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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: EKCK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00183

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245322**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **COLONIAL ACRES HEALTH CARE CTR**
(L4) **5825 ST CROIX AVENUE**
(L5) **GOLDEN VALLEY, MN** (L6) **55422**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/13/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 04 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
01/31

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

12.Total Facility Beds **88** (L18)

13.Total Certified Beds **39** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
39				
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Jessica Sellner, Unit Supervisor 10/13/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 10/14/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 10/30/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245322

October 14, 2014

Mr. Todd Carsen, Administrator
Colonial Acres Health Care Center
5825 St Croix Avenue
Golden Valley, Minnesota 55422

Dear Mr. Carsen:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective the above facility is certified for or recommended for:

39 Skilled Nursing Facility Beds

Your facility's Medicare approved area consists of all 39 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

October 14, 2014

Mr. Todd Carsen, Administrator
Colonial Acres Health Care Center
5825 St Croix Avenue
Golden Valley, Minnesota 55422

RE: Project Number S5521023

Dear Mr. Carsen:

On September 8, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 21, 2014. This survey found the most serious deficiencies 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 October 13, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 21, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 30, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 21, 2014, effective September 30, 2014 and therefore remedies outlined in our letter to you dated September 8, 2014, will not be imposed.

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

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,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245322	A. Building B. Wing	10/13/2014

Name of Facility	Street Address, City, State, Zip Code
COLONIAL ACRES HEALTH CARE CTR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

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 **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **09/30/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **09/30/2014**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **09/30/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/30/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **09/30/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **09/30/2014**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **09/30/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/30/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **09/30/2014**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **09/30/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	10/14/2014	29249	10/13/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/21/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: EKCK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00183

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245322**

2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **COLONIAL ACRES HEALTH CARE CTR**
(L4) **5825 ST CROIX AVENUE**
(L5) **GOLDEN VALLEY, MN** (L6) **55422**

4. TYPE OF ACTION: **2** (L8)

1. Initial	2. Recertification
3. Termination	4. CHOW
5. Validation	6. Complaint
7. On-Site Visit	9. Other
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/21/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY ~~04~~ (L7)

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

FISCAL YEAR ENDING DATE: (L35)
01/31

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

12.Total Facility Beds **88** (L18)

13.Total Certified Beds **39** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
39				
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date : 09/22/2014
Marilyn Kaelke, HFE NE II (L19)

18. STATE SURVEY AGENCY APPROVAL — Date: 10/28/2014
Kate JohnsTon, Enforcement Specialist (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 10/28/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0532

September 8, 2014

Mr. Todd Carsen, Administrator
Colonial Acres Health Care Center
5825 St. Croix Avenue
Golden Valley, Minnesota 55422

RE: Project Number S5322023

Dear Mr. Carsen:

On August 21, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7365
Fax: (320)223-7365

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 September 30, 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 September 30, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 21, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 21, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING _____ B. WING _____	08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL ACRES HEALTH CARE CTR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	**F 000** This Credible Allegation of Compliance has been prepared and timely submitted. Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiency were correctly cited, and is also not be construed as admission against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of Deficiencies as a condition to participate in the Medicare program. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with allegations of non-compliance or admissions by the Facility.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225		

