needed for pain On 6/26/14, at 8:30 (LSW)-A explained couple weeks at th R71 had been drin drinking had never conversations with R71 seemed rathe had not asked R71 chemical depender was unable to find had been offered C Alcoholics Anonym reported to be held documentation wa: offered to attend. - At 9:21 a.m. LPN drinking nearly eve were aware when and R71's medicat supervisor was not documented in the 24-hour status rec - At 9:55 a.m. the of reported she had of facility. - At 12:50 p.m. LP	Glucophage, Simvastatin, Lantus, Check blood sugar nating times 8:00 a.m. and m. and 8:00 p.m., Novolog on for blood sugars of 50-199=3 units, 200-249=6 nits, 300-349=12 units, profen, Tylenol every 6 hours , and Tylenol orally at night as in, and Robaxin every 8 hours in feet. D a.m. licensed social worker d she had only worked for a e facility, and was unaware king. LSW-A stated R71's come up in IDT meetings or li- the resident. LSW-A thought r frail and ill, but stated she l about her nor offered R71 an ncy (CD) counseling. LSW-A any documentation that R71 CD treatment or counseling. hous (AA) meetings were d across the street and no s found that R71 had been I-A stated R71 went out ery night." LPN-A stated staff the resident had been drinking tions were then held and the tified. Incidents were	n y	250			
EORM CMS-2	567(02-99) Previous Version	is Obsolete Event ID: EFP	C11	F	acility ID: 00260 If conti	nuation sheet F	ane 26 of 101

Facility ID: 00260

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		AND HUMAN SERVICES				FORM	07/15/201 APPROVE 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245387	B. WING				
NAME OF F	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	±	
ST OLAP	RESIDENCE				FREMONT AVENUE NORTH NEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO OATE
F 250	 At 1:18 p.m. LPN-much and missed if treatments. LPN-H to R71 6/1/14 throut. At 2:26 p.m. the ir (IDON) stated he energident's care plan update resident's care plan update resident's care primary physician at telephone. RN-B st she consumed one The facility's Care F noted, "The care pl pre-admission/intal and periodic basis of The resident and/ou with the entire care planning process. Cor maintain the resi physical, mental an comprehensive car initial care conferent The care plan is up meet the needs of 1 comprehensive care involved in the care The Interdisciplinart dated 5/11, noted, " communication bett team to positively a residents, and to pr interdisciplinary cor positive outcomes 	returned with smell of alcohol. H stated R71 went out so her evening medications and verified no insulin was given hgh 6/4/14. hterim director of nursing xpected all staff to follow the h and for nursing staff to are plan as needed. B who worked for R71's it the clinic was interviewed via ated R71 had told a physician to two beers per night. Planning IDT policy dated 5/11 anning process begins during ke and continues on a regular throughout the resident stay. r their representative, along team is involved in the care Care is planned to help attain ident's highest practicable d psychosocial well being. The te plan is reviewed during the nee and on an ongoing basis. dated on an ongoing basis to the resident. The te plan is used by all personnel	F2	250			
		re plan interventions to help	1	Eesilik	ID: 00260 If contin	uation sheet P	

	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY
		245387	B. WING			
NAME OF I	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	angene and	
ST OLAF	RESIDENCE		1	912 FREMONT AVENUE NORTH		
	<u></u>			INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETIC DATE
F 250	Continued From pa	age 27	F 250			
	improve outcomes	-		F 253-D		
F 253	483.15(h)(2) HOUS		F 253			
SS=D	MAINTENANCE S	ERVICES		A. The scooter of R2 has been	en	
	The facility must be	ovide housekeeping and		cleaned.		
		ces necessary to maintain a		B. The rooms of R105, R8, F		
		nd comfortable interior.		R47, R17, R43, R37, R19		
				R84 have been cleaned an maintenance has been con		
				C. The translucent privacy w		
		NT is not met as evidenced		covering has been replace		
	by: Record on observe	tion, interview and document		Second Floor Resident Ba		
		failed to ensure 1 of 2 residents				
		ooter was kept clean, and failed		Corrective Actions as it applies to	other	
		and sanitary environment for		Residents:		
		(R105, R8, R71, R67, R47,				
		19, R11, R84). In addition failed		A. Resident wheelchairs and		3
		or 1 of 3 general Resident d for environmental concerns.		have been cleaned accord	ing to the	Ĵ
	1 JESTICOLLICAICME			schedule and also PRN. B. Resident rooms have been	n anditad	
	Findings include:			They have been cleaned a		
				have been completed acco		
		proximately 9:00 a.m. an		the facility plan.	5. amb 10	D
		r was conducted with the ronmental services director			/	ſ
		eeping staff. During the tour		Date of Completion: August 8, 20	14	
		erns were identified				
				Recurrence will be prevented by:		
	R2's motorized sco	ooter was not clean.		A. Facility staff members ha		
	00 6/02/14 at 4:00	0 p.m. R2 was observed		educated on the Wheelch Cleaning, Resident Room		Ļ
		a motorized scooter which		and the Facility Maintena		6
		built up of food particles on the		expectations at the All Str		
	base of the feet ar	nd thick fluffy material all around		Meetings completed the v		r
	the entire frame of	the motorized scooter.		28-14.		
		1 a.m. observed D0 wheeling		B. Daily audits x 2 weeks, the		
		4 a.m. observed R2 wheeling then asked who cleaned her		weekly x 4 weeks then m		
	I HIO HIG CICVALUL W	aon donvo mao vicanou nel	1	months. Findings will be	renorted	1

Event ID:EFPC11

Facility ID: 00260

If continuation sheet Page 28 of 101

ATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·	ECONSTRUCTION		E SURVEY PLETED
		245387	B. WING			
NAME OF F	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP COD	E	
ST OLAF	RESIDENCE		1	912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 253	Continued From pa	age 28	F 253			
	scooter, resident st for me." On 6/27/14, admini scooter was not cle are cleaned once a	istrator verified the motorized ean. ESD stated "Wheelchairs a month and are wiped down if		to the QAPI/QA Com review and follow up recommendations. The Committee will deter audits may be discont	he QAPI/QA mine when th	
	indicated R2 had ir	mum Data Set dated 5/9/14, ntact cognition, used a lker for mobility and was ransfers.		Responsible Person: Environmental S Director, DON, Administrator or their Designee.		¢
	Wheelchairs log, it wheelchairs had be there were no nam	e facility Audit Cleaning Of was revealed several een cleaned on 5/14/14, but es or room numbers of the log. No records provided for				
	4/01/14, indicated a checked and clean addition the policy needs to be cleaned	ng policy revised 7/09 - all wheelchairs were to be led on a monthly basis. In directed "Any wheelchair that ad more than once a month will 4th Wednesday of the month."	n that hth will			
	ROOM ODOR: R105's room was r	not kept free of smells.				
		B a.m. a strong malodorous om was noticed which seemed I by the entryway.				
	of urine in the room practical nurse (LF	D a.m. noted still a fainter odor n than on 6/24/14, licensed PN)-M was asked but stated manager to walk into room 329				

, *v*

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X3) DATE SURV 245387 B. WING ENDER STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH ST OLAF RESIDENCE MINNEAPOLIS, MN 55411 WINNEAPOLIS, MN 55411 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (2) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE (2)			AND HUMAN SERVICES				FORM): 07/15/2014 (APPROVED). 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ST OLAF RESIDENCE 2912 FREMONT AVENUE NORTH (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1. No. 1. DOM: N		and a second	(X3) DA	TE SURVEY
ST OLAF RESIDENCE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMP TAG OC			245387	B. WING	·			
ST OLAF RESIDENCE MINNEAPOLIS, MN 55411 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP 0/2	NAME OF I	PROVIDER OR SUPPLIER		1	s	TREET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DA	ST OLAF	RESIDENCE						
	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	DULD BE	(X5) COMPLETION DATE
F 253 Continued From page 29 and identify the malodorous scent. -At approximately 8:08 a.m. Interim director of nursing (IDON) verified a tain urine dor in the room, and stated it was more noticeable in the entry way. F 253 On 6/27/14, the administrator stated an extraction had been done on Monday and Wednesday using urine-off substance. F 105'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 III repair. On 6/23/14, at 4.55 p.m. R8's bathroom archway metal was noted to be inwill repair. On 6/23/14, 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 III repair. 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.	F 253	and identify the ma -At approximately & nursing (IDON) ver room, and stated it entry way. On 6/27/14, the add had been done on urine-off substance R105's was admitte admission MDS da moderately impaire extensive assistant (ADL's) including to limitation in range r of both upper and I Review of 3RD Flo revealed room 329 deep cleaned last of R8's bathroom was On 6/23/14, at 4:55 metal was noted to paint chipped off, tf all scraped up and was noted to be sc edges. On 6/27/14, both a R8's annual MDS of had intact cognition extensive assistant toileting.	Iodorous scent. 3:08 a.m. Interim director of ified a faint urine odor in the was more noticeable in the ministrator stated an extraction Monday and Wednesday using a. ed to the facility on 4/28/14, ted 5/4/14, indicated R105 had id cognition, required limited to ce with activities of daily living bileting and had a functional notion impairment to one side ower extremities. or Deep Clean dated May-14, where R105 resided had been on 5/15/14. a noted to be in ill repair. b p.m. R8's bathroom archway be heavily scraped up, with ne mid lower closet doors were lower bathroom door frame raped up which created jagged dministrator and ESD verified. dated 5/22/14, indicated R8 in and required limited to ce with ADL's which included		253			

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DEPARTMENT OF HEALTH					FORM	07/15/2014 APPROVED
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) DATE	0938-0391 SURVEY PLETED
	245387	B. WING	·			
NAME OF PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF RESIDENCE				2 FREMONT AVENUE NORTH		
		,	MIN	INEAPOLIS, MN 55411		
PREFIX (EACH DEFICIENC'	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETION DATE
 metal in R71's roor rusty patches and p scraped up. In add metal was scraped On 6/27/14, ESD v all the time he iden R71's admission M R71 had intact cog toileting and used a mobility. R67's bathroom wa On 6/23/14, at 5:41 archway metal into to have multiple sc On 6/27/14, ESD v see" R67's quarterly ME R67 was independ moderately impaired R47's room entry at to be in ill repair. On 6/23/14, at 4:58 the room entry and observed to be heat gouged. On 6/27/14, ESD v 	 45 a.m. the air vent radiator m was noted to have several paint was scratched and ition the archway to bathroom I up and with paint chipped. rerified the findings stated not titified the concerns. IDS dated 4/14/14, indicated unition, was independent with a walker and wheelchair for as noted to be in ill repair. 1 p.m. during R67's bathroom bathroom was observed with trapes and with chipped paint. verified the finding stated "Yes I DS dated 3/24/14, indicated lent with toileting and had ed cognition. and bathroom doors were noted 9 p.m. during R47's edges of d bathroom doors were avily scuffed, scraped and 	F2	253			

Event ID: EFPC11

Facility ID: 00260

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		AND HUMAN SERVICES				FORM	07/15/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245387	B. WING				
NAME OF F	PROVIDER OR SUPPLIER		·		TREET ADDRESS, CITY, STATE, ZIP CODE	····	_
ST OLAF	RESIDENCE				912 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 253	Continued From pa	age 31	F2	253			
	bathroom door, clo were noted to be se archway scraped, r addition two of the	5 p.m. R17's lower frame of the set door, and entry room door cratched up, metal on the nissing paint into bathroom. In air vents radiator metals were patches and with scraped up					
	R17 cognition was	S dated 4/22/14, indicated moderately impaired and assist with toileting.					
	Service Monthly In 5/27/14, and 5/30/ had been inspected indicated "Good wi	e facility Environmental spection logs dated 5/14/14, 14, it was revealed R17's room d on 5/14/14, and was th Grading: 1= Good 2= Fair bom door condition, edges, and floors.					
	R43's room radiator was noted to be in ill repair. On 6/23/14, at 6:00 p.m. during room observatior R43's radiator in room was noted to have multiple rusty patches and with chipped paint.						
		rerified stated monthly room but had not identified the					
		DS dated 6/16/14, indicated nsive assist with toileting and nition.					

Event ID: EFPC11

Facility ID: 00260

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		AND HUMAN SERVICES				FORM	07/15/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	P	IPLE CONSTRUCTION			E SURVEY PLETED
		245387	B. WING _				
NAME OF I	PROVIDER OR SUPPLIER	5	·	STREET ADDRESS	S, CITY, STATE, ZIP COL	DE	
ST OLAP	RESIDENCE			2912 FREMONT MINNEAPOLIS	AVENUE NORTH 5, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	IDER'S PLAN OF CORR CORRECTIVE ACTION SI EFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 253	Continued From pa	age 32	F 2	53			
	observations the ra chipped paint, the different color patc the archway to the board the sheet roo several gouged are with black marks. On 6/27/14, ESD s rooms having diffe	m. during R37's room idiator was noted to have wall was noted to have hes all around the room and bathroom above the base ok was exposed and had eas and was heavily scuffed tated he was aware of some rent paint but had not					
	R37's quarterly ME R37 required total including transfers a functional limitati	bom and verified the concerns. OS dated 4/20/14, indicated to extensive assist with ADL's , R37 had intact cognition, had on to both upper and lower impairment and used a bility.					
	observed to have r marked around the R19 faced when ly	ith ill repair. a.m. R19's room walls were nultiple white paint patches a south portion of room where ing in bed and the radiator was iple rusty patches and with					
	"Not all the time" w R19's room had th from nails on the w	verified the concerns stated when asked if he was aware e patches and indicated was vall from hanging pictures he not to indicate when the holes					
FORM CMS-2	567(02-89) Previous Version	s Obsolete Event ID: EFPC	1	Facility ID: 00260	If con	Inuation sheet P	1 age 33 of 101

If continuation sheet Page 33 of 101

		AND HUMAN SERVICES				FORM	07/15/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	the second second		ECONSTRUCTION	(X3) DATE	SURVEY
		245387	B. WING		······································		
NAME OF F	PROVIDER OR SUPPLIER		·		IREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				M2 FREMONT AVENUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 253	R19's quarterly MD R19 required exten including toileting a cognition. R11's room was wi On 6/23/14, at 5:31 metal was noted to and with chipped p door had a dented the bathroom door were both observed created jagged edg black marks. On 6/27/14, ESD v R11's quarterly MD cognition and requ with ADL's and R1 ⁻ his both upper extr R84's room was wi On 6/23/14, at 3:57 window was obser scraped and had c bathroom door frar and had gouges wi On 6/27/14, ESD v R84's quarterly ME	S dated 6/17/14, indicated isive to total assist with ADL's and had moderately impaired th ill repair. p.m. R11's bathroom archway be heavily scuffed, scrapped aint. In addition the left closet hole and the lower portion of frame and room entry door d to have gouges which ges and were scuffed with erified concerns. IS indicated he had intact ired limited to extensive assist t had a functional limitation on emities. It hill repair. 7 p.m. R84's radiator under the ved with rusty patches, hipped paint. In addition the me was noted to be scuffed hich created jagged edges. rerified. DS dated 4/18/14, indicated lent with toileting and had	F2	253			
	2ND FLOOR RES	IDENT RESTROOM					
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: EFPC	11	Fa	cility ID: 00260 If continu	ation sheet P	age 34 of 10

ATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and the second second	CONSTRUCTION	OMB NO. (X3) DATE COMF	
		245387	B. WING			
AME OF F	ROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE		
	RESIDENCE			2 FREMONT AVENUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	IULD BE	(X5) COMPLETIC DATE
F 253	Continued From pa		F 253			
F 280 SS=D	Restroom room 20 open and upon loo was noted the priva covering was peels with jagged edges (cm) x 14 cm surve parking lot and acr On 6/27/14, ESD a The administrator of Resident Room Cl review date 10/02/ damaged items, su outlets, nurse call unsafe condition, i each nursing static 483.20(d)(3), 483. PARTICIPATE PL/ The resident has t incompetent or oth incapacitated under participate in plann changes in care an A comprehensive within 7 days after	and administrator both verified. stated, "We will get it fixed." eaning (General) policy with 02, directed "Write any uch as drapes, electrical cords, etc., repairs needed, or in the maintenance books at on." 10(k)(2) RIGHT TO ANNING CARE-REVISE CP he right, unless adjudged herwise found to be er the laws of the State, to ning care and treatment or	F 280		3	
	for the resident, and disciplines as deter and, to the extent	ered nurse with responsibility nd other appropriate staff in ermined by the resident's needs, practicable, the participation of esident's family or the resident's				