approved
9/18/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Healthcare Administrator (X6) DATE: 9/18/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING _____ B. WING _____	08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL ACRES HEALTH CARE CTR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure alleged violations of misappropriation of money for 1 of 1 resident reviewed, (R42) who made allegations of missing money was reported to the state agency immediately. In addition, the facility failed to ensure 1 of 1 residents (R35), who had an injury of unknown origin was reported to the state agency. Findings include: R35's admission minimum data set (MDS) dated 7/31/14, identified the resident had diagnoses which included a history of a stroke, hemiplegia, and aphasia. The MDS identified R35 had severe cognitive impairment and required extensive assistance for bed mobility, transferring, and dressing. A nursing progress note dated 8/11/14, at 7:00 p.m., identified R35 was found to have an 8 x 4 centimeter (cm) eccymotic area over the left	F 225	**F225 D** Investigate/Report Allegations/Individuals **RESIDENT:** R42 and R35 successfully met goals and discharged. **IDENTIFY OTHERS AFFECTED:** Review of all VA reports filed on this unit has been reviewed to identify timely reporting of reportable events occurred. **INTERVENTIONS:** All staff training sessions are being held throughout the month of September specifically addressing Resident Rights and Vulnerable Adult reporting. Separate 'Caregiver' meetings held September 11 & 12th, 2014 providing additional training on VA reporting and filing an OHFC report. Agenda to include but not limited to – review of Colonial Acres revised Policy/Protocol including definition of injury of unknown source, definition of misappropriation of funds and reinforcement of reporting Immediately. **MONITOR:** All OHFC reports will be audited on unit for assurance that alleged violation are reported to the state agency immediately. Results will be reviewed by Health Care Administrator, Director of Nursing and Quality Assurance IDT. **DATES OF COMPLETION:** September 30, 2014 **RESPONSIBLE:** Director of Nursing, Nurse Manager	

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F 225	Continued From page 2	F 225		

breast. The center of the bruise was described as dark blue and the periphery was turning yellow. There was no investigation regarding the bruise of unknown origin, and it had not been reported to the state agency.

An occurrence report dated 8/11/14, at 7:00 p.m., indicated R35 had a bruise which was 8 x 4 cm and the resident was unable to report what happened, and there was no witnesses which could be interviewed. On 8/20/14, the occurrence report indicated the facility believed the bruise was from the resident wearing a splint on her left hand, which she would lay on while laying on her left side which may have caused brusing. R35's bruise of unknown origin was never reported to the state agency.

During interview on 8/20/14, at 8:07 a.m. clinical manager (CM)-A stated she was aware of R35's bruise of unknown origin which was identified on 8/11/14, however, there was no documentation regarding an investigation of the bruise, and she stated the nurse who first identified the bruise of unknown origin should have reported immediately to the state agency before doing an investigation. CM-A stated all staff were trained to report bruises of unknown origin.

During interview on 8/20/14, at 9:25 a.m. the director of nursing (DON) stated staff should have reported R35's bruising of unknown origin immediately to the state agency and then completed a written investigation, which had not been done.

R42's admission MDS dated 3/26/14, identified R42 had no cognitive impairment.

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F 225	Continued From page 3 A Missing Items Report dated 4/21/14, indicated R42 reported missing money in the amount of $27.00. In the report, R42 stated she had money stored in a wallet inside a purse which was located in her bedroom nightstand. R42 stated there were still coins in the wallet, however, $22.00 of one dollar bills, and one five dollar bill were missing for a total of $27.00. The missing money was reported to the state agency on 4/23/14, which was two days after R42 reported the missing money. During interview on 8/20/14, at 9:25 a.m. DON stated the staff had investigated R42's missing money first, and didn't submitted the report immediately to the state agency before investigating which is what all staff is trained to do. The DON stated the facility protocol was to report immediately.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure alleged violations of misappropriation of money for 1 of 1 resident reviewed, (R42) who made allegations of missing money was reported to the state agency immediately per facility policy. In addition, the facility failed to ensure 1 of 1 residents (R35),	F 226	**F226** Development/Implement Abuse/Neglect, ETC Policies **RESIDENT**: R42 and R35 successfully met goals and discharged. **IDENTIFY OTHERS AFFECTED**: Review of all VA reports filed on this unit has been reviewed to assure facilities Vulnerable Adult Procedure has been followed. Human Resources have reviewed all files of hired staff to assure references were checked per protocol.	