		AND HUMAN SERVICES				D: 07/15/2014 MAPPROVED D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1			TE SURVEY
		245387	B. WING	· ۵		
NAME OF	PROVIDER OR SUPPLIER		*	ST	REET ADDRESS, CITY, STATE, ZIP CODE	***
ST OLAI	RESIDENCE			1	12 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		1	PROVIDER'S PLAN OF CORRECTION	(175)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	legal representative	nge 35 e; and periodically reviewed am of qualified persons after	F2	280		
	by: Based on observa review, the facility f of 3 residents (R2, consumption and a changed. Findings include: R2s care plan was is independent with R2's diagnoses inc epilepsy, chronic of brain injury and mu the Resident Admis The quarterly Minin 5/9/14, identified th ADLs except walkin area assessment (R2 was at risk for c extensive assist ne ADLs and monitor transfers and locon toileting. R2's care plan date required "assistanc groomingall ADL.	NT is not met as evidenced tion, interview and document ailed to revise care plans for 2 R71) reviewed for alcohol/drug ccidents whose status had not revised to reflect resident activities of daily living (ADL). luded schizophrenia, lupus, ostructive pulmonary disease, scle weakness obtained from ssion Record dated 1/16/13. num Data Set (MDS) dated e resident was independent all ng in the corridor. The care CAA) dated 11/11/13 indicated lecline in ADLs related to eded. Staff was to assist with for changes with bed mobility, notion on unit, dressing and ed 11/25/13, identified R2 ie with dressing, bathing, " The undated "Team 2 for nursing assistants			 F 280-D Corrective Action: A. The care plan of R2 has been revised to reflect her current AD transfer and ambulation needs. B. The care plan of R71 has been revised to include the Risk/Bene of missing meds and treatments a 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 ongoing and care plans are revised information about the resident ar the residents condition changes. The care plans of current resident 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 	fit and as as

TATEMEN	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	0938-039 E SURVEY PLETED
		245387	B. WING			
	RESIDENCE	a fan gegennen, mei	29	TREET ADDRESS, CITY, STATE, ZI 212 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411		P
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES 37 MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 280	and ADLs. During observation independently tran four wheeled walk scooter and transf difficulty. During an intervier nursing assistant will transfer by her (LPN)-A stated, "In herself." During an intervie trained medication does not usually of and does "most th stated she has ne help when she is During an intervie coordinator stated quarterly and ann responsible for th been a work in pr- nursing used to d should have been Review of the fac [interdisciplinary of indicated "the car during pre-admiss regular and perior resident/patient s Change in Status	red assist of one for transfers n on 6/25/14, at 12:14 p.m. R2 insferred from her bed, used a er to ambulate over to her ferred into the scooter without w on 6/25/14, at 11:35 a.m. (NA)-E stated R2 gets up and rself. Licensed practical nurse t's OK for her to transfer by w on 6/26/14, at 4:55 p.m. in assistant (TMA)-B stated R2 eall for help, she self-transfers ings by herself." TMA-B further ver seen her call light on to get down on the floor. w on 6/27/14, at 8:10 a.m. MDS d she updated the care plans ually, further stating "I am e updating the care plan, it has ogress, the previous director of o them, there was a mix, yes it	F 280	of 7-28-14. B. Daily audits x 2 weekly x 4 week months. Finding to the QAPI/QA review and follo recommendation	ks then monthly x gs will be reported Committee for ow up ns. The QAPI/QA determine when the iscontinued.	3

Event ID: EFPC11

Facility ID: 00260

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		AND HUMAN SERVICES			FORM	: 07/15/201 1 APPROVE - 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		245387	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	£	STR	REET ADDRESS, CITY, STATE, ZIP C	ODE	P
ST OLAF	RESIDENCE		1	I2 FREMONT AVENUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE
F 280	Continued From pa	age 37	F 280			
a.	R71					
		ata Set (MDS) dated 4/14/14, core of 15 which indicated				
		ogress notes dated 5/27/14, s included alcohol abuse, s pain.				
	out drinking nearly when the resident medications were was notified. Incid progress notes and On the 6/12/14, 24 returned to facility explained that R71	a a.m. LPN-A stated R71 went every night. Staff were aware had been drinking, and R71's then held and the supervisor ents were documented in the d on the 24-hour status record. -hour report it was noted R71 smelling of alcohol. LPN-A had to return by a certain n informed of this policy.				
		aytime receptionist (R)-K often witnessed R71 leave the				-
	resident had return alcohol, becoming	DT) notes revealed the ned to the facility after drinking intoxicated and/or very n LOA on 4/24/14, 5/6/14, t 6/12/14.				
	drank three beers bring any alcohol i one had talked to	/26/14, at 5:35 p.m. she only when on LOA, and did not nto the facility. R71 stated no her about the risks versus ning alcohol and missing nightl reatments.	У			

		AND HUMAN SERVICES				FORM	07/15/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245387	B. WING				
NAME OF F	ROVIDER OR SUPPLIER		·]	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				2	912 FREMONT AVENUE NORTH		
STOLAF	RESIDENCE			N	INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 280	Continued From pa	age 38	F 2	280			
	R71's medical reco and omissions in pi was frequently abs medications were of consistently receive R71's care plan dat problem of R71 be missing medication there a goal statem minimize risks to the dated 4/8/14, did not treatments. On 6/26/14, at 2:26 nursing (IDON) sta follow resident care revise careplans as The facility's Care I noted, "The care pl pre-admission/intal and periodic basis The resident and/o with the entire care planning process. (or maintain the res physical, mental ar comprehensive care initial care conferent	and revealed inconsistencies hysician orders. The resident ent from the facility when ordered, therefore, did not e her medications as ordered. ted 4/8/14, did not include the coming intoxicated and a doses while on LOA, nor was nent or interventions to he resident. R71's careplan ot include daily inhaler and neb 6 p.m. the interim director of ted he expected nursing to eplans and to implement and					
SS=D	involved in the care 483.20(k)(3)(ii) SE PERSONS/PER C	re plan is used by all personnel e of the resident." RVICES BY QUALIFIED ARE PLAN	}	282			
FORM CMS-2	567(02-99) Previous Versions	s Obsolete Event ID: EFPC	11	Fa	cility ID: 00260 If continu	ation choot E	age 39 of 10

If continuation sheet Page 39 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/15/2014 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · / ·		CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
·		245387	B. WING	à			
NAME OF	PROVIDER OR SUPPLIER		L	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
STOLA	RESIDENCE			29	12 FREMONT AVENUE NORTH		
JI ULA				MI	NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	The services provide must be provided b accordance with ea care. This REQUIREMEN by: Based on observat review, the facility f accordance with the care for 1 of 1 resic removal reviewed for the facility failed to of 5 residents (R2) and the facility failed to of 5 residents (R2) and the facility failed to of 5 residents (R2) and the facility failed (R83, R34) call ligh according to the ca Findings include: Dialysis: On 6/25/14, at 7:15 (LPN)-A was obser door in front of the -At 7:16 LPN-A was and entered R45's -At 7:18 a.m. nursin observed wheeling -At 7:22 a.m. obser wheelchair (W/C) a up looking around and was observed left arm when she -At 8:32 a.m. obser tray and R45 was of	led or arranged by the facility y qualified persons in ich resident's written plan of NT is not met as evidenced tion, interview and document alled to provide services in e resident's written plan of lent (R45) for dialysis dressing or dialysis; the facility failed to lan of care for 1 of 3 residents activities of daily living (ADIs); offer psychiatric services for 1 according to the plan of care d to ensure 2 of 2 residents ts were readily accessible re plan. is a.m. licensed practical nurse ved standing outside R45's medication cart documenting. s observed applying gloves room then came out briefly. ng assistant (NA)-A was R45 to the dining room (DR). ved resident sitting on her tt the DR appeared all dressed wearing a short sleeve shirt to have dressing to her upper pulled her sleeve up. ved staff bring R45's breakfast observed eating independently. was observed wheeling R45		282 Fac	 F 282-D Corrective Action: A. R 45 now has the dressir from her dialysis site in twhen she returns from d The area is monitored pe B. The care plan and group R45 now reflects the loc dialysis fistula. The dial plan has been updated to monitoring for signs of i the fistula and what to de bleeding at the site. C. R31 had her nails trimm cleaned. D. The care plan and group R31 has been updated to need to do routine nail c day. E. The care plan of R2 has updated to include non-pharmacological intervet treat behaviors in addition psychotropic medication referral has been made for receive psychiatric servities. F. The call light of R83 is it reach when the resident room. His care plan was and revised as appropriated and revised. Ity ID: 00260 If continue 	the evenir ialysis. er protoco sheet of ation of th lysis care o include nfection co o if there ed and sheet of o reflect th are on bat been ntions to bon to her is. A for her to ces. now withi is in his s reviewed te.	ig in is in

STATEMEN"	TOF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A, BUILDING		OMB NO. 093 (X3) DATE SUP COMPLETI	RVEY
		245387	B. WING			
	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE CON	(X5) MPLETION DATE
F 282	On 6/25/14, at 10:5 went to R45's room awake covered up. sleeve up and verifi dialysis the previou LPN-A stated "They by the evening shift facility." -At 10:53 a.m. LPN gauze secured with left upper arm note symptoms of infect blood noted on the for bruit using a ste R45's diagnoses in end stage renal dis mellitus (DM), prolit alcohol induced per from the Diagnoses 1/13/14. R45's Brie (BIMS-tool used to R45 had moderate activities of daily liv (MDS) indicated R4 physical assistance The care plan date hemodialysis relate The care plan indic fistula but did not ic plan directed "May hours after return fi free of infection" Physician Orders d	en came out briefly. 2 a.m. LPN-A and surveyor observed R45 lying in bed LPN-A pulled R45's left shirt ed R45's bandages from s day on 6/24/14, were still on. 7 are supposed to be removed when she returns to the -A was observed removing white paper tape from R45's d area had no signs and on and a small amount of gauze. LPN-A also listened to thoscope. cluded acute kidney disease, ease (ESRD), diabetes ferative retinopathy and rsistent dementia obtained a Report- Clinical dated f Interview for Mental Status measure cognition) indicated impairment in cognition. The ing (ADL's) Minimum Data Set 15 required limited to extensive of one staff with all cares. d 3/14, identified R45 needed d to end stage renal disease. ated R45 had an access site lentify the location. The care remove dressing to shut site 4 tom dialysis." Goal "Will be ated 5/30/14, did not identify a for care and removal of the	F 282	 B. The Care Plan policy h reviewed and revised. C. The Nail Care policy h reviewed and revised. D. The Call Light policy w and revised. Date of Completion August 8, Recurrence will be prevented by A. Facility staff members educated on the Hemood Care Plan, Nail Care ar Policy at the All Staff n completed the week of B. Random daily audits x then weekly x 4 weeks monthly x 3 months. F be reported to the QAP Committee for review a up recommendations. QAPI/QA Committee w determine when the aud discontinued. 	as been vas reviewed 2014 2	

		AND HUMAN SERVICES				FORM	07/15/2014 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1 1 1 1 1 1 1		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245387	B. WING				
NAME OF	PROVIDER OR SUPPLIER		****	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAI	- RESIDENCE				912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 282	When interviewed d registered nurse (F MDS coordinator vi address the locatio she usually did not in the care plan as Administration Rec how the nursing as floated to the unit w were not familiar w RN-A stated the flo the nurses would b and was not respon NA Team Assignme When interviewed d interim director of r reasonable profess should address the nursing assistant T indicated the locati care plan should ad and symptoms of in after dialysis as dir IDON verified the N and care plan lacke When asked about removing the band supposed to remov treatment and the n before she leaves the When interviewed dialysis registered dialysis runs were about the dressing Dialysis/Nursing Fa dated 4/15, 14, 4/15	on 6/25/14, at 10:46 a.m. RN)-A who was also the facility erified the care plan did not in of R45's fistula. RN-A stated indicate the location of the site it was in the Treatment ord (TAR). When asked about sistants and other staff who yould know the location that ith R45's fistula site location, ors were set up the same and is able to know from the TAR nsible for writing/updating the	F	282			

Event ID: EFPC11

Facility ID: 00260

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							FORM	07/15/2014 APPROVED
STATEMENT	RS FOR MEDICARE	(X1) PROVIDER		a da fame		E CONSTRUCTION	(X3) DATE	0938-0391 E SURVEY PLETED
		24	45387	B. WING				
NAME OF I	PROVIDER OR SUPPLIER	4		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
					29	912 FREMONT AVENUE NORTH		
SIOLA	RESIDENCE				M	IINNEAPOLIS, MN 55411		
(X4) ID		ATEMENT OF DEF				PROVIDER'S PLAN OF CORREC		(X5) COMPLETION
PRÉFIX TAG	(EACH DEFICIENC REGULATORY OR I			PREFI TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION DATE
F 282	Continued From pa	age 42		F 2	282			
	concerns about the	-	eina left on until					
	she returned back							
	practitioner and the							
	involved and am st							
	to the facility." DRN							
	are supposed to be dialysis like yester							
	she got up immedi							
	left in place they ca							
	cause an infection							
	indicated to DRN h							
	staff to clarify the c							
	and surveyor gave							
	getting off the phor told her the dressir							
	evening after "Just							
	When interviewed 11:40 a.m. NA-A st							
	site is on the left a							
	dressing on the ar							
	before." When ask							
	incase R45 had ble							
	knew if she would							
	arm NA-A stated s							
	leave the room to g surveyor and state							
	I." as she pointed a							
	down the hallway.		ang by the barr					
	ADLs:							
	On 6/23/14, at 7:2							
	interview, R31 's f							
	staff did not always							
	stated "sometimes							
1	there." The F-A fur resident really only							
	he had not been th							
	know if staff assist							
FORM CMS-2	567(02-99) Previous Version	s Obsolete	Event ID: EFPC1	1	Fa	cility ID: 00260 If contin	uation sheet F	Page 43 of 10

		AND HUMAN SERVICES				FORM	07/15/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245387	B. WING				
NAME OF F	ROVIDER OR SUPPLIER	↓ ₩₩,₩₩₩,₩₩₩,₩₩,₩₩,₩₩,₩₩,₩₩,₩₩,₩₩,₩₩,₩₩,₩	·]	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				12 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 282	Continued From pa	age 43	F	282			
	lying down in bed, a -At 5:55 p.m. R31 v far to the right in he talked with her she assistance, and sm conversation with N conversation she le again. When suppe up straight without times she used her things. Staff was no no one was observ On 6/24/14, at 8:00 in the 2nd floor din her wheelchair. R3 her fingers to scoo jelly container. - At 1:00 p.m. R31) a.m. the resident was sitting ing room, sitting up straight in 1 ate her toast, and then used p the last of the jelly out of the was observed to eat lunch, vith her right hand and					
	admission diagnos disturbances, Alzh malnutrition, was g	to the facility on 12/17/08, with les of dementia with behavioral eimer, chronic kidney disease, liven a regular diet with eight loss per the Admission					
	had short term and severely impaired was totally depend mobility, and trans one staff for toiletir extensive assistan	ated 6/18/14, indicated R31 d long term memory loss and decision making skills. R31 lent on two staff for bed fers, and totally dependent on ng and dressing. R31 required ce of one staff for personal notion on the unit, and limited		-			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:			PLE CONSTRUCTION		TE SURVEY MPLETED
		245387	B. WING		· • • • • • • • • •		
	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
F 282	assistance of one annual Care Area 12/20/13, lacked id R31's care plan la R31 had a cognitiv deficit, and directer for the resident, in to ensure the right enough to be clea On 6/27/14, at 2:1 trim the fingernails that with LPN-I an NA trim the nails. -At 2:16 p.m. NA-E R31's fingernails, were long and had underneath the nails -At 2:16 p.m. NA-E R31's fingernails, were long and had underneath the nails -At 2:16 p.m. VA-E R31's fingernails, were long and had underneath the finger On 6/27/14, at 2:3 was expected to tr unless the resider would trim the finger On 6/27/14, at 2:3 was expected to tr unless the resider would trim the finger on provide assistance and described assistance and described assistance and provide assistance and providing caree dependent for AD Staff was unclear resident 's nails; t	staff for eating. The last Assessment (CAA) dated dentification of ADL's. st revised 6/18/14, indicated ve loss, and self-care ADL d the staff to provide total care cluding passive range of motion hand can be opened well ned. 4 p.m. NA-B stated the nurses of R31, she then went to verify d LPN-I returned and stated the B accompanied to observe the NA-B verified the fingernails a brown debris substance ills. NA-B stated "she just got -B then proceeded to clean the the fingernails. NA-B stated e she was supposed to clean mails. 5 the IDON verified the staff rim nails on bath day routinely, it was diabetic, then the nurse gernails. ted 8/2013, directed the staff to e to residents as necessary, sisting a resident to complete es. The policy lacked direction is to residents who are	F2	282	2		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIEF/CLIA IDENTIFICATION NUMBER:	. (X2) MULT A. BUILDI	IPLE CONSTRUCTION		TE SURVEY MPLETED
		245387	B. WING_			
NAME OF F	PROVIDER OR SUPPLIER		Lesson I	STREET ADDRESS, CITY, STATE, ZI	P CODE	
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(XS) COMPLETIC DATE
F 282	Continued From pa	age 45	F 2	82		
	12:14 p.m.to indep used a four wheele to the scooter and sitting in the scooter called surveyor over mold in the water a supposed to have During observation 7:21 a.m. R2 was at the doorway of I to sue these peopl down, I was up un mind, I needed to know [referring to angry and loudly y checked it for gang	and interviewed on 6/25/14, at bendently transfer from her bed, ad walker and ambulated over got in without difficulty. R2 was er, right hand was shaking and er and whispered "they have and I am allergic to it, they are the best ice and water here." In and interview on 6/26/14, at dressed, sitting in her scooter her room. R2 stated "I'm going e, and I have it all written til 1:00 a.m. with a lot on my sit and write, it's broken you leg fracture]." R2 then got eilled "just say broken will you, I grene, I know what it looks like herer too." R2 then apologized		·		
	injury, morbid ober obtained from the dated 1/16/13.	cluded schizophrenia, brain sity and muscle weakness Resident Admission Record				
	for alteration in the schizophrenia. The time when speakin does not understa	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 dated 5/21/14, inc	obtained from physician orders				

STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and a second second	11-11-11-11-1-1-1-1-1-1-1-1-1-1-1-1-1-	ISTRUCTION	(X3) DA), 0938-03 TE SURVEY MPLETED
		245387	B. WING				
NAME OF	PROVIDER OR SUPPLIER	<u> </u>	'r	STREET	ADDRESS, CITY, STATE, ZIP CO	DDE	
ST OLAF	RESIDENCE				REMONT AVENUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 282	antipsychotic medi medication used for medication used for Review of Behavio June 2014 indicate averaging one to the obsessive statement treatments, health, inability to calm, we complaints regardine records however do non pharmacologic if they were effective Additional Behavio past three months provided. During an interview social worker (SW yesterday because didn't get them back happens she is an with her and she sis said I would check During an interview LPN-F stated he sis immediately starte and got her leg fra talk with her and sis she does fixate a line During an interview	cation), clonazepam (a r anxiety) and paroxetine (a r depression). r Monitoring Records dated d R2 had increased behaviors are times per day such as nts and anxiousness regarding appointments and staff, sepiness, paranoia - obsessive ing health concerns. The id not outline what alternative cal interventions were used and ve. r Monitoring Records for the were requested but not v on 6/27/14, at 7:52 p.m.) stated R2 was angry a she borrowed cigarettes and ck. "We have noticed when that gry and yells a lot, I checked tarted yelling, getting mad, so I back." v on 6/27/14, at 8:07 a.m. aw R2 that morning and she d yelling about the day she fell cture. LPN-F stated "I tried to he went off and started yelling, pt and gets delusional." v on 6/27/14, at 2:11 p.m.		82			
		as not received psych services ess she saw in house psych ure."				×	

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		AND HUMAN SERVICES				F	ITED: 07/15/20 ORM APPROV 3 NO: 0938-03
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245387	B. WING	3			
NAME OF	PROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		·
ST OLA	F RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(XS) COMPLET DATE
F 282	During an interview stated to her knowl psychiatric services one." SW stated sh psych doctor to see (medical doctor) on her file that she has plan of care was no obtaining psych ser behaviors averagin such as obsessive regarding treatmen staff, inability to cal obsessive complair Call Lights: R83's call light was On 6/24/14, at 8:54 were observed han call light button. On 6/24/14, at 2:15 in bed which was lo call lights were obs not accessible for F On 6/26/14, at 3:15 lying in his bed with not accessible. R83's fall care plan to "Keep call light was On 6/23/14, at 4:01	on 6/27/14, at 3:37 p.m. SW edge R2 had not seen s, "unless she went out to see he did contact the in house the her, but she needed an MD der, "I don't see anything in seen one in the past." The ot followed for social services rvices as R2 had increased g one to three times per day statements and anxiousness ts, health, appointments and m, weepiness, paranoia - nts regarding health concerns. not at reach. a.m. R83's both call lights ging on the wall around the p.m. R83 was observed lying overed to the floor and both erved still hanging on the wall R83. p.m. R83 was again observed a call light hanging on the wall dated 12/23/13, directed staff n reach at all times."	F	283	2		

Event ID: EFPC11

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. C STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPL 245387 B. WING DAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
2912 FREMONT AVENUE NORTH	
ST OLAF RESIDENCE MINNEAPOLIS, MN 55411	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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. F 282 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 283 SS=E RECAP STAV/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a necapitulation of the resident's stay, and a final summary of the resident's legal representative. <	

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Event ID: EFPC11

Facility ID: 00260

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		AND HUMAN SERVICES			FORM.	07/15/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	No. 10 10 10 10		E CONSTRUCTION (X3) DATE	SURVEY PLETED
		245387	B. WING			
NAME OF F	ROVIDER OR SUPPLIER	k			TREET ADDRESS, CITY, STATE, ZIP CODE	
ST OLAF	RESIDENCE				912 FREMONT AVENUE NORTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 283	by: Based on interview failed to complete a 19 discharged resid R16, R91, R98, R1 R38) reviewed for o Findings include: During stage one c discharged residen recapitulation of the of resident cares at facility. All records summary of residen Discharges occurre 6/9/14, were as foll R99 was admitted discharged home of R24 was admitted discharged home of R97 was admitted discharged home of R16 was admitted discharged to the making statements R91 was discharge living facility (ALF) discharge form ind abuse and anxiety, height and weight. R98 was discharge	NT is not met as evidenced y and record review the facility a recapitulation of stay for 13 of dents (R99, R24, R64, R97, 02, R64, R103, R32, R42, closed records. losed record review the t records did not contain a e residents' stay, or summary nd treatments while in the lacked recapitulation of stay or nt cares and treatments. ed between 1/21/14, through ows: to the facility 1/28/14, and in 2/4/14. to the facility 2/4/14, was in 3/31/14. to the facility 2/25/14, and on 2/8/14. to the facility 2/25/14, and on 2/8/14. to the facility 2/25/14, after wanting to kill herself. ed to the attached assisted on 2/27/14. A transfer located diagnoses of cocaine vital signs at discharge and ed home on 2/11/14. It was edical record if services were		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. 	
	set up prior to disc R102 was admitted	harge. I to the facility 3/5/14, was sent			20 ⁻ 1 ⁻ .	

Event ID: EFPC11

Facility ID: 00260

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If continuation sheet Page 50 of 101

	FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	FORM OMB NO. (X3) DAT COM	0938
		245387	B. WING				
NAME OF PROV	IDER OR SUPPLIER	1		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF RE	SIDENCE				12 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COM
to traw Ref dis R1 dis se R3 dis R4 ph R4 less wa no rec co su R3 rec 2:: Ma ov the co su R3 rec u su Ov e su Co su R3 ref co su R3 ref R4 ref R3 ref R3 ref R4 ref R4 ref R5 ref R4 ref R5 ref R5 ref R5 ref R4 ref R5 r R5 r R5 r R5 ref R5 r R5 r R5 r R5 r R5 r R5 r R5 r R5	chea and chemo int to go back to 4 was admitted charged to the o 03 was admitted charged to the o charged to the o charged to the o charged to the o 2 was admitted charged to the o 2 was admitted scharged to be missin capitulation of st cord after the he ordinator was in rveyor interventi 8 was admitted sident remained 50 p.m. when sh emorial Medical erdose of pill wh e smoke room." vealed the R38 h ectly from the ho stay was added S coordinator was rveyor interventi n 6/25/14, at 2:38 rified all the disc mmary of the re he recapitulation	ital 4/8/14, for cellulitis of the otherapy treatment and did n nursing home area. to the facility 3/13/14, and community 4/2/14. d to the facility 3/10/14, and community 6/3/14, with hospi to the facility 5/1/14, and community 5/15/14. to the facility on 5/21/14. A note dated 5/30/14, indicate with his care and wanted to te on 5/30/14, indicated R42 00 a.m. and his belongings a g from his room. A nursing ay was added to the medical alth information services (His terviewed on 6/25/14, after on. to the facility on 4/16/14. Th in the facility until 4/28/14, at e was sent to NMMC (North Center) due to possible ich got from other residents On 4/29/14, the nurses notes had been discharged home ospital. A nursing recapitulati to the medical record after th as interviewed on 6/25/14, at	ot ce d are S) e t s on ne d d t	283	 B. Ddaily audits x 2 weeks weekly x 4 weeks then months. Findings will to the QAPI/QA Comm review and follow up recommendations. The Committee will determ audits may be discontin Responsible Person: DON and Administrator or Designee. 	monthly x be reported littee for QAPI/QA line when the	

		AND HUMAN SERVICES				FORM): 07/15/2014 / APPROVED). 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED
		245387	B. WING	·			
NAME OF	PROVIDER OR SUPPLIER	* · · · · · · · · · · · · · · · · · · ·			ET ADDRESS, CITY, STATE, Z		
ST OLAP	RESIDENCE				FREMONT AVENUE NORTH NEAPOLIS, MN 55411	H	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Prefi Tag		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETION DATE
F 283	Continued From pa	ige 51	F	283			
F 309 SS=D	gave Retention Gu on ensuring resider accurate, organized policy lacked who we residents medical re- accurate. 483.25 PROVIDE C HIGHEST WELL B Each resident mus provide the necess or maintain the high mental, and psycho- accordance with the and plan of care. This REQUIREME by: Based on observa- review, the facility of dressing was remo- risk of access site resident (R45) revi- failed to offer psych residents (R2) revi- medications; and the care/services for the resident (R71). Findings include: On 6/25/14, at 7:15 (LPN)-A was observa-	olicy dated August 8, 2013, idelines but lacked information its medical records were d and complete. In addition the was responsible to oversee the records were complete and CARE/SERVICES FOR EING t receive and the facility must vary care and services to attain hest practicable physical, bisocial well-being, in e comprehensive assessment NT is not met as evidenced tion, interview and record failed to ensure dialysis site oved after dialysis to reduce the infection or clotting for 1 of 1 ewed for dialysis; the facility hiatric services for 1 of 5 ewed for unnecessary he facility failed to provide ne highest well being for 1 of 1	F	1	upon return from B. The care plan and R45 has been up location of the of There are specific care and remove dressing as well there is bleeding C. The care plan of non-pharmacolo for behaviors in medication. Be sheets are in pla pharmacologica The resident is Psychiatric serv D. R71 has been re She was seen by	oved in the evenin m dialysis. Ind group sheet of pdated to state the dialysis fistula. fic instructions or val of the dialysis l as what to do if g. of R2 now address ogical intervention addition to ehavior Monitorin ace and include m al interventions. now receiving vices. e-assessed for pai by the e practitioner for	e n ns ng on-

Event ID: EFPC11

Facility ID: 00260

If continuation sheet Page 52 of 101

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A BUILDING (x) PROVIDER JUNCE 245387 (x) A MUTTHE CONSTRUCTION A BUILDING (x) A DUALTHE CONSTRUCTION A BUILDING NAME OF PROVIDER OF SUPPLIER ST OLAF RESIDENCE 245387 a WHO 245387 STREET ADDRESS, CITY, STATE, 2P CODE 2012 FREMONT AVENUE NORTH- MINNEAPOLIS, MIN 55411 MAME OF PROVIDER OF SUPPLIER ST OLAF RESIDENCE STREET ADDRESS, CITY, STATE, 2P CODE 2012 FREMONT AVENUE NORTH- MINNEAPOLIS, MIN 55411 MAME OF PROVIDER OF SUPPLIER ST OLAF RESIDENCE STREET ADDRESS, CITY, STATE, 2P CODE 2012 FREMONT AVENUE NORTH- MINNEAPOLIS, MIN 55411 MAME OF PROVIDER OF SUPPLIER ST OLAF RESIDENCE STREET ADDRESS, CITY, STATE, 2P CODE 2012 FREMONT AVENUE NORTH- MINNEAPOLIS, MIN 55411 MAME OF PROVIDER OF SUPPLIER ST OLAF RESIDENCE STREET ADDRESS, CITY, STATE, 2P CODE 2012 FREMONT AVENUE NORTH- MINNEAPOLIS, MIN 55611 MAME OF PROVIDER OF SUPPLIER ST OLAF RESIDENCE STREET ADDRESS, CITY, STATE, 2P CODE 2012 FREMONT AVENUE NORTH- MINNEAPOLIS, MIN 55611 F 3005 Continued From page 52 -AT 716 a Licensed practical nurse (LPN)-A was observed wheeling R45 bit bit dining room appeared dressed wheeling R45 bit bit dining room appeared dressed and room where the resident was in bed. LPN-A was observed wheeling R455 back to her room then came out briefly. -A 110:32 a.m. LPN-A was observed wheeling R455 back to her room then came out briefly. -A 110:32 a.m. LPN-A was observed to be enrowed by the evening shift when she returns to the facility. -A 110:32 a.m. LPN-A was observed to be removed by the evening shift when she returns to the			AND HUMAN SERVICES			F	ITED: 07/15/2 ORM APPRO NO: 0938-0	VED
NAME OF PROVIDER ON SUPPLICR STREET ADDRESS, CITY, STATE, 2P CODE ST OLAF RESIDENCE 2312 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 Providers PLANDARD CONTRUCT AVENUE NORTH MINNEAPOLIS, MN 55411 PROVIDERS CITY, STATE, 2P CODE PRETX EACH DEFICIENCES PIETX PROVIDER AVENUE NORTH MINNEAPOLIS, MN 55411 PROVIDERS CITY, STATE, 2P CODE PARAMET AVENUE NORTH EACH DEFICIENCES PIETX EACH DEFICIENCES F 309 Continued From page 52 - AT 7.18 a licensed practical nurse (LPN)-A was observed wheeling R45 to the dring room. - AT 7.22 a.m. observed resident stitting on her wheelchair (W/C) at the dining room appeared dressed in a shot sleeve shirt and had a dressing to her upper left arm whon she pulled her sleeve up. - At 8:32 a.m. Deserved staff bring R45's breakfast tray and R45 was observed eating independently. - AT 9:10 a.m. NA-A was observed resident file. G. R71 has been offred Chemical Dependency Counseling. - AT 10:53 a.m. LPN-A and surveyor went to R45's room where the resident was in bod. LPN-A lift B45's left shift sleeve up and verified the bandages from dialysis were from the previous day on 624/14, and twere still in place. LPN-A stated "They are supposed to be removed by the evening shift when she returns to the facility". The Care Plan policy, Medication Utilization and Prescribing Policy. IDT Stand Up Policy, Medication Utilization and these off administratic for Notifying Practitioners of Chinical Ated 1/13/14. The care plan dated 3/14, i				1		I.		¥
ST OLAF RESIDENCE 2912 FREMONT AVENUE NORTH MINRAPOLIS, MR 535111 CAL DEFICIENCY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG D PREFX TAG Continued From page 52 -AT 7:16 a licensed practical nurse (LPN)-A was observed aphying gloves and entered R45's room then came out briefly. F 309 -AT 7:16 a.m. a nursing assistant (NA)-A was observed wheeling R45 to the dining room. -AT 7:22 a.m. observed regime room. -AT 7:22 a.m. observed regime room appeared dressed in a short sleve shirt and had a dressing to her upper left arm whon she pulled her sleve up. At 8:32 a.m. observed stift bring R45's breakfast tray and R45 was observed wheeling R45 back to her room then came out briefly. F 309 On 6/25/14, at 10:52 a.m. DFN-A and surveyor went to R45's room where the resident was in bed. LPN-A stated 'They are supposed to be removed by the evening shi twhen she returns to the facility." F 10:53 a.m. LPN-A and surveyor went to R45's room where the resident was in bed. LPN-A stated 'They are supposed to be removed by the evening shi twhen she returns to the facility." F 10:53 a.m. LPN-A and surveyor went to R45's room where the resident was in bed. LPN-A stated 'They are supposed to be removed by the evening shi twhen she returns to the facility." I. The care plan policy, Medication Utilization and Prescribing Policy, Medication Utilization and Prescribing Policy, Pain Assessment Policy, Physician Meres Back to her room then gauze. LPN-A also listened to for bruit using a stethoscope. Corrective Actions as it applies to other Residents: A. The Care Plan policy, Medication Utilization and Prescribing Policy, Physician Medication Orders and the Guidelines for Notifying Practitioners of Clinical Acted 1/13/14. The care plan dated 3/14, iden			245387	B. WING				٦
ST OLAF RESIDENCE MINNEAPOLIS, MN 55411 (X) ID PHEFIX TAG SUMARY STATEMENT OF DEPICIENCES INCLUSS AND STATEMENT OF DEPICIENCES INTERCESS AND AND	NAME OF F	PROVIDER OR SUPPLIER		·	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX TAG TEACH CORRECTIVE ACTION SHOLDUB BE CROSS-HEFERENCED TO YEAPPOPHATE DEFICIENCY CONTINUE APPOPHATE DEFICIENCY F 309 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 7:22 a.m. observed resident siting on mer wheelchair (W/)C at the dining room peared 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 eating independently. -AT 9:10 a.m. NA-A was observed eating independently. -AT 9:10 a.m. NA-A was observed wheeling R45 back to her room then came out briefly. F 309 Cn 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 bandges from diaylsis 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 tacility." -At 10:53 a.m. LPN-A was observed removing gauze secured with white paper tape from R45's left tuper arm noted area han o signs and symptoms of infection and a smail amount of blood noted on the gauze. LPN-A also listened to for bruit using a stethoscope. Corrective Actions as it applies to other Residents: A. The Care Plan policy, Medication Order Policy, Physician Service Policy, Hemodialysis Policy, Pain Assessment Policy, Physician Bertor defined the date fire of R45 had an access site if tuba but did not identify the location. The care plan indincated R45 had an access site fire tab but	ST OLAF	RESIDENCE						
 -At 7:16 a licensed practical nurse (LPN)-A was observed applying gloves and entered R4S's room then came out briefly. -At 7:18 a .m. a nursing assistant (NA)-A was observed resident sitting on her wheelchair (W/C) at the dining room. -At 7:22 a.m. observed resident sitting on her wheelchair (W/C) at the dining room. -At 8:32 a.m. observed staft bring R45's breakfast tray and R45 was observed etaing independently. -At 8:32 a.m. observed staft bring R45's breakfast tray and R45 was observed etaing independently. -At 8:32 a.m. observed staft bring R45's breakfast tray and R45 was observed etaing independently. -At 8:32 a.m. observed staft bring R45's breakfast tray and R45 was observed etaing independently. -At 8:32 a.m. LPN-A and surveyor went to R45's room where the resident was in bed. LPN-A litted R45's left shirt sleve 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 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 ducted R45 had an access site fistula buil din to id welly the location. The care 	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		
FORM CMS-2567(02-99) Previous Versions Obsolele Event ID: EFPC11 Facility ID: 00260 If continuation sheet Page 53 of 10		-At 7:16 a licensed observed applying i room then came ou -At 7:18 a.m. a nurs observed wheeling -At 7:22 a.m. obser wheelchair (W/C) a dressed in a short s to her upper left arr up. -At 8:32 a.m. obser tray and R45 was of -At 9:10 a.m. NA-A back to her room th On 6/25/14, at 10:5 went to R45's room bed. LPN-A lifted F verified the bandag previous day on 6/2 LPN-A stated "They by the evening shift facility." -At 10:53 a.m. LPN gauze secured with left upper arm note symptoms of infect blood noted on the for bruit using a ste R45's diagnoses in end stage renal dis the Diagnoses Rep The care plan date hemodialysis relate The care plan indic fistula but did not ic plan directed "May	practical nurse (LPN)-A was gloves and entered R45's at briefly. sing assistant (NA)-A was R45 to the dining room. ved resident sitting on her t the dining room appeared sleeve shirt and had a dressing n when she pulled her sleeve ved staff bring R45's breakfast beserved eating independently. was observed wheeling R45 hen came out briefly. 22 a.m. LPN-A and surveyor of where the resident was in R45's left shirt sleeve up and les from dialysis were from the 24/14, and were still in place. y are supposed to be removed t when she returns to the 1-A was observed removing n white paper tape from R45's d area had no signs and ion and a small amount of gauze. LPN-A also listened to thoscope. cluded acute kidney disease, ease (ESRD) obtained from hort-Clinical dated 1/13/14. d 3/14, identified R45 needed ad to end stage renal disease. ated R45 had an access site fentify the location. The care remove dressing to shut site 4			 addresses non-pharmacologic interventions to treat pain. F. The care plan of R71 address need to educate the resident of risks of missing medications out on LOA and the risks of alcohol interacting with her medications. G. R71 has been offered Chemid Dependency Counseling. H. The Sliding Scale Insulin ord R71 has been clarified and it discontinued. I. The medication orders and the administration for R71 have 1 reviewed by the physician/nu practitioner and changes mad appropriate. Corrective Actions as it applies to othe Residents: A. The Care Plan policy, Medic Utilization and Prescribing P IDT Stand Up Policy, Medic Order Policy, Physician Serv Policy, Hemodialysis Policy, Assessment Policy, Physiciaa Medication Orders and the Guidelines for Notifying Practitioners of Clinical Prob have been reviewed and revis appropriate. 	es the on the while cal ler of was mes of been arse le as er ation olicy, ation ice , Pain n	