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F 226	Continued From page 4 who had an injury of unknown origin was reported to the state agency according to facility policy. In addition, the facility failed to perform reference checks for 3 of 5 employees, (C-A, TMA-A, and OT-A) who's employee records reviewed. Findings include: The facility's Vulnerable Adult Procedure last revised 7/13, instructed if there were knowledge of a physical injury which was not reasonably explained or potential financial exploitation, a report should be filled immediately with the Common Entry Point as required by state law. Further, the policy directed before new employees were to be permitted to work with residents, references provide by the prospective employee would be checked. R35's admission minimum data set (MDS) dated 7/31/14, identified the resident had diagnoses which included a history of a stroke, hemiplegia, and aphasia. The MDS identified R35 had severe cognitive impairment and required extensive assistance for bed mobility, transferring, and dressing. A nursing progress note dated 8/11/14, at 7:00 p.m., identified R35 was found to have an 8 x 4 centimeter (cm) eccymotic area over the left breast. The center of the bruise was described as dark blue and the periphery was turning yellow. There was no investigation regarding the bruise of unknown origin, and it had not been reported to the state agency per facility policy. An occurrence report dated 8/11/14, at 7:00 p.m., indicated R35 had a bruise which was 8 x 4 cm and the resident was unable to report what	F 226	**INTERVENTIONS:** Colonial Acres Vulnerable Adult Procedure has been revised and updated as of September 2014. 'Caregiver' meetings held September 11 & 12th, 2014 providing additional training on VA reporting and filing an OHFC report. Agenda to include but not limited to – review of Colonial Acres revised Policy/Protocol including definition of injury of unknown source, definition of misappropriation of funds and reinforcement of reporting Immediately. **MONITOR:** All OHFC reports will be audited on unit for assurance that alleged violation are reported to the state agency immediately per facility policy. Results will be reviewed by Health Care Administrator, Director of Nursing and Quality Assurance IDT. Human Resources will audit all newly hired employees monthly for pre-hire reference checks. Results will be reviewed with Health Care Administrator and Quality Assurance IDT. **DATES OF COMPLETION:** September 30, 2014 **RESPONSIBLE:** Director of Nursing, Nurse Manager	

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F 226	Continued From page 5	F 226		

happened, and there was no witnesses which could be interviewed. On 8/20/14, the occurrence report indicated the facility believed the bruise was from the resident wearing a splint on her left hand, which she would lay on while laying on her left side which may have caused bruising. R35's bruise of unknown origin was never reported to the state agency per facility policy.

During interview on 8/20/14, at 8:07 a.m. clinical manager (CM)-A stated she was aware of R35's bruise of unknown origin which was identified on 8/11/14, however, there was no documentation regarding an investigation of the bruise, and she stated the nurse who first identified the bruise of unknown origin should have reported immediately to the state agency before doing an investigation per facility policy and training. CM-A stated all staff were trained to report bruises of unknown origin.

During interview on 8/20/14, at 9:25 a.m. the director of nursing (DON) stated staff should have reported R35's bruising of unknown origin immediately to the state agency and then completed a written investigation, which had not been done.

R42's admission MDS dated 3/26/14, identified R42 had no cognitive impairment.

A Missing Items Report dated 4/21/14, indicated R42 reported missing money in the amount of $27.00. In the report, R42 stated she had money stored in a wallet inside a purse which was located in her bedroom nightstand. R42 stated there were still coins in the wallet, however, $22.00 of one dollar bills, and one five dollar bill were missing for a total of $27.00. The missing

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F 226	Continued From page 6 money was reported to the state agency on 4/23/14, which was two days after R42 reported the missing money, and not immediately per facility policy. During interview on 8/20/14, at 9:25 a.m. DON stated the staff had investigated R42's missing money first, and didn't submitted the report immediately to the state agency before investigating according to the facility policy. The DON stated the facility policy instructed staff to report immediately, and then complete an investigation. Cook-(C)-A employee file was reviewed and the facility did not do any reference checks before hire. Occupational therapist (OT)-A employee file was reviewed and the facility did not do any reference checks before hire. Trained medication assistant (TMA)-A employee file was reviewed and the facility did not do any reference checks before hire. During interview on 8/19/14, at 3:30 p.m., human resources director (HSD) stated checking references was an important step and it was the facility's policy to do so. HSD confirmed reference checks had not been completed for cook-A, OT-A nor TMA-A.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		

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F 241	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R69), who required assistance with activity of daily living (ADLs) were dressed in a dignified manner. Findings include: During dining observation in the main dining room on 8/18/14, at 5:25 p.m. R69 was wheeled into the dining room in a geri-chair and was wearing a hospital gown and was covered with a blanket. R69's admission Minimum Data Set (MDS) dated 8/19/14, identified the resident had aphasia (inability to speak), was rarely able to make herself understood, and required extensive assistance with dressing and eating. The care area assessment (CAA) dated 8/19/14, identified R69 had an altered level of alertness and dosed off during the interview. She would exhibit episodes of staring into space and then would regain eye contact and appear alert. She had a varied level of alertness since her admission to the facility with only periods of smiles and eye contact. The CAA reported the resident had an underlying dementia and had suffered a hip fracture with subsequent surgery, urinary tract infection and the hospital report of the R69 experiencing " 2 strokes " . She had very limited verbalization and was generally aphasic. R69's care plan dated 8/14/14, noted a deficit in the resident's ability to perform her activities of	F 241	**F241 D** Dignity **RESIDENT:** R69 has passed away **IDENTIFY OTHERS AFFECTED:** Observation of all residents currently on this unit has been conducted to assure residents dignity is being respected in regards to appropriate clothing. **INTERVENTIONS:** CRC Dignity policy/standards of care revised and reviewed with caregivers. Caregivers also received additional training on maintaining resident dignity during mandatory meetings September 11 & 12, 2014, especially as it relates to dressing and grooming. Staff has been reminded that if a resident does not have appropriate clothing or personal items to contact Social Services and they will follow up with family. **MONITOR:** Random resident audits will be conducted on this unit, related to grooming and appropriately dressing residents per facility 'shift routine' directions – which were reviewed and revised as appropriate. Results will be reviewed by Health Care Administrator, Director of Nursing and Quality Assurance IDT. **DATES OF COMPLETION:** September 30, 2014 **RESPONSIBLE:** Director of Nursing, Nurse Manager	

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F 241	Continued From page 8 her daily living and staff were directed to involve the resident and her family in making decisions and choices for her care. The care plan also directed staff to dress the resident in clothing which could be easily removed for toileting. R69 was observed on 8/18/14, at 4:56 p.m., lying on her bed wearing a hospital gown. On 8/19/14, at 6:10 p.m. R69 was observed sitting in a geri-chair and was wearing a hospital gown and was covered with a blanket. During interview on on 8/19/14, at 9:44 a.m. family member (FM)-A was interviewed via phone and stated since R69 was admitted to the facility about a week ago, the resident had been wearing a hospital gown almost continuously. FM-A stated staff had not discussed it with her nor did she request the resident remain in a hospital gown. During interview on 8/19/14, at 1:33 p.m. registered nurse (RN)-D stated since R69's admission to the facility she had been wearing a hospital gown because it was easier for nursing assistants to care for her due to her recent hip fracture. During interview on 8/20/14, at 2:18 p.m. social worker (SW)-A stated she was not aware the resident had not been wearing clothing and just discovered the R69 did not have clothing in her closet. SW-A stated staff dress residents unless the resident or families request them not to and she was not aware of any such requests made by R69 or her family. SW-A stated staff should notify social services if residents don't have clothing, and social services would contact the family. SW-A stated staff had not contacted her	F 241		