	RS FOR MEDICARI	E & MEDICAID SERVICES		LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		245387	B. WING		
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
ST OLAF	RESIDENCE		i	912 FREMONT AVENUE NORTH AINNEAPOLIS, MN 55411	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CHOSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIO
F 309		rom dialysis." Goal was "Will	F 309	Date of Completion. August 8	, 2014
	The activities of da Set (MDS) dated 4 limited to extensive staff with all cares. Mental Status (BIN cognition) indicated impairment in cogr Physician orders d specific instruction shunt site dressing When interviewed registered nurse (F (MDS) coordinator address the location she usually did not in the care plan as Administration Rec how the nursing as floated to the unit were not familiar w RN-A stated the float the nurses would be and was not respon NA Team Assignm When interviewed interim director of reasonable profest should address the nursing assistant T indicated the location care plan should a and symptoms of i	ally living (ADLs) Minimum Data /15/14, indicated R45 required e physical assistance of one R45's Brief Interview for AS-tool used to measure d R45 had moderate nition. ated 5/30/14, did not identify s for care and removal of the g. on 6/25/14, at 10:46 a.m. RN)-A (who was also the facility) verified the care plan, did not on of R45's fistula. RN-A stated i indicate the location of the site it was in the Treatment cord (TAR). When asked about assistants and other staff who would know the location that with R45's fistula site location, pors were set up the same and be able to know from the TAR nsible for writing/updating the		 Recurrence will be prevented b A. Facility staff members educated on the Care I Medication Utilization Prescribing Policy, ID Policy, Medication Or Physician Service Poli Hemodialysis Policy, Assessment Policy, PI Medication Orders an Guidelines for Notifyi Practitioners of Clinic at the All Staff Meetir the week of 7-28-14. B. Daily audits x 2 week weekly x 4 weeks ther months. Findings wil to the QAPI/QA Com review and follow up recommendations. Th Committee will deterr audits may be discont Responsible Person: DON and Administrator or Designee 	s were Plan policy, h and T Stand Up der Policy, icy, Pain hysician d the ing al Problems has completed s, then h monthly x 3 l be reported mittee for he QAPI/QA nine when the inued.

		AND HUMAN SERVICES				FORM	: 07/15/201 APPROVE . 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION		E SURVEY IPLETED
		245387	B. WING)			
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				912 FREMONT AVENUE NORTH		
					MNNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 309	Continued From pa	ace 54	F	309			
		A Team Assignment sheet					
	and care plan lacks	ed the location of the fistula.					
		his expectation for staff ages IDON stated "They are	{				
		e the dressing on the day of					
	treatment and the r	hight shift would in the morning					
	before she leaves t	hat's how I understand it."					
	When interviewed	on 6/25/14, at 11:25 a.m.					
	dialysis registered	nurse (DRN) stated R45's					
-		going well and when asked					
		concerns addressed in the acility Communication Forms					
	dated 4/15,14, 4/19)/14, 4/24/14, 5/8/14, 5/13/14,					
		RN stated "There had been					
		bandages being left on until for dialysis and the nurse					
		e nephrologist had been					
		ill not sure why this is not clear					
		I further stated "The bandages e removed the evening after					
		tay or latest this morning when					
		ately. When the bandages are					
		an cause the site to clot or to the fistula." Surveyor					
		le needed to speak to a facility					
	staff to clarify the d	lressing removal instruction					
		phone to LPN-A who after					
		he stated the dialysis nurse had ngs was to be removed the	1				
		as I had told you earlier."					
		on 6/25/14, at approximately					
		ated "I know resident's dialysis					
		m because there is always a n and the nurse had told me	1				-
	•	ed if she knew what to do					
		eeding from the site or if she					-
	knew if she would	take a blood pressure on that					<u> </u>

If continuation sheet Page 55 of 101

STATEMEN	T OF DEFICIENCIES OF CORRECTION	<u>A MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	OMB NO. 093 (X3) DATE SU COMPLET
		245387	B. WING _	· · · · · · · · · · · · · · · · · · ·	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	ODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE CO
F 309	arm NA-A stated s leave the room to surveyor and state I." as she pointed down the hallway. Dialysis (Program 8/13/14, directed ti care of the access "Band-Aids or gau dialysis." During observation 12:14 p.m. R2 was transfer from her b walker and ambula in without difficulty right hand was sha and whispered "the am allergic to it, th best ice and water During observation 7:21 a.m. R2 was at the doorway of to sue these peop down, I was up um mind, I needed to know [referring to angry and loudly y checked it for gan- and I saw skin car for the outburst. R2's diagnoses ind injury, morbid obe	he would apply gloves and go get the nurse then looked at d "I will ask the nurse now can at LPN-A standing by the cart Guidelines) policy reviewed ne care plan should address site, and to removing dressing ze 4 hours after discharge from n and interview on 6/25/14, at s observed to independently bed, used a four wheeled ated over to the scooter and go . R2 was sitting in the scooter, aking and called surveyor over ey have mold in the water and ey are supposed to have the	t)9	

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION	(X3) DA). 0938-03 TE SURVEY MPLETED
		245387	B. WING				
	PROVIDER OR SUPPLIER			29	TREET ADDRESS, CITY, STATE, ZIP COD 912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411	<u> </u>	f
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 309	The care plan date for alteration in tho schizophrenia. The time when speakin does not understar service to obtain or as needed. The lac non pharmacologic behavior and if the R2's quarterly MDS had intact cognition walker for mobility transfers. The MDS behaviors in the las R2's medications of dated 5/21/14, inclu- antipsychotic medi- medication used for Review of Behavio June 2014 indicate averaging one to th obsessive stateme treatments, health, inability to calm, we complaints regardi records however d non pharmacologic if they were effective Additional Behavio past three months provided.	d 10/16/13, identified potential ught process due to staff was directed to allow R2 g, repeat questions if resident id and be patient and social der for in house psych to see sked evidence of alternative al interventions were used for y were effective. 6 dated 5/9/14, indicated R2 n, used a wheelchair and and was independent with 5 also noted R2 displayed no st week. btained from physician orders uded ziprasidone (an cation), clonazepam (a rr anxiety) and paroxetine (a r depression). r Monitoring Records dated d R2 had increased behaviors and anxiousness regarding appointments and staff, sepiness, paranoia - obsessive ng health concerns. The id not outline what alternative cal interventions were used and ve. r Monitoring Records for the were requested but not		809			

Facility ID: 00260

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		AND HUMAN SERVICES					07/15/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·			(X3) DATE	
		245387	B. WING		<u> </u>		
NAME OF F	PROVIDER OR SUPPLIER	A	·		REET ADDRESS, CITY, STATE, ZIP CODE		
STOLAF	RESIDENCE		ĺ		12 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411		
04015	SHMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT	10N	(¥5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	Continued From pa	age 57	F.	309			
		ediately she gets worked up,					
	she will borrow ciga	arettes in the smoking room					
	and will get very an doesn't get them bi	ngry when she is out and ack."					
		v on 6/27/14, at 7:52 p.m.) stated R2 was angry					
		she borrowed cigarettes and					
		k. "We have noticed when that					
		gry and yells a lot, I checked tarted yelling, getting mad, so I	ļ				
	said I would check						
	LPN-F stated he sa immediately started and got her leg frac talk with her and sl	v on 6/27/14, at 8:07 a.m. aw R2 that morning and she d yelling about the day she fell cture. LPN-F stated "I tried to he went off and started yelling, ot and gets delusional."					
	LPN-I stated R2 ha	v on 6/27/14, at 2:11 p.m. as not received psych services less she saw in house psych ure."					
	stated to her know psychiatric service one." SW stated si psych doctor to se (medical doctor) o	w on 6/27/14, at 3:37 p.m. SW riedge R2 had not seen is, "unless she went out to see he did contact the in house the her, but she needed an MD rder, "I don't see anything in as seen one in the past."					
	orders for pain me the resident had fr	er-treated pain, physician edication were not followed, and requent leaves of absence acility during medication es.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: EFPC11

Facility ID: 00260

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		TE SURVEY
		245387					
NAME OF P	ROVIDER OR SUPPLIER		<u>'</u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				912 FREMONT AVENUE NORTH		
				N	MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 309	Continued From pa	age 58	FS	309			
	11:55 a.m. As the r	in her room on 6/24/14, at esident rubbed her upper left experiencing some pain "20					
	neck, left shoulder explained that the	ft forehead, back of head, and upper left arm. She Tylenol she had received					
	reported this to the obtained other pair	bed. Although she had nurse, she stated they had not n medication for her pain. R71 killing me. I've been having a					
	serious headache t week." R71 said sh	the same way for about a he had a follow up appointment and would like pain relief.					
	mid-abdominal pair in her head and ne addition, her abdor couple of days and nurse. She reporte evening. Later at 1	a.m. R71 reported having n of an "8 or 9" as well as pain ck had pain on the left side. In nen had been tender the last I she planned to inform the dly slept well the previous 10:09 a.m. R71 was observed vay and reported she was r.					
	neuropathy and alv bottoms of her feet 10, and said when	5 p.m. R71 reported she had ways experienced pain on the t. R71 rated her pain 20 out of her left foot was touched pain ire left side of her body. The					
	resident said she h over" that Tylenol v could get better pa different things to t	nad told the staff "over and vas ineffective, and wished she in relief. She had tried to do ake her mind off the pain, but e pain she was not even					
	listening to music a resident explained	as she previously enjoyed. The that in the past she had been tin 800 mg (commonly used to					

	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE	0938-03 E SURVEY PLETED
		245387	B. WING	.				
NAME OF F	PROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZI	P CODE		
ST OLAF	RESIDENCE				12 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD	BE	(XS) COMPLET DATE
F 309	Continued From pa	ge 59	FS	309				
	assistant (TMA)-As headache that morn routinely prescribed stated they did not most of the time sh	a.m. trained medication stated R71 had reported a ning. If a resident was I pain medication, TMA-A use the 0-10 pain scale, but e did ask R71 to rate her pain pain, she was to report it to the						
		ta Set (MDS) dated 4/14/14, core of 15 which indicated						
	revealed diagnoses nurse practitioner (resident had been s The resident report	pgress notes dated 5/27/14 s including chronic pain. A NP) note on 4/15/14 the seen for an evaluation of pain. ed to the NP, "I am in too ed to increase my Neurontin						
	Neurontin 8:00 a.m Tylenol every 6 hou including at night fo Robaxin every 8 hou the 6/14 Medication showed R71 did no medications eight t due to LOAs. A tel revealed changes t and noon, add Tyle needed and increa- daily. On 6/27/14, F physician orders w	vsician orders included , 12:00 p.m. and 8:00 p.m., irs as needed for pain, or gout pain, as well as burs as needed for pain in feet h Administration Record (MAR it receive her 8:00 p.m. imes including Tylenol 500 mg ephone order dated 5/12/14, o "medications" to 8:00 a.m. nol 1000 mg at night as se Neurontin to 600 mg twice R71's original unsigned ere noted in the primary ocated at the nursing station.)					

		AND HUMAN SERVICES				FORM	07/15/2014 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245387	B. WING	i			
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE	-			912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION OATE
F 309	just went to the sm boring on the unit. her "worker" today added, "It's okay he here." At 10:36 a.m. a lice explained that whe were to sign out at reported residents LOAs, rather it was resident had a physicia resident had a physicia the resident can lea At 10:53 a.m. a lice stated she did not l or assessed reside would be a physicia resident's record. L interdisciplinary tea Thursdays to talk a assessments were kept, but if an indiv a note would be wr Other IDT meeting basis, and she had any such meetings At 11:05 a.m. LPN- residents had appr At 11:07 a.m. LSW orders in either 5/1 facility included in t addition, R71's phy alcoholic beverage p.m. the administra	n. She stated she sometimes oke room because it was She was planning to meet with to look at apartments and ere, but I wouldn't want to live ensed practical nurse (LPN)-F n a resident left on a LOA, they the reception area. LPN-F were not evaluated regarding s based on whether the sician's orders for LOA either dications. "If there is an order, ave." ensed social worker (LSW)-A know if the facility had a policy ents related to LOAs, but there an order regarding this in a .SW-A explained that the am (IDT) met weekly on thout residents whose MDS due. No meeting notes were idual resident was mentioned itten in the resident's record. s were held on an as needed I not attended or been aware of for R71.		309		· · · · · · · · · · · · · · · · · · ·	

Event ID: EFPC11

Facility ID: 00260

If continuation sheet Page 61 of 101

		AND HUMAN SERVICES				FORM	: 07/15/2014 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI			(X3) DA	TE SURVEY MPLETED
		245387	B. WING	à	<u></u>		
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, 2		P
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORT	Н	
					MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 309	Continued From pa	age 61	F	309			
	out drinking nearly "bubbly." Staff wer been drinking, and held and the super- were documented if the 24-hour status R71 had to return b informed of this pol At 9:55 a.m. the da reported she had o facility. At 12:50 p.m. R71 and announced, I'n apartment." At 1:31 R71, "That's our pa likes to party." LPN everyday after lunc transportation, and alcohol. The day n the oncoming shift time she left. R71 transportation. If th family was called to whereabouts. At 1: when a resident be alcohol use, they u documented it in th p.m. LPN-A reporte not to have alcohol [R71] drinks on the to encourage her n denied drinking. At	1 a.m. LPN-A stated R71 went every night, and returned e aware when the resident had her medications were then visor was notified. Incidents in the progress notes and on record. LPN-A explained that by a certain time, and had been licy. aytime receptionist (R)-K fiften witnessed R71 leave the was standing near the elevator in leavingchecking on an 1 p.m. LPN-A stated regarding arty girl. Everybody knows she I-A stated R71 left nearly th, arranging her own taxi I sometimes returning with nurse passed on information to where R71 went and what arranged her own taxi cab he resident did not return, her to see if they knew of her ease intoxicated or smelled of isually notified the doctor and he progress notes. At 1:46 ed staff was aware R71 was I, "but what can you do when the street?" Although staff tried not to drink, the resident also t 1:47 p.m. LPN-F stated the d incidents on the 24-hour					
	smelling of alcohol						
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: EFPC	11	F	acility ID: 00260	If continuation sheet	Page 62 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The second second		CONSTRUCTION	FORM OMB NO. (X3) DATE	07/15/2014 APPROVED 0938-0391 E SURVEY PLETED	
AND FLAN O	FURREUTION		A. BUILDI	NG _		COM	FLEIED	
		245387	B. WING					
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP COD	E		
STOLAF	RESIDENCE				12 FREMONT AVENUE NORTH			
			MINNEAPOLIS, MN 55411					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	{	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 309	Continued From pa	ge 62	F 3	09				
	resident had intact include the problem and missing medica was there a goal st minimize risks to the Physician progress revealed diagnoses notes revealed the facility after drinking intoxicated and/or v on 4/24/14, 5/6/14, On 6/26/14, at 3:17 R71's primary phys telephone. RN-B s at the clinic that shi night, and there wa resident's medical reported the reside intoxicated. R71's p at 3:35 p.m. and st from the facility had headache last wee was drinking, wishe he could not prever physician reported the facility was not to take LOAs. On 6/26/14, at 4:23 not been informed drinking alcohol wh medication use. R	ted 4/8/14, indicated the cognition. The plan did not of R71 becoming intoxicated ation doses while on LOA, nor aternent or interventions to e resident. notes for R71 dated 5/27/14, s including alcohol abuse. IDT resident had returned to the g alcohol, becoming very intoxicated while on LOA 5/8/14, 6/9/14, and 6/12/14. Tp.m. RN-B who worked for ician was interviewed via tated R71 had told a physician e consumed 1-2 beers per s no documentation in the file that the facility had nt had returned from LOAs ohysician was then interviewed ated that in fact a staff person d reported the resident had a k, and "yes" he was aware she ed she would stop, but legally nt her from drinking. The R71 made poor choices, but a jail, therefore, she was free						
EOBM CMS-24	R71 had a "reaction 567(02-99) Previous Versions	n" where she was itching all becomes obsolete Event ID: EFPC		Faci	lity ID: 00260 If conti	nuation sheet F		

	OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MULTIF		(X3) DAT	. 0938-039 E SURVEY
ND PLAN O		DENTIFICATION NUMBER:	A. BUILDING	a <u></u>		PLETED
		245387	B. WING			
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	
ST OLAF	RESIDENCE		1	2912 FREMONT AVENUE NO MINNEAPOLIS, MN 55411		
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F 309	Continued From p	ade 63	F 309			
		and as needed and as needed				
		lergy medication) was	1			
		was "effective." The physician				
		sing were updated.				
		on 6/26/14, at 8:30 a.m. that				
		ed for a couple weeks at the naware R71 had been drinking.				
		I never come up in IDT				
		versations with the resident.				
		'1 seemed rather frail and ill,				
		cher about her LOAs. LSW-A				
		any documentation R71 had				
		nical dependency (CD)				
	treatment or couns	seling.				
	R71 reported on 6	/26/14, at 5:35 p.m. she only				
	drank three beers	when on LOA, and did not				
		nto the facility. She stated no				
		ner about the risks versus				
	benefit of consum	ng alconol.				
	The facility's Care	Planning IDT policy dated 5/11				
		lanning process begins during	}			
	pre-admission/inta	ke and continues on a regular				
		throughout the resident stay.				
		or their representative, along				
		e team is involved in the care Care is planned to help attain				
		sident's highest practicable				
		nd psychosocial well being. The	e			
		re plan is reviewed during the				
	initial care confere	nce and on an ongoing basis.				
		pdated on an ongoing basis to				
	meet the needs of					
	involved in the car	re plan is used by all personne e of the resident "				
	anvoived in the Car					
	R71's medical rec	ord revealed inconsistencies				
	567(02-99) Previous Version	s Obsolete Event ID: EFPO		Facility ID: 00260	If continuation sheet	

	MENT OF HEALTH						PRINTED: FORM A OMB NO. (PPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUP IDENTIFICATION	PLIER/CLIA				(X3) DATE	
		2453	87	B. WING	<u> </u>			
NAME OF F	ROVIDER OR SUPPLIER	<u>* =</u>				REET ADDRESS, CITY, STATE, ZIP CODE	anna an	<mark></mark> -
ST OLAF	RESIDENCE					INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIEI Y MUST BE PRECEDE SC IDENTIFYING INFO	D BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309	Continued From pa and omissions in pl was frequently abs, medications were p consistently received The primary physic via telephone on 6/ if the resident had of would want her to r He was unaware th been discontinued. The 6/14 MAR sho had been discontin 6/26/14, at 5:30 p.r physician order in t had actually been of informed the surve sheet dated 5/20/1 LPN-E said at that should have called whether the sliding been continued or verified orders writt were considered to remained the same the date of the phy consultation sheet. In an interview with she stated had bee insulin, but it had h was aware when h as the bottoms of h her fingertips numb The following morr explained that "who orders around the	hysician orders. T ent from the facili prescribed, theref e her medications ian for R71 was i 26/14, at 3:17 p.r elevated blood pr receive sliding scale in soliding scale in wed the sliding scale in soliding scale in wed the sliding scale in che sliding scale i	ity when ore, did not as ordered. Interviewed m. He verified essure, he ale insulin sulin had cale insulin owever, on d there was no ord to show it N-E then sultation a not noted. ibing nurse clarify buld have PN-E also tation sheet ther they e made) as of e on the at 5:35 p.m. ling scale nued. She as elevated, very cold and LPN-F ranscribed oth. The staff		309			
FORM CMS-2	567(02-99) Previous Version	s Obsolete	Event ID: EFPC1	1	Fac	Sility ID: 00260 If continu	uation sheet Pa	age 65 of 101

		AND HUMAN SERVICES				FORM	07/15/2014 APPROVED 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI				SURVEY PLETED		
		245387	B. WING	ì					
NAME OF I	PROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE				
STOLAR	RESIDENCE			2	912 FREMONT AVENUE NORTH				
	TLOIDLINGE		MINNEAPOLIS, MN 55411						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE		
F 309	MARs printed by the each month. The s a hurry" and misse 5/20/14. The order MAR, however, a li of 6/6/14 had been not the correct way previous director of staff to file consult tab in a resident's in have been the reas missed. On 6/27/14, at 8:10 called R71's prima to clarify the 5/20/1 no insulin had been between 6/1/14 and explained that on 5 administration time 8:00 a.m. and noor missing evening m telephone order sig signed by the phys 8 AM et. [and] noor the names of the n times they were to standards of practi On 6/27/14, at 1:50 telephone order, Li expected the nurse order to clarify eac physician to determ changing each me medications should LPN-F also verified	orders with the pre-printed the pharmacy on the 22nd of taff person "must have been in d the consult order dated r still appeared on the 6/14 ine had been drawn and a date added. LPN-F stated it was to discontinue an order. The f nursing (DON) had instructed orders under the consultation record which LPN-F said it may son the order change had been 0 a.m. LPN-H reported she had ry physician the previous day 4 insulin order. LPN-H verified n administered to the resident d 6/4/14. At 1:18 p.m. LPN-H 5/12/14, R71's medication as had all been changed to to n, due to her LOAs and redications and treatments. A gned by a LPN, but not yet lcian read, "[Change] meds to n. The order did not specify nedications, doses, and the be administered according to ce.		309					
FORM CMS-2	67(02-99) Previous Version	had been re-written to be s Obsolete Event ID:EFPC	11	Fa	cility ID: 00260 If contin	uation sheet P	560 66 of 101		

		& MEDICAID SERVICES	T				0938-0
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTIO)N		E SURVEY PLETED
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NAME OF P	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STREET ADDRESS	S, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE			2912 FREMONT			
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administer p.m. and s on the 5/1 monthly Ju medication LPN-F cou perhaps it returned fr Although I a progress no note by On 6/27/1 LPN-D sta nurses acc current ev time the re the time of	administered at 8:0 p.m. and some med on the 5/14 MAR. L monthly June order medication times pu LPN-F could not off perhaps it could har returned from the h Although LPN-F ve a progress note reg no note by the trans On 6/27/14, at 2:13 LPN-D stated after nurses accepted ho current even though time the resident har	hued From page 66 histered at 8:00 a.m. 12:00 p.m. and 4:00 and some medications were left at 8:00 p.m. a 5/14 MAR. LPN-F also verified R71's hly June orders had reverted back to the hation times previous to the 5/14 order. F could not offer an explanation, but said ps it could have happened when she ed from the hospital at the end of May. Ugh LPN-F verified he would have expected gress note regarding the change, there was te by the transcribing nurse to that effect. 27/14, at 2:13 p.m. the nurse manager, D stated after a resident hospitalization, s accepted hospital discharge orders as ht even though they may have differed at the he resident had been sent to the hospital. At ne of the next scheduled visit with the		09	· ·		
	telephone order da medication times to some of the medica changed to 8:00 a.t some remaining at telephone order. LF requested due to R and because she w medications and tre provide documenta medications were in order. A nurse practitioned R71 requested an of	ted 5/12/14, changing R71's b 8:00 and noon. She verified ations had in fact been m., noon, and 4:00 p.m., with 8:00 p.m. inconsistent with the PN-D said the change was (71's LOAs "nearly every night" vas missing her evening eatments. She was unable to tion showing the why the noonsistent with the telephone r note dated 4/15/14, revealed evaluation of her pain, sleep, n in too much pain you need to					

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	. 0938-039 E SURVEY MPLETED
		245387	B. WING			
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH		ŀ
				MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	DULD BE	(X5) COMPLETIO DATE
F 309	Continued From pa	ge 67	F 309			
	dated 5/9/14 betwe physician. The DOI Neurontin tid [three prior to admission. [times]) and ES Tyle option to increase a we look into that? A meds in morning an she comes back fro intoxicated. No cha Statins, [three times extended release, o hold these if neces: she is a little thing a aggravates gout Ha her drinking she bo back by curfew just meds and others th intoxication." The m specified by the DO physician orders dii medications. The p did take a look at h made worse by her increase in neuront tylenol. Its okay to No further direction of arbitrarily holding medication adminis by the physician in A consultation sheed insulin should be di order was not spece	et dated 5/20/14, read R71's scontinued, however, the ific, and did not indicate gularly scheduled insulin or				

Event ID: EFPC11

Facility ID: 00260

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		AND HUMAN SERVICES				FORM	07/15/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245387	B. WING				
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP (CODE	
	RESIDENCE				912 FREMONT AVENUE NORTH		
	CUMMADY CTA	TEMENT OF DEFICIENCIES	a	14	PROVIDER'S PLAN OF CO	PRECTION	(75)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	nursing (IDON) stat follow the policy reg the nurse who wrot to the physician. T order was not prop specified the medic the nurse who trans followed their policy from hospitalization have been notified whether he agreed changed. The IDC wait until the physic R71's medications administration were	and their times for e as follows:					
	Prilosec, Miralax, S vitamin D3, Cozaai 2) At 8:00 p.m. Sim 3) At 8:00 a.m. and Glucophage, Adva 4) At 8:00 a.m. 12: Albuterol, ferrous s 5) PRN medication Robaxin every 8 hd 6) Insulin orders of started 5/19/14, Cf at alternating times Novolog injection 1 units, 200-249=6 u 300-349=12 units, R71's 6/14 MAR sl medications and tr the facility and retu	00 p.m. and 8:00 p.m. sulfate, ibuprofen is of Tylenol every six hours, burs as needed for pain in feet Lantus 10 units at bedtime teck blood sugar 2 times daily s 8/12/4/8 starting 4/19/14, 120-149=2 units, 150-199=3 units, 250-299=9 units, >350=15 units starting 5/19/14 howed R71 missed eatments due to absence from urning having consumed redications included			clifty ID: 00260 [f	continuation sheet	

STATEMENT	OF DEFICIENCIES F CORRECTION	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		245387	B. WING		_	
	ROVIDER OR SUPPLIER	••••••••••••••••••••••••••••••••••••••		STREET ADDRESS, CITY, STA 2912 FREMONT AVENUE N MINNEAPOLIS, MN 554	IORTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLA X (EACH CORRECTIV CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE DIENCY)	(X5) COMPLETIO DATE
F 309 F 312 SS=D	2 mg, Trazodone 1 Robaxin 500 mg, s Administration Rec accuchecks. The 5 Ventolin nebulizer units, and the TAR sugar tests. On 6/27/14, R71's orders were found white binder at the supervisor LPN-F Trazodone, 5/12/1 a.m. and noon, ad Neurontin, 5/22/14 apnea] setting at 1 stocking, 6/25/14 [emergency room] monthly orders aw signature. The facility's Interc policy dated 5/11 r communication be team to positively a residents, and to p interdisciplinary co positive outcomes assessments or ca improve outcomes 483.25(a)(3) ADL DEPENDENT RES	mg, Simvastatin 10 mg, Detrol 100 mg, Tylenol 500 mg, and six times. Treatment cord (TAR) showed 15 missed 5/14 MAR showed 14 missed treatments and Lantus 10 the showed six missed blood original unsigned physician in R71's primary physician's nursing station and verified by included: 4/25/14discontinue 4change medications to 8 d Tylenol and increase order for CPAP [for sleep 2, 6/3/14discontinue ted ok to send resident to ER , and 6/14 and unsigned vaiting the primary physician's tween the interdisciplinary affect outcomes for the provide an ongoing process of ommunication with a focus on for the residents. The IDT will nd make changes necessary to are plan interventions to help s for residents." CARE PROVIDED FOR	F3	309		

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FORM CMS-2567(02-99) Previous Versians Obsalete