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F 241	Continued From page 9 regarding R69 not having any clothing in the facility. A Dignity policy was requested but not provided.	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the communication care plan was followed for 1 of 1 resident, (R7) who was hearing impaired. Findings include: R7's admission face sheet dated 3/2/14, identified R7 had hearing impairment. R7's admission Minimum Data set (MDS) dated 3/9/14, identified R7 had no cognitive impairment, and had minimal difficulty with hearing and wore a hearing aid. R7's Care Area Assessment (CAA) completed on 3/14/14, identified the resident had sensorineural hearing loss bilaterally and used a left hearing aid. The CAA identified R7 had chronic hearing loss and effective communication was considered to be essential to meet her needs and maintain her comfort and safety. R7 care plan dated 5/21/14, directed staff to maintain eye contact with the resident while	F 282	F282 D Care Plan **RESIDENT:** R7's Care plan has bee reviewed and updated. Resident has an appt. scheduled with audiology to have new hearing aides made. Orders for monthly debrox obtained. **IDENTIFY OTHERS AFFECTED:** Initial Communication Care plans are being reviewed for all current residents on unit and updated as needed. 'Custom note' will be made in Accunurse for plan outside of standard communication guidelines. **INTERVENTIONS:** Care plans are updated and maintained in the 'hard' copy chart on the unit. All caregiver staff has access to the care plan. Communication is addressed as part of the nursing weekly flow charting – it had not been included for Medicare and HMO residents due to daily charting but will now be expected on all residents on this unit – with care plan revisions as appropriate. Caregiver staff meetings in September will include review of the updated 'Standard' communication guidelines for all residents.	

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F 282	Continued From page 10 speaking, speak slowly and distinctly, and to listen for feedback to ensure the resident understood. Staff were directed to make sure R7 had her left hearing aide in place while speaking to the resident and assist her as needed. During interview on 8/18/14, at 4:52 p.m. R7 stated she was hard of hearing, especially on her left side. R7 stated some of the nursing assistants, "Yell at me and I'm afraid to ask them for things." R7 stated she didn't know what some of the nursing assistants were saying to her because she could not understand them. R7 stated she felt some of the nursing staff did not respect her limitations, such as her lack of hearing without her hearing aids in. R7 stated she had a hearing aid for her left ear, and staff do not consistently speak to her on her left side and ensure the hearing aide is in so she can understand them. During interview on 8/19/14, at 1:30 p.m. trained medication assistant (TMA)-B stated R7 had a communication barrier and wore a hearing aid. TMA-B stated she was not aware of any special communication plan for R7. During interview on 8/19/14, at 1:45 p.m. registered nurse (RN)-D stated R7 was hard of hearing and wore a hearing aid. RN-D stated she was not aware of any special communication plan for R7. During interview on 8/19/14, at 1:50 p.m. NA-D stated R7 was hard of hearing and was not aware of any special plan that she was to do to communicate with the resident. During interview on 8/20/14, at 7:20 a.m. RN-E	F 282	**MONITOR:** Random audits will be conducted on unit for to verify initial communication care plans are complete, updated and available for all staff. Audit will include monitoring of weekly charting flow by nurses. **DATES OF COMPLETION:** September 30, 2014 **RESPONSIBLE:** Director of Nursing, Nurse Manager	