Event ID: EFPC11

Facility ID: 00260

If continuation sheet Page 70 of 101

TATEMENT	OF DEFICIENCIES OF CORRECTION	KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		E SURVEY PLETED
		245387	B. WING			
	PROVIDER OR SUPPLIER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 912 FREMONT AVENUE NORTH MNNEAPOLIS, MN 55411		
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F 312	by: Based on observa review, the facility of 3 residents (R3: daily living (ADLs). Findings include: On 6/23/14, at 7:2 interview, R31's fa staff did not always stated "sometimes there." The family years old, the resid sweats. The family been there at mea assisted R31 to ea On 6/23/14, at 3:0 lying down in bed, -At 5:55 p.m. R31 far to the right in h assistant (NA)-C, 1 straight without as simple conversation the conversation s again. When supp up straight without times she used he things. Staff was r no one was obser	NT is not met as evidenced tion, interview and document failed to provide nail care for 1 1) observed for activities of 1 p.m. during a stage 1 family mily member (F)-A stated "the s trim R31 's fingernails, and a have to do it when I get member further stated, at 98 dent really only likes to eat a member stated he had not I times and did not know if staff at or not. 0 p.m. R31 was observed to be and appeared asleep. was in the dining room leaning er wheelchair. When nursing talked with her she sat up sistance, and smiled and had a on with NA-C, immediately after he leaned to the extreme right er arrived at 6:05 p.m. R31 sat assistance and fed herself, at a fingers to scoop up sweet learby in the kitchenette area, ved to assist R31.		 F 312-D Corrective Action: A. R 31 has received nail care plan and group sh the need to complete n bath day and PRN. Corrective Action as it applies the Residents: A. The Nail Care Policy I reviewed and revised. Date of Completion: August 8, Recurrence will be prevented by A. Facility Staff was educe revised Nail Care Policy Staff Meetings complete of 7-28-14. B. Daily audits x 2 weeks then months. Findings will to the QAPI/QA Communities will determ audits may be discontined will determ audits may be discontined will determ audits may be discontined will complete the staff or the prevented will determ audits the staff or the	eet reflect ail care on to other as been 2014 y: ated on the cy at the All ted the week the monthly x be reported nittee for e QAPI/QA	к 3

		AND HUMAN SERVICES				RINTED: FORM MB NO.	APPR
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STOLAF	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
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F 312	fingers to scoop the container. On 6/26/14, at 1:00 eat lunch, scooping and shoveling into 1 R31 was admitted to current admission of behavioral disturba kidney disease, ma diet with supplement A quarterly Minimum 6/18/14, indicated F term memory loss making skills. R31 staff for bed mobilities dependent on one R31 required exten personal hygiene a limited assistance of annual Care Area A identification of AD R31's care plan las R31 had a cognitive (activities of daily lip staff to provide total including passive ra- right hand can be of	e her toast, and then used her e last of the jelly out of the jelly p.m. R31 was observed to g food up with her right hand her mouth. to the facility on 12/17/08, with diagnoses of dementia with nces, Alzheimer, chronic unutrition, was given a regular nts for weight loss. m Data Set (MDS) dated R31 had short term and long and severely impaired decision was totally dependent on two y, and transfers, and totally staff for toileting and dressing. Isive assistance of one staff for nd locomotion on the unit, and of 1 staff for eating. The last Assessment (CAA) lacked		312			
	nurses trim the fing to verify that with lid and returned and s	p.m. NA-B stated that the gernails of R31, she then went censed practical nurse (LPN)-I aid that the NA trim the nails. accompanied to observe the s Obsolete Event ID: EFPC:			acility ID: 00260 If continuati		

		AND HUMAN SERVICES				F	ORM /	07/15/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.1.1			1) DATE	SURVEY PLETED
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NAME OF F	ROVIDER OR SUPPLIER	I	L	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
	RESIDENCE				2912 FREMONT AVENUE NORTH			
				P	MINNEAPOLIS, MN 55411	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE		(X5) COMPLETION DATE
F 312	Continued From pa	ne 72	·	312				
F 323 SS=D	were long and had underneath the nail done eating. " NA- debris from under t On 6/27/14, at 2:35 (IDON) verified stat bath day routinely, diabetic, then the n The ADL policy dat provide assistance and described assi daily personal care on providing cares dependent for ADL who was to trim the NA care sheet did n bath day. 483.25(h) FREE O HAZARDS/SUPER The facility must er environment remai as is possible; and	the interim director of nursing ff was expected to trim nails on unless the resident was urse would trim the fingernails. ed 8/13, directed the staff to to residents as necessary, sting a resident to complete s. The policy lacked direction to residents who are functions. Staff was unclear e resident 's nails, the undated not direct staff to trim nails on F ACCIDENT	F	323	3			
	by: Based on observa review, the facility f investigations were	NT is not met as evidenced tion, interview and document failed to ensure post fall e completed to identify the root or 1 of 3 residents (R58)						

Event ID: EFPC11

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TATEMENT	OF DEFICIENCIES F CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		(X3) DATE SURVEY COMPLETED	
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NAME OF F	ROVIDER OR SUPPLIEF	2	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE			912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
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F 323	Continued From p reviewed for accid Findings include:		F 323			
	On 6/27/14, at 2:1 sitting on his whee looking and saying residents as they f -At 2:20 p.m. R58 off as he sat on hi walking past him. -At 2:30 p.m. R58 then woke up look himself back to the clipped on the edg was observed to c and her head jerk door. -At 2:42 p.m. R58 abruptly after he w approximately five then again stood to to his W/C. R58 w and was grabbing bedding's when so shaky as he trans R58's diagnoses i failure, glaucoma, hypertension, mus vascular disease the Resident Adm R58's quarterly M 5/20/14, indicated cognition and had memory concerns	was observed dozing on and s W/C and staff were observed continued dozing in his W/C ed down the hallway wheeled e room observed the call light ge of the bed and R58 again doze off with his eyes closed, ing up and down facing the was observed standing up voke up from his W/C for e seconds and sat on his bed up and transferred himself back ras observed to be unsteady the armrests of the W/C and elf-transferring and legs were		 F323- D Corrective Action: A Fall Risk Assessment has been completed for R58 and new interventions have been added the care plan and group sheet. B. R58 had a medication review completed by the physician/num 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 S Meetings completed the week of 28-14. 	se se Staff	

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TATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	an a far a ta	TIPLE CONSTRUCTION	(X3) C	IO. 0938-039 DATE SURVEY COMPLETED	
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F 323	bowel and bladder vision. Falls Care / 11/25/13, identified related to impaired Falls care plan dat at risk for falling re Goal "Will remain directed "Keep bed locked, place resid program, keep cal provide environme assist 1-2 resident transfers/mobility/t Fall Risk assessm R58 had falls since not indicate how m wheelchair for mot score was "35 Mod Physician Orders of was receiving the -Coreg (used to tre Milligrams (mg) or -Imdur extended re angina attacks) 90 angina. -Lisinopril (Used to congestive heart fa morning. -Trazodone (anti-ot treat insomnia) 50 -Risperidone 0.5 m needed for agitatio	occasionally incontinent of and had moderately impaired Area Assessment dated I R58 was at risk for falls I mobility. ed 11/6/13, identified R58 was lated to vascular dementia. iree from injury." Care plan d in lowest position with brakes lent in a fall prevention I light at reach at all times, ont free of clutter and staff to with all oileting." ent dated 5/14/14, indicated e his last assessment but did hany, had history of falls, used a bility, weak gait and his total derate Risk." dated 5/29/14, indicated R58 following medications: eat blood pressure) 6.25 ally daily for hypertension. elease (ER- used to prevent mg orally every morning for the test blood pressure and allure) 5 mg orally every lepressant and used also to mg orally two times daily as	F 3	 B. Daily audits x 2 wwweekly x 4 weeks months. Findings to the QAPI/QA Creview and follow recommendations. Committee will de audits may be disc Responsible Person: DON Administrator or Designee 	then monthly will be repor ommittee for up The QAPI/0 termine whe ontinued.	red r QA	

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PRINTED: 07/15/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245387 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH ST OLAF RESIDENCE MINNEAPOLIS, MN 55411 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE ID PREFIX TAG (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 323 Continued From page 75 F 323 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 trving 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 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: EFPC11 Facility ID: 00260 If continuation sheet Page 76 of 101

		AND HUMAN SERVICES			FO	ED: 07/15/2014 RM APPROVED NO: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION (X3)	DATE SURVEY COMPLETED
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F 323	Continued From pa	uge 76	F	323	3	
	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."					
	the unit during the of 1:30 p.m. to 5:00 a facility had compre falls, to determine a help decrease his redoor open to freque near bed at all time were repeated and care plan. On 6/27/14, at 3:22 nursing (IDON) after reports from Febru interventions were no evidence medic determine if they h IDON further states	six falls in his room and around evening and night hours, from .m. there was no indication the ssively re-assessed R58's appropriate interventions to risk of falls besides leaving his ently monitor, w/c being placed as and monitor for trends which had not been added to the fall 2 p.m. Interim director of er reviewing the incident ary to June verified no new put into place and there was rations were reviewed to ad any bearing on the falls. d "I have not been able to sychotropic yet, which is what I installed."				
F 329 SS=D	2013, directed "All resident and the in up. The 24 hour fo changes to care pl 483.25(I) DRUG R UNNECESSARY I		F	32	9	
	unnecessary drugs drug when used in	ug regimen must be free from s. An unnecessary drug is any excessive dose (including or for excessive duration; or				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: EFPC11

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Facility ID: 00260

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STATEMENT C		& MEDICAID SERVICES		(OMB NO. (0938-0391
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	indications for its u adverse conseque should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs therapy is necessa as diagnosed and record; and resider drugs receive grad behavioral interver	nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any	F 329	 F329-D Corrective Action: A. The use of Restoril and A for R6 has been reviewed orders were obtained to it GDR for Ambien. The can has been reviewed and re appropriate. B. R2 had the Percocet regin reviewed and the Percocet discontinued. The Geoder reviewed for GDR by compharmacist on 7-17-14. The plan has been revised to it target behaviors and non-pharmacological intervention. 	l and mplement are plan vised as nen et has been on was nsultant The care include	
	by: Based on interview facility failed to ensi- indication for conti- unnecessary medi- ensure parameters medication, a grad attempted for antip non-pharmacologie implemented and to (R2) who were rev medications. Findings include:	NT is not met as evidenced w and document review, the sure 1 of 5 residents (R6) had nued use reviewed for cations and the facility failed to s were outlined for a pain ual dose reduction (GDR) was sychotic medications and cal interventions were monitored for 1 of 5 residents iewed for unnecessary		 Corrective Actions as it applies to Residents: A. The Antipsychotic Medic Policy has been revised. B. The Sleep Disorders-Clim Protocol has been implen C. The policy for Administr Pain Medications has been implemented. Date of Completion: August 8, 200 Recurrence will be prevented by: A. Facility staff members we educated on the Antipsyc Medication Use Policy, the Disorders- Clinical Proto the Policy for Administra 	ere hotic ho	
	Physician and nurs	se practitioner notes dated		Pain Medications at the A	Il Staff	

		AND HUMAN SERVICES	******	********	FOF	D: 07/1 MAPPF O: 0938	ROVED
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ST OLA	F RESIDENCE			1	12 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411		
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	12/2/13, 1/22/14, 4, were reviewed and for its extended use manufacturer's rec Prescription Order received Ambien 10 every bedtime (a h) used short term, le from 9/4/13 to 6/27 for its extended use manufacturer's rec R6's diagnoses inc insomnia, manic de affective personalit annual Minimum D The Psychotropic I Assessment (CAA) was receiving a se- staff to monitor for of medications in u Review of R6's Phy signed by the nursi and 4/23/14, reveal dispense ninety tat lacked to indicated R6's Record of Me CP monthly reveal made on 2/19/14, S Please review and multiple hypnotic a temazeparn [Resto or Zolpidem [Ambie	10/22/13, 11/20/13, 11/22/13, /17/14, 4/18/14, and 6/18/14, lacked a clinical justification e as directed by the ommendations. dated 9/4/13, indicated R6 0 milligrams (mg) by mouth ypnotic medication commonly ss than 14 days, for insomnia) /14, without clinical justification e as directed by the ommendations. luded but were not limited to epression, schizophrenia, and y disorder obtained from lata Set (MDS) dated 1/10/14. Drug Use Care Area) dated 1/10/14, indicated R6 dative/hypnotic and directed side effects and effectiveness ise. ysician Telephone orders e practitioner (NP) of 1/22/14 led NP had authorized to olets on both times however, justification for continued use. dication Regimen Review by ed recommendations had been 5/14/14, and 6/17/14, "1. document ongoing need for gents. Could a reduction of pril- also used to treat insomnia en] be tried?"		329 Fac	Meetings completed the week or 28-14. B. Daily audits x 2 weeks, then weekly x 4 weeks then monthly months. Findings will be report to the QAPI/QA Committee for review and follow up recommendations. The QAPI/Q Committee will determine when audits may be discontinued. Responsible Person: DON and Administrator or their Designee	x 3 ed A the	79 of 10

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER		29	TREET ADDRESS, CITY, STATE, ZIP COD 912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411	E	I
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F 329	was not able to be instead a Staff Asse indicated "No" for tr or sleeping too mud feeling tired or havi During interview on appeared sleep and brief breaks as she down the hallway a back. When asked stated "I don't sleep the staff come and never rested at all." never slept well." When interviewed of NP stated when asi issues NP stated "N provider setting and mental issues and medications since I asked if R6 require use Ambien despite recommendation, N that because I don' When interviewed of consultant pharmad recommended facil continued indication 2/19/14, but had re subsequent reviews information back ar she decided to write recommendation. Of even clear why R6	interviewed on her mood and essment Of Resident Mood rouble falling or staying asleep on but indicated "Yes" for ing little energy. 6/25/14, at 8:05 a.m. R6 d was dozing as she made propelled her wheelchair is he body was slammed to the how she sleeps at night R6 o well at night at all because wake me up all night and am 'R6 further stated "I have on 6/26/14, at 10:12 a.m. the ked if he saw R6 for her psych (es and No am new in this d resident has long history of I have not changed her started seeing her." When d documentation for continued a the manufacturer IP stated "I really can't tell you	F 329			

		AND HUMAN SERVICES				FORM	07/15/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER	• • • • • • • • • • • • • • • • • • •			TREET ADDRESS, CITY, STATE, ZIP CODE		
STOLAF	RESIDENCE				912 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411		
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F 329	Continued From pa	ige 80	F	329			
	nursing (IDON) sta	6 a.m. the interim director of ted "I would like to see a GDR tive dose by the NP and a use."					
	epilepsy, chronic ol brain injury obtaine Record dated 1/16	luded schizophrenia, lupus, ostructive pulmonary disease, d from the Resident Admission (13. R2 was currently on edication but with no d for use.					
	had intact cognitior walker for mobility	6 dated 5/9/14, indicated R2 n, used a wheelchair and and was independent with 6 also noted R2 displayed no st week.					
	- Oxycodone/apap Percocet) one to tv as needed for pain - ziprasidone (Geo schizophrenia and	don -used to treat the manic symptoms of bipolar psule (one capsule orally two					
	- clonazepam (Klor in epilepsy and for disorder) 1 mg tab daily). - paroxetine (Paxil	 anopin - used to control seizures the treatment of panic et (one tablet orally two times - an antidepressant) 25 mg (50 mg) orally daily). 			~		
	(MAR) for June 20 Percocet:	ication Administration Record 14, indicated R1 had received time on 6/18/14, for pain level					

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		AND HUMAN SERVICES			FOF	ED: 07/15/2014 RMAPPROVED IO: 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) E	DATE SURVEY
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ST OLAF	RESIDENCE			2912 FREMONT AVENUE MINNEAPOLIS, MN 55		
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F 329		ige 81 0 pain level scale with	F 32	9		
	10 on a one to 10 p worst - Three tablets on 6 level of nine and or on a one to 10 pain worst. - Two tablets on 6/2 of seven and one ta one to 10 pain leve - One tablet on 6/2 one to 10 pain leve - One tablet on 6/2 one to 10 pain leve - One tablet on 6/2 one to 10 pain leve - One tablet on 6/2 of eight/nine and of a one to 10 pain leve During an interview licensed practical r Percocet order had ranges for medicat that indicated pain one tablets. During an interview IDON acknowledge "tweaked." When a protocol that LPN-F only for the assess	me on 6/19/14, for pain level of pain level scale with 10 being 6/21/14; two tablets for pain ne tablet for pain level of eight nevel scale with 10 being 23/14; one tablet for pain level ablet for pain level of 10 on a 1 scale with 10 being worst. 4/14 for pain level of 10 on a 1 scale with 10 being worst. 5/14 for pain level of 10 on a 1 scale with 10 being worst. 26/14; one tablet for pain level ne tablet for pain level of 10 on vel scale with 10 being worst. 26/14; one tablet for pain level ne tablet for pain level of 10 on vel scale with 10 being worst. 26/14; one tablet for pain level ne tablet for pain level of 10 on vel scale with 10 being worst. 26/14; one tablet for pain level of 10 on vel scale with 10 being worst. 26/14; one tablet for pain level of 10 on vel scale with 10 being worst. 26/14; one tablet for pain level of 10 on vel scale with 10 being worst. 26/14; one tablet for pain level of 10 on vel scale with 10 being worst. 26/14; one tablet for pain level of 10 on vel scale with 10 being worst. 26/14; one tablet for pain level of 10 on vel scale with 10 being worst. 26/14; one tablet for pain level of 10 on vel scale with 10 being worst. 26/14; one tablet for pain level of 10 on vel scale with 10 being worst. 26/14; one tablet for pain level of 10 on vel scale with 10 being worst. 26/14; one tablet for pain level of 10 on vel scale with 10 being worst. 26/14; one tablet for pain level of 10 on vel scale with 10 being worst. 26/14; one tablet for pain level of 10 on vel scale with 10 being worst. 26/14; one tablet for pain level of 10 on vel scale with 10 being worst. 26/14; one tablet for pain level of 10 on vel scale with 10 being worst. 26/14; one tablet for pain level is tablet for pain and that there ocol. Although R2 received				
	the orders lacked p determine how ma	lication per physician orders, parameters for staff to follow to ny pain medications to receive severity/level of pain.				

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PRINTED: 07/15/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 245387 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH ST OLAF RESIDENCE **MINNEAPOLIS, MN 55411** PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE (X4) ID PREFIX TAG PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 329 Continued From page 82 F 329 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

FORM CMS-2567(02-99) Previous Versions Obsolete

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	T	X3) DAT	0938-0391 E SURVEY IPLETED
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NAME OF	PROVIDER OR SUPPLIER	<u></u>		Γ	STREET ADDRESS, CITY, STATE, ZIP CODE			
					2912 FREMONT AVENUE NORTH			
STULA	RESIDENCE				MINNEAPOLIS, MN 55411			
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F 329	non pharmacologic if they were effective the behavior monitor was revealed both interventions and n administering psych During interview or stated she indicate she wanted more of not being attempted environment, stable CP stated she expression why or what happe attempted. During an interview LPN-I acknowledge pharmacological in "When we work wit so we know what we reduction had been Additional Behavio past three months provided. The facility "Review Medication" policy the time of monthly record would be re- indications for use medication, docum measurable target refused to address by the pharmacy, of documentation for recommendations,	al interventions were used and ve. During document review of pring records and care plan, it lacked non-pharmacological nonitoring used for R2 prior to hotropic medication. n 6/26/14, at 10:36 a.m. the CP d "check GDR doc" because of a reason why the GDR was d and more than "in supportive e with current management." ected an explanation, such as ns when a GDR has been v on 6/27/14, at 8:25 a.m.,	F	32	29			

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	FIPLE CONSTRUC	TION	NO. 0938-039 DATE SURVEY COMPLETED
		245387	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	A	T T	STREET ADDRE	ESS, CITY, STATE, ZIP CODE	
ST OLAF	RESIDENCE				NT AVENUE NORTH .IS, MN 55411	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACI	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 329	The policy however non-pharmacologic monitoring.	r did not address implementing cal interventions and	F 3	F 431- D Correctiv A.	ve Action: The medication carts, treatmer	
F 431 SS=D	483.60(b), (d), (e) I LABEL/STORE DF The facility must er a licensed pharmag of records of receip controlled drugs in accurate reconcilia records are in orde controlled drugs is reconciled. Drugs and biologic labeled in accordar professional princip appropriate access instructions, and th applicable. In accordance with facility must store a locked compartme controls, and perm have access to the The facility must pr permanently affixed comprehensive Dr Control Act of 1976 abuse, except whe package drug distr	RUGS & BIOLOGICALS mploy or obtain the services of cist who establishes a system ot and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be nee with currently accepted oles, and include the sory and cautionary te expiration date when State and Federal laws, the all drugs and biologicals in nts under proper temperature it only authorized personnel to keys. rovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and S and other drugs subject to in the facility uses single unit ibution systems in which the minimal and a missing dose can	F 4	31 B. C. D. E. F. G. H. I. J.	carts and medication coms have been checked for expired medications. Replacement medications have been ordered appropriate. Internal and External medication are now stored separately on the medication carts, treatment cart and in the medication rooms are medication carts, treatment cart and in the medication rooms are medication refrigerators. Multi-use Insulin pens have be labeled appropriately by the pharmacy. The Insulin Pens of R45 and R were replaced and properly lab Medication room refrigerators been cleaned and defrosted. The Advair Diskus of R4 has be replaced. The expired stock anti-diarrheat medications have been replaced. The rectal suppositories of R15 R51, R86 and R101 are now st separately from internal medications. The nasal medication of R15 is stored separately. The liquid oral medications of are also stored separately. The expired medications from have been discarded from the 3 floor refrigerator.	ve l as ons ne ts nd een 81 eled. have peen al d. 5, ored s R15 R63

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STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	OMB NO. (X3) DATE COM	
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ST OLAF				2912	ET ADDRESS, CITY, STATE, ZIP CODI FREMONT ÁVENUE NORTH IEAPOLIS, MN 55411 PROVIDER'S PLAN OF CORRE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5 COMPLE DAT
F 431	This REQUIREME by: Based on observa- review, the facility (trained medication nurse carts (2nd F TMA cart and 3rd I of expired medication were stored separ the facility failed to insulin pens were residents (R45, R8 R63, R95). In addi system to ensure 1 refrigerators were medications were These practices ha 67 residents who not Findings include: 2ND FLOOR REF On 6/26/14, at 3:0 storage tour with I the freezer was ob inch thick build up observed to be en unclear when the defrosted and was cleaning and defror refrigerator stated find out.	NT is not met as evidenced tion, interview and document failed to ensure 3 of 6 TMA n aide) medication carts and loor Nurses cart, 2nd Floor Floor Nurse cart) had kept free ions, rectal, nasal medications ately from oral medications and properly ensure multi-use properly labeled for 9 of 9 81, R4, R15, R51, R86, R101, tion, the facility lacked a he medication storage cleaned, defrosted and expired not stored in the refrigerator. ad the potential to affect 36 of resided at the facility. RIGERATOR FREEZER 9 p.m. during medication censed practical nurse (LPN)-B paserved to have a two-three frost. A glass thermometer was cased in the frost. LPN-B was refrigerator was last cleaned or a unclear on the schedule for posting of the medication storage she would have the supervisor 1 a.m. when asked if the facility		R	 L. Rectal medications ar separately in the Medi- refrigerators. Corrective Actions as it applies lesidents: A. The Medication Stora- been revised. B. The Labeling of Medi- Policy has been revised. Date of Completion: August 8 Recurrence will be prevented to A. Facility staff member educated on the revised Storage and Labeling Medications Policy at Meetings completed to 28-14. B. Daily audits x 2 week weekly x 4 weeks the months. Findings will to the QAPI/QA Com- review and follow up recommendations. T. Committee will deter audits may be discontal 	ication Room s to other ge Policy ha ications ed. 3, 2014 by: s were ed Medication of the All Staff the week of 7 cs, then n monthly x ll be reported amittee for the QAPI/QA mine when the tinued.	n s s

		AND HUMAN SERVICES				FO	ED: 07/15/2014 RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION G	(X3)	DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER	.		Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
STOLAE	RESIDENCE				2912 FREMONT AVENUE NORTH		
OI OLM	11COIDE110E				MINNEAPOLIS, MN 55411		
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F 431	not seen a cleaning temperature logs." responsible IDON s shift am not sure." 2ND FLOOR NUR On 6/25/14, at 3:11 for R45 and R81 d names hand writter -At 3:15 p.m. LPN- verified both pens stated the pens can that was how they was going to show the refrigerator. -At 3:20 p.m. LPN- box of Novolog Fle had a pharmacy la come with a pharm replace them with the R45's Minimum Da indicated R45 had R81's MDS dated diabetes. When interviewed stated the labels w from pharmacy if m IDON further state needs to make it m medications should each nurse has to	SE CART p.m. two Novolog Flex Pens ated 6/16/14, and 6/13/14, with n on a bright green sticky. D who was the supervisor lacked pharmacy labels but me from the pharmacy and were labeled and indicated he surveyor other pens stored in D came back to the cart with a x Pens and each one of them bel then stated "I guess they hacy label. I am going to new ones."		43			

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<u>ENTER</u>	RS FOR MEDICARE	E & MEDICAID SERVICES			<u>OMB NO. 093</u>	38-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SUI COMPLET	
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AME OF I	PROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
	RESIDENCE					
				NNEAPOLIS, MN 55411		
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F 431	Continued From pa	age 87	F 431			
	storage tour with L for breathing) 250/ opened 5/2/14, wit "Discard 30 days a used to store the in stock supply SM a tablets dispensed 4/14, on the box. -At 3:19 p.m. LPN- outdated stated "It further stated "Exp supposed to be stor R4's Minimum Dat revealed R4 had p dated 5/16/14, rev cognition impairmed The Advair Diskus Information by Gla 5/19/14, noted to s	3 p.m. during medication PN-B R4's Advair Diskus (used 50 microgram (mcg) dated h instructions printed in red after opening" on plastic bag nhaler and a box of house nti-diarrheal 2 milligram (mg) 10/21/12, with expiration date -B verified the inhale was was opened 5/2/14." LPN-B bired medications were not bred in the cart." ta Set (MDS) dated 11/19/13, pulmonary disease and MDS ealed R4 had moderate ent. Package Insert and Label axoSmithKline LLC last revised store the "Advair Diskus at				
	and 25°C). Keep in and sunlight, store and only open whe throw away Advair after you open the reads 0, whicheve 3RD Floor NURSE On 6/26/14, at 3:4 storage tour with 1					

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES				FORM	07/15/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA					E SURVEY PLETED
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NAME OF F	ROVIDER OR SUPPLIER	* · · · · · · · · · · · · · · · · · · ·		S.	TREET ADDRESS, CITY, STATE, ZIP	CODE	
STOLAF	RESIDENCE			1	912 FREMONT AVENUE NORTH		
ALIA 115	CI INGAA DV STA	TEMENT OF DEFICIENCIES	15		PROVIDER'S PLAN OF CO	OPRECTION	015
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F 431	Canasa 1000 mg s mild to moderately idiopathic mucosal involving only the re anatomically limited R51's Bisac-Evac s treat constipation), suppositories 10 m suppositories 10 m Bactroban 2% Nas ointment. It is used the nose called 'Sta with two bottles of c R15's Citalopram s and Certavite-antio R15's MDS 5/25/14 lung disease, an os R51's MDS dated 5 bowel and had no c R86's MDS dated 5 bowel and had no c R86's MDS dated 5 bowel and had no c R86's MDS dated 5 bowel incontinence On 6/26/14, at 3:44 medication were st LPN-C stated "I do supervisor to answ here and today is r	uppositories (used to treat active ulcerative proctitis - an inflammatory disease ectum and is therefore an d form of ulcerative colitis), suppositories 10 mg (used to R86's Bisac-Evac g, R101's Bisac-Evac g, nasal ointment for R15 al Ointment (an antibiotic to kill a group of bacteria in aphylococci') stored together oral liquid medications for of 10 mg/5ml (anti-depressant xidant (a multivitamin). 4, revealed R15 had restrictive stomy and had depression. 5/16/14, R51 was incontinent of constipation. 9/19/13, indicated R86 had d the medications were still refrigerator. 15/28/14, indicated R101 had e and had no constipation. 4 p.m. when asked if the upposed to be separated n't know but will find my rer that I just started to work ny fifth day."		431			
FORM CMS-2	3RD FLOOR REFI		211	Fa	cility IO: 00260	continuation sheet P	2ace 89 of 101

JENTER	RS FOR MEDICARE	& MEDICAID SERVICES	an Air an A		OMB NC) <u>. 0938-03</u> 9
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DA CO	TE SURVEY MPLETED
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IAME OF F	PROVIDER OR SUPPLIER	den en annound an annou	STF	REET ADDRESS, CITY, STATE, ZIP CO	DDE	
T OLAF	RESIDENCE		1	2 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411		
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F 431	surveyor with accessorage room direct In the refrigerator of R63's one infusion mg (an antibiotic) v "06/22/14" and two infusion ball device "6/6/14" for both str boxes of Bisac-Eva R63's MDS dated 6 infections but did h at the facility. R95's MDS dated 6 continent of bowel On 6/26/14, at app nurse manager ap had order for both the hospital. When was with discarding acknowledged med discarded and rem O 6/27/14, at 11:38 storing medication have a distinct obje aware of that being the policy does not medications." Whe antibiotics should h stated "Yes they sh removed."	7 p.m. LPN-C assisted the ss to the locked medication thy behind the nursing station. crisper drawer was observed ball device of Vancomycin 500 with a discard date after Ceftriaxone 1 gram (gm) is with a discard date after ored together with R95's two ac suppositories. 5/24/14, had no current ave intravenous therapy while 5/10/14, noted R95 to be and have no constipation. roximately 5:36 p.m. LPN-F proached surveyor stated R63 antibiotics but was currently in a sked what the expectation g medications LPN-F dications should have been loved from the refrigerator. 8 a.m. when asked about s together IDON stated "I don't ection on that and I was not g stored in the same area and t address that about separating en asked if the infusion device have been discarded IDON nould have been discarded or	F 431			
		keshift, incomplete, damaged, are returned to the pharmacy				

		& MEDICAID SERVICES		OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2LE CONSTRUCTION (X3) DATE SURVEY COMPLETED
		245387	B. WING	
AME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 431	for proper labeling	before storing. 3. No	F 431	
	medications are av All such medication Medications for ext	ated, or deteriorated allable for use in this facility. as are destroyed. 4. rernal use are clearly marked ored separately from other		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 SPREAD, LINENS The facility must es Infection Control P safe, sanitary and	stablish and maintain an rogram designed to provide a comfortable environment and development and transmission	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.
	Program under wh (1) Investigates, cc in the facility; (2) Decides what p should be applied to (3) Maintains a rec actions related to in (b) Preventing Spre (1) When the Infect	stablish an Infection Control ich it - introls, and prevents infections rocedures, such as isolation, to an individual resident; and ord of incidents and corrective infections. ead of Infection tion Control Program		 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
	prevent the spread isolate the resident (2) The facility mus communicable disc from direct contact direct contact will t (3) The facility mus	t prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. It require staff to wash their irect resident contact for which		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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		AND HUMAN SERVICES				FORM	07/15/2014 APPROVED
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY
		245387	B. WING				
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
STOLAD	RESIDENCE			2	2912 FREMONT AVENUE NORTH		
STULA	RESIDENCE			ľ	WINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441		-	F4	441			
	by: Based on interview facility failed to ens program included t employee infection there was any corre	NT is not met as evidenced w, and document review, the ure the infection control racking and trending of s and illness to determine if elation with resident infections. tial to affect all 67 residents ity.					
	The interim directo identified as the inf review of the facility from August 2013 t revealed the facility employee infection control program. TI 10:23 a.m. that he Review of the facili Prevention Program and the Infection C dated May 2011 we direction for trackin During an interview licensed practical r	r of nursing (IDON) was ection control contact. During y Resident Infection Log(s) hrough May 2014, the log y did not track or trend s/illness as part of the infection he IDON stated on 6/27/14, at was not told how they do it. ty Infection Control and n policy dated November 2009 ontrol Surveillance policy ere reviewed and lacked ng employee infection/illness. y on 6/27/14, at 10:29 a.m. hurse (LPN)-E stated that in neetings the employee call-in's					

Facility ID: 00260

If continuation sheet Page 92 of 101

		AND HUMAN SERVICES				0		APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '					E SURVEY PLETED
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NAME OF F	ROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZI			F
ST OLAF	RESIDENCE				12 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411	l		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD	BE	(X5) COMPLETION DATE
F 441	be addressed. During an interview	any infections or illness would w on 6/27/14, at 10:31 a.m. the d human resources (HR)	F 4	41				
	During an interview human resources track employee ab of nursing (DON) illness/infections. I the attendance infe	v on 6/27/14, at 10:55 a.m. the director (HRD) stated she does sences but the former director						
	IDON stated the H infection summary	w on 6/27/14, at 11:10 a.m. the IRD was "not aware of the remployee infection , further stating that it was not ed "but it will be."						
	HRD stated "I make bring it to standup shows what they of surveyor a June 20	w on 6/27/14, at 11:48 a.m. the ke out the absentee report and ; the employee absentee report alled in for. HRD gave the 013 absentee report stating was all we found, we didn't find						
F 514 SS = E	employee and resi could be related to 483.75(I)(1) RES	vere reviewed to determine if ident infections/illness were or	F	514				

1997 - A**ng Pang September 1999** - September 1999 - Charles Martin, Salahan ang Karang Ka

TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION (X3) DATE SUR COMPLETE	VEY
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NAME OF	PROVIDER OR SUPPLIER	.		STREET ADDRESS, CITY, STATE, ZIP CODE	
ST OLAI	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) PLETI DATE
F 514	The facility must maresident in accorda standards and prace accurately docume systematically orga The clinical record information to ident resident's assessm services provided; i preadmission scree and progress notes This REQUIREMENT by: Based on docume facility failed to mai medical records for inconsistencies and orders, as well as a 19 discharged resid R16, R91, R98, R1 Findings include: R71's medical record and omissions in pl was frequently absis medications were p consistently received The primary physic via telephone on 6/ if the resident had of would want her to r	aintain clinical records on each nice with accepted professional tices that are complete; inted; readily accessible; and nized. must contain sufficient ify the resident; a record of the ents; the plan of care and the results of any ening conducted by the State; NT is not met as evidenced int review and interview, the ntain complete and accurate of 1 resident (R71) who had domissions in physician recapitulation of stay for 11 of lents (R99, R24, R64, R97, 02, R64, R103, R32). rd revealed inconsistencies hysician orders. The resident ent from the facility when prescribed, therefore, did not a her medications as ordered. ian for R71 was interviewed 26/14, at 3:17 p.m. He verified plevated blood pressure, he eceive sliding scale insulin. a sliding scale insulin had	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. 	