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F 282	Continued From page 11 stated she was unaware of any plan for communicating with R7 but she was aware R7 was very hard of hearing. RN-E stated R7 had reported to her she was frustrated at times with trying to communicate with some of the nursing assistants. On 8/20/14, at 8:10 a.m. NA-A was observed leaning over R7, while the resident was lying flat in bed. NA-A was about six inches from R7's face and was shouting at the resident. R7 stated to NA-A "Please speak slower so I can understand you!" NA-A then left R7's room without saying anything further to R7. TMA-A entered R7's room to administer her medications and R7 asked for the, "Black box," which contained R7's hearing aid. R7 independently put the hearing aid into her left ear. After R7 put in her hearing aid, she was able to communicate without difficulty with TMA-A. During interview on 8/20/14, at 2:45 p.m. clinical manager (CM)-A stated she expected all staff to use face to face communication with R7, and then pause for confirmation of effective communication. A requested for the facility's policy regarding working with Hearing Impaired clients was made. A policy was not provided, however, an undated document labeled Communication information was provided which instructed staff to address hearing Impaired by lowering their voice, don't shout, speak slowly and clearly, and give the person plenty of time to understand.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 12 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess and monitor skin conditions for 2 of 2 residents (R35 and R25) reviewed for non-pressure related skin issues. Findings include: R35's readmission minimum data set (MDS) dated 7/31/14, identified R35 had diagnoses including history of a stroke and hemiplegia. R35 was identified as having severe cognitive impairment and required extensive assistance from staff for bed mobility, transferring, and dressing. A nursing progress note dated 8/11/14, identified R35 had an 8 x 4 centimeter (cm) eccymotic area over the left breast. The center of bruise was described as dark blue and the periphery was turning yellow. Staff documented they would continue to monitor the bruise. During interview on 8/20/14, at 8:07 a.m., clinical manager (CM)-A stated skin checks are done on a weekly basis on bath days, which included documentation on the treatment administration record (TAR) and a nursing progress note of any skin issues noted. CM-A reviewed R35's clinical	F 309	**F309 D** Provide Care/Services for highest well being **RESIDENT:** R35 successfully met her goals and has discharged home. R25 remains a long term resident on this unit. His skin tears and bruises have resolved. Nursing orders were transcribed to treatment sheet to monitor bruises and treat skin tear per MD orders. **IDENTIFY OTHERS AFFECTED:** It is the expectation of this facility that a weekly comprehensive skin assessment is conducted by a licensed nurse. This is usually scheduled on the residents 'bath' day. All current residents on the unit were reviewed to assure current skin assessments have been completed. **INTERVENTIONS:** Licensed staff has received re-training regarding the expectation for weekly skin assessment and documentation. Reviewed Skin Care Flow Chart policy to record progress of healing at least weekly. Training also received regarding transcribing appropriate treatment and monitoring of bruises and minor skin injuries to the Treatment Sheets. Other caregivers received training regarding daily skin inspection per Accunurse plan of care and reporting of all changes in a resident's skin condition.	

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F 309	Continued From page 13 chart and stated there was no documentation to show there had been any monitoring of R35's bruise since the initial identification on 8/11/14, 9 days earlier. R25's quarterly minimum data set (MDS) dated 5/20/14, identified the resident had moderate cognitive impairment, required extensive assistance of two staff for toileting, dressing, transfers, and bed mobility. On 8/18/14, at 5:25 p.m. R25 was observed with bruising on the left side of his face by his eye, as well as an abrasion on the left side of his forehead. Bruising was also noted on the right upper arm, most of which was covered by a dressing. Review of a facility incident report dated 8/10/14, at 8:15 p.m. identified R25 fell when attempting to self-transfer to bed. R25 had sustained a skin tear to his right elbow measuring 8 cm x 4.5 cm, 6 cm x 3 cm skin tear to the left hand, 7 cm x 2.5 cm bruise to the left eye, and 4 cm x 2 cm abrasion to the left lateral face. Current physician orders contained a treatment order dated 8/16/14, to monitor the dressing on right elbow and change the dressing as needed. During interview on 8/20/14, at 2:30 p.m. registered nurse (RN)-A stated on 8/16/14, R25 approached her and asked her to look at his elbow because he stated it hadn't, "been looked at in a while." RN-A verified no treatment was documented prior her looking at it on 8/16/14, and she initiated the physician order to direct staff to monitor R25's skin issues. RN-A stated this should have been implemented when the fall	F 309	**MONITOR:** Random audits will be conducted on unit to assure completion of weekly skin assessments and monitoring of newly acquired skin injuries. Results will be reviewed by Health Care Administrator, Director of Nursing and Quality Assurance IDT **DATES OF COMPLETION:** September 30, 2014 **RESPONSIBLE:** Director of Nursing, Nurse Manager	