Event ID: EFPC11

Facility ID: 00260

If continuation sheet Page 94 of 101

		AND HUMAN SERVICES			FORM	07/15/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	a féar fa straig		E CONSTRUCTION (X3) DAT	E SURVEY PLETED
		245387	B. WING			
NAME OF F	PROVIDER OR SUPPLIER		T	SI	TREET ADDRESS, CITY, STATE, ZIP CODE	
ST OLAF	RESIDENCE				12 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	The 6/14 MAR show had been discontin 6/26/14, at 5:30 p.m physician order in the had actually been of informed the survey sheet dated 5/20/14 LPN-E said at that should have called whether the sliding been continued or of verified orders writt were considered to remained the same the date of the physic consultation sheet. In an interview with she stated had been insulin, but it had had was aware when had as the bottoms of her her fingertips number The following morn explained that "who orders around the 2 was to check new of MARs printed by the each month. The sit a hurry" and misser 5/20/14. The order MAR, however, a li of 6/6/14 had been not the correct way previous director of staff to file consult tab in a resident's r have been the reas	wed the sliding scale insulin ued on 6/6/14, however, on n. LPN-M verified there was no he resident's record to show it discontinued. LPN-E then yor that on a consultation 4, the insulin was not noted. point, the transcribing nurse the physician to clarify scale insulin should have discontinued. LPN-E also en on the consultation sheet be current (whether they e or changes were made) as of sician's signature on the R71 on 6/26/14, at 5:35 p.m. n prescribed sliding scale ad been discontinued. She er blood sugar was elevated, er feet became very cold and b. ing at 8:03 a.m. LPN-F bever has time" transcribed 25th of each month. The staff orders with the pre-printed e pharmacy on the 22nd of taff person "must have been in d the consult order dated still appeared on the 6/14 ne had been drawn and a date added. LPN-F stated it was to discontinue an order. The f nursing (DON) had instructed orders under the consultation ecord which LPN-F said it may son the order change had been	F 5		 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 	
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: EFPC1	1	Fac	lity ID: 00260 If continuation sheet F	age 95 of 101

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		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES F CORRECTION	(X1). PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION		E SURVEY PLETED
		245387	B. WING				
NAME OF F	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
ST OLAF	RESIDENCE		2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411				
000 15				10101.01	PROVIDER'S PLAN OF CORREC		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 514	Continued From pa	age 95	F٤	514			
	called R71's primate to clarify the 5/20/1 no insulin had been between 6/1/14 and explained that on 5 administration time 8:00 a.m. and noor missing evening m telephone order sig signed by the phys 8 AM et. [and] noor the names of the m times they were to standards of practic On 6/27/14, at 1:50 telephone order, LI expected the nurse	a.m. LPN-H reported she had ry physician the previous day 4 insulin order. LPN-H verified a administered to the resident d 6/4/14. At 1:18 p.m. LPN-H i/12/14; R71's medication is had all been changed to to a, due to her LOAs and edications and treatments. A gned by a LPN, but not yet ician read, "[Change] meds to a. The order did not specify nedications, doses, and the be administered according to ce.					
	physician to determ changing each me medications should LPN-F also verified medication orders administered at 8:0 p.m. and some me on the 5/14 MAR. I monthly June orde medication times p LPN-F could not of perhaps it could have returned from the b	The dication order with the nine the appropriateness of dication, and which d have remained the same. d that as of 5/21/14 R71's had been re-written to be 00 a.m. 12:00 p.m. and 4:00 idications were left at 8:00 p.m. LPN-F also verified R71's rs had reverted back to the previous to the 5/14 order. ffer an explanation, but said ave happened when she nospital at the end of May. erified he would have expected					
	a progress note re	garding the change, there was iscribing nurse to that effect.					

		AND HUMAN SERVICES				FORM	: 07/15/2014 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY APLETED
		245387	B, WING	à			
NAME OF	PROVIDER OR SUPPLIER	L.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLA	F RESIDENCE				2912 FREMONT AVENUE NORTH		
					MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 514	On 6/27/14, at 2:13 LPN-D stated after nurses accepted he current even thoug time the resident in the time of the next resident, the primal changes. LPN-D co telephone order da medication times to some of the medica changed to 8:00 a. some remaining at telephone order. LF requested due to F and because she w medications and tr provide documenta medications were i order. An email thread wa dated 5/9/14 betwee physician. The DO Neurontin tid [three prior to admission. [times]] and ES Tyl option to increase a we look into that? A meds in morning a she comes back fin intoxicated. No ch Statins, [three time extended release, hold these if neces she is a little thing aggravates gout He her drinking she bo	age 96 p.m. the nurse manager, a resident hospitalization, papital discharge orders as h they may have differed at the ad been sent to the hospital. At t scheduled visit with the ry physician was to note any ponfirmed she had written the ted 5/12/14, changing R71's b 8:00 and noon. She verified ations had in fact been m., noon, and 4:00 p.m., with 8:00 p.m. inconsistent with the PN-D said the change was 171's LOAs "nearly every night" vas missing her evening eatments. She was unable to tion showing the why the nconsistent with the telephone as provided to the surveyor ten the former DON and N wrote, "came in on 300 mg times daily] and took 800 mg Thinking 600 mg (06, 12 enol at noc? [night] With after evaluation further. Can Also would like most or all nd noonish/before dinner, as om sisters every night ange to her TID, ER, or s daily, unknownpossibly cholesterol medication] we will sary. States 2 beers only but and who knows (plus beer aha). I am not concerned with others no one and makes it t that staff don't give her some	F	514			

Facility ID: 00260

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		I AND HUMAN SERVICES				FORM	07/15/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		245387	B, WIN	G	<i>,</i>		
NAME OF F	PROVIDER OR SUPPLIER	£	t	S	TREET ADDRESS, CITY, STATE, ZIP COD	Æ	
ST OLAF	RESIDENCE			1	B12 FREMONT AVENUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IC PRE TA	FIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 514	meds and others the intoxication." The medication." The medications. The did take a look at he made worse by here increase in neuron tylenol. Its okay to No further direction of arbitrarily holding medication adminis by the physician in A consultation sheet insulin should be do order was not spect whether this was re- sliding scale insulin On 6/26/14, at 2:26 nursing (IDON) stat follow the policy re- the nurse who wro- to the physician. To order was not prop specified the medic the nurse who tran- followed their polic from hospitalization have been notified whether he agreed changed. The IDC wait until the physic R71's medications administration wer- 1) At 8:00 a.m. asp	hey hold d/t [due to] safety nedications held were not DN, nor were there specific recting staff to hold certain physician's response read ler and agree that is likely r drinking. I think that your tin idea is fine, as well as give those meds at AM/no n regarding the staffs' prace g medications and/or char- stration times was address his response. et dated 5/20/14, read R71 iscontinued, however, the cific, and did not indicate egularly scheduled insulin n. 6 p.m. the interim director tad he expected nursing to garding physician orders a te the orders should be tal he IDON said the 5/12/14 herly written and should ha cation changes. In additio iscribed R71's orders had y, and upon return to the fin, the primary physician sh of changes to determine I or wanted any orders DN said it was "not okay" to cian's next visit. and their times for e as follows: pirin, Celexa, folic acid,	with c n gout r con." trice nging sed 1's or of o and lking rve m, not facility hould o just	514			
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID	D:EFPC11	Fac	cility ID: 00260 If cont	inuation sheet P	age 98 of 101

	E SURVEY APLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ST OLAF RESIDENCE 2912 FREMONT AVENUE NORTH	
ST OLAF RESIDENCE 2912 FREMONT AVENUE NORTH	
I ST OLAF RESIDENCE	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514 Continued From page 98 F 514 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 9:00 p.m. Alboterol, ferrous sulfate, ibuprofen 5) PRN medications of Tylenol every six hours, Robaxin every shours as needed for pain in feet 6) insulin orders of Lantus 10 units at bedtime started 5/19/14, Check blood suga 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: 4/25/14discontinue Trazodone, 5/12/14change medications to 8 a.m. and noon, add Tylenol and increase Neurontin, 5/22/14okt to send resident to ER [emergency room], and 6/14 and unsigned motified by 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. The IDT will review residents and make changes necessary to assessments or care plan interventions to help improve outcomes for the residents." ProfNMCM525702-99 Previous Wersion Obsette Event ID:EPPC11 Fatility ID:0020	

		AND HUMAN SERVICES				FORM	: 07/15/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245387	B. WING	i			
NAME OF	PROVIDER OR SUPPLIER	t	1	s	TREET ADDRESS, CITY, STATE, ZIP COD)E	Þ
ST OLA	RESIDENCE				912 FREMONT AVENUE NORTH MNNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 514	Continued From pa	ige 99	F	514			
	discharged residen recapitulation of the of resident cares ar facility. All records summary of residen Discharges occurre 6/9/14, were as foll R99 was admitted discharged home of R24 was admitted discharged home of R97 was admitted discharged home of R97 was admitted discharged home of R97 was admitted discharged to the h making statements R91 was discharge living facility (ALF) discharge form ind abuse and anxiety, height and weight. R98 was discharge unclear from the m set up prior to disc R102 was admitted to acute care hosp trachea and chemo want to go back to R64 was admitted discharged to the of R103 was admitted discharged to the of services.	to the facility 1/28/14, and in 2/4/14. to the facility 2/4/14, was in 3/31/14. to the facility 1/21/14, and in 2/8/14. to the facility 2/25/14, and iospital on 3/27/14, after wanting to kill herself. do to the attached assisted on 2/27/14. A transfer icated diagnoses of cocaine vital signs at discharge and ed home on 2/11/14. It was edical record if services were harge. If to the facility 3/5/14, was sent ital 4/8/14, for cellulitis of the otherapy treatment and did not nursing home area. to the facility 3/13/14, and community 4/2/14. If to the facility 3/10/14, and community 6/3/14, with hospice to the facility 5/1/14, and					

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Event ID: EFPC11

Facility ID: 00260

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	- 5 M	ECONSTRUCTION		E SURVEY
		245387	B. WING	_			
ME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
T OLAF	RESIDENCE				912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
X4) ID		TEMENT OF DEFICIENCIES	ID	L	PROVIDER'S PLAN OF CORREC		(X5) COMPLETI
TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)		COMPLETI DATE
F 514	Continued From pa	ae 100	F	514			
		o the facility on 5/21/14. A					
	physician progress	note dated 5/30/14, indicated		1			
		with his care and wanted to					
		e on 5/30/14, indicated R42 00 a.m. and his belongings are					
		from his room. A nursing					
	recapitulation of sta	y was added to the medical					
		alth information services (HIS)					
	surveyor intervention	erviewed on 6/25/14, after					
		o the facility on 4/16/14. The					
		n the facility until 4/28/14 at					
		was sent to NMMC (North					
		Center) due to possible ch got from other residents in					
		On 4/29/14, the nurses notes					
	revealed the R38 h	ad been discharged home					
		spital. A nursing recapitulation	1.				
		to the medical record after the s interviewed on 6/25/14, and					
	surveyor intervention						
		p.m. the HIS coordinator					
		narged medical records lacked					
	Summary of the rec	apitulation of stay she stated of stay would be at the front					
		here then it's not been done.					
	You know I work in	medical records and you need					
	to talk to nursing at	bout that."				*	
	Medical Records p	olicy dated 8/8/13, gave					1
	Retention Guideline	es but lacked information on					
	ensuring residents	medical records were					
		and complete. In addition,					
		ho was responsible to oversee cal records for completeness					
	and accuracy.	arecords for completeness					
			5		1		

		AND HUMAN SERVICES				FORM OMB NO.	07/15/2014 APPROVED 0938-0391
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245387	B. WING	·		06/3	30/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT		(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO		DATE
					DEFICIENCY)		
K 000	INITIAL COMMENT	TS	к	000	É		
	FIRE SAFETY				POCok 7-29-14		
	-	OC WILL SERVE AS YOUR			POCOM		
		COMPLIANCE UPON THE					
\sim	SIGNATURE AT TH	HE BOTTOM OF THE FIRST			6 1-29-19		
3		S-2567 FORM WILL BE					
11	USED AS VERIFIC	ATION OF COMPLIANCE.			$c\chi$		
14		FAN ACCEPTABLE POC, AN					
4	ONSITE REVISIT O	OF YOUR FACILITY MAY BE					
		MPLIANCE WITH THE					
N		AS BEEN ATTAINED IN					
$\langle \langle \rangle$	ACCORDANCE W	ITH YOUR VERIFICATION.					
X		Survey was conducted by the					
		nent of Public Safety. At the	ł				
	not in substantial co	St Olaf Residence was found on the state of					
	requirements for pa	articipation in					
		at 42 CFR, Subpart 482.41 Fire, and the 2000 edition of					
	National Fire Protect	ction Association (NFPA)					
	Standard 101, "The	Life Safety Code" (LSC),					
1	Chapter 19 Existing	Health Care.				D	
é	PLEASE RETURN					7 1	
1		R THE FIRE SAFETY			1111 0 0 0010	11	
e	DEFICIENCIES TO).			JUL 2 8 2014		
ENT: 6-26-	Healthcare Fire Ins						
	State Fire Marshal 445 Minnesota St.,				MN DEPT. OF PUBLIC SAF STATE FIRE MARSHAL DIV	ETY	
TA	St. Paul, MN 55101	-5145, OR			State the Manonal DIV	SIUN	
4	By email to:	ALLAND LAN					
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER INTERSEMTATIVE'S SIGN	NATURE		C TITLE A. ((X8) DATE
ny deficione	v stalament ending with	an esteriek (*) denotes a deficiency wh	ich the ine	stituti	on may be excused from correcting provid	ing it is deter	ZS//4

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245387	B. WING_	the second se		06/30/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) Completio Date	
K 000	Marian. Whitney@s THE PLAN OF COD DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the deficit 2. The actual, or pr 3. The name and/o responsible for com prevent a reoccurre St Olaf Residence basement. The orig in 1964, is separate fire rated barrier an Type I (332) constr sprinkler protected system with smoke corridor system, in open to the corrido automatic fire depa The facility has a co census of 66 at the The requirement at is NOT MET as evit	tate.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE PRMATION: what has been, or will be, done ency. poposed, completion date. r title of the person rection and monitoring to ence of the deficiency. s a 4-story building with a inal building was constructed of from a church with a 2 hour d was determined to be of uction. The facility is fully fire The facility has a fire alarm detection throughout the common areas and areas r system and is monitored for rtment notification. apacity of 80 beds and had a time of the survey. 42 CFR, Subpart 482.41 (b), denced by:	K 00	K 020 Corrective Action: A. Facility will install a n the proper fire rating s Date of Completion: August 8, Responsible Person: Director of Environmental Services	pecifications 2014		
K 020 SS=F	Stairways, elevator shafts, chutes, and between floors are having a fire resista	FETY CODE STANDARD shafts, light and ventilation other vertical openings enclosed with construction ance rating of at least one ay be used in accordance with	К 02				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	WR NO: 0938-03	191	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		245387	B. WING			06/30/2014		
NAME OF PROVIDER OR SUPPLIER ST OLAF RESIDENCE				2912 FREMO	ess, City, State, Zip Code NT AVENUE NORTH LIS, MN 55411			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG			BE COMPLET	(X5) Completion Date	
K 020	Continued From pa 8.2.5.6. 19.3.1.1		кo	20				
	Based on observa failed to maintain v LSC(00) Section 19 could affect all resi Findings include: On facility tour betw on 06/30/2014, obs mechanical room of stairwell is not fire This deficient pract	ween 9:15 AM and 10:45 AM servation revealed that the loor in the third floor southeast						
FORM CMS-25	67(02-99) Previous Versions	s Obsolete Event ID:EFPC2	l :1	Facility ID: 00260	li contini	If continuation sheet Page 3 of 3		