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F 309	Continued From page 14 occurred and injuries were sustained but was not. During interview on 8/20/14, at 9:25 a.m. the director of nursing (DON) stated the facility protocol was to monitor bruising or skin issues on a weekly basis which included writing a nursing progress note to, "Tell the story of its progress." Review of the facility policy, Skin Care Flow Chart dated 9/1/10, instructed progress of healing was to be documented in the clinical record at least weekly.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with facial hair removal and appropriate clothing for 1 of 1 resident (R69) who was reviewed for activities of daily living. Findings include: R69 was admitted to the facility on 8/6/14. The admission Minimum Data Set (MDS), dated 8/19/14, indicated diagnosis that included pathologic fracture of the hip, aphasia (inability to speak) and dementia. The MDS indicated R69 did not speak, had acute changes of mental	F 312	**F312D** ADL Care provided for dependent residents **RESIDENT:** R69 has passed away **IDENTIFY OTHERS AFFECTED:** All residents on this unit have been reassessed to assure they receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene per residents preferences and per facility established Dignity Policy. All MDS's on this unit reviewed for ADL CAA completion.	

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F 312	Continued From page 15 status and required extensive assistance from two staff with bed mobility, transfers, dressing, toilet use, and personal hygiene. R69 had functional limitation in range of motion (ROM) on the upper and lower extremity of one side of her body, and a wheelchair was used for mobility. The care area assessments (CAAs) completed on 8/14/14, did not address activities of daily living. R69's care plan dated 8/14/14, included diagnosis of late effects of cerebrovascular disease (CV), dysphagia (swallowing problem), and muscle weakness. The care plan identified deficits of activities of daily living (ADL) related to post-surgical interventions, deconditioning from recent illness, possibility of stroke, and inability to make her needs known. Interventions included complete set-up for ADLs, total to extensive assistance of two (2) staff for bed mobility, positioning, bathing, grooming, and toileting. The care plan directed staff to dress R69 in clothing that was easily removed for toileting. R69 was observed on 8/18/14, at 5:25 p.m. in the dining room in a geri-chair, wearing a hospital gown and covered with a blanket while staff provided eating assistance. Family member (FM)-A was interviewed via phone on 8/19/14, at 9:44 a.m. and stated R69 had been wearing a hospital gown almost continuously since admission. FM-A reported that staff had not discussed it with her nor did she request this. FM-A stated she assumed it was easier for staff to put R69 into a gown, rather than street clothing. In addition, FM-A reported R69 was not shaved the previous weekend during a	F 312	**INTERVENTIONS:** CRC Dignity policy/standards of care revised and reviewed with caregivers. Caregivers also received additional training on maintaining resident dignity during Caregiver meetings September 11 & 12, 2014, especially as it relates to dressing and grooming. Staff has been reminded that if a resident does not have appropriate clothing or personal items to contact Social Services and they will follow up with family. MDS team to review all resident for identification of resident needs and preferences. **MONITOR:** Random resident audits will be conducted on this unit, related to grooming and appropriately dressing residents per facility 'shift routine' directions - which were reviewed and revised as appropriate. MDS's will be reviewed for accurate CAA documentation. Results will be reviewed by Health Care Administrator, Director of Nursing and Quality Assurance IDT. **DATES OF COMPLETION:** September 30, 2014 **RESPONSIBLE:** Director of Nursing, Nurse Manager	

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F 312	Continued From page 16 visit. FM-A talked to nursing staff about R69's facial hair removal and hoped it was being done. FM-A was concerned about staff not providing facial hair removal because R69 would have been upset to be seen with facial hair. R69 was observed on 8/20/14, at 7:00 a.m. lying in bed, dressed in a hospital-like gown with several facial hairs observed on both sides of the chin. R69's personal care was observed on 8/20/14, at 9:10 a.m.. Nursing assistant (NA)-A and NA-C gave R69 a clean gown, saying there was no other clothing available. R69 was transferred via Hoyer lift into the geri-chair and positioned with pillows and covered with a sheet. NA-C reported personal cares were done and was on route to get R69 some breakfast. Regarding facial hair removal, both nursing assistants acknowledged they observed facial hair but did not know if R69 had a razor. Registered nurse (RN)-D, interviewed on 8/19/14, at 1:33 p.m., stated R69 had been wearing a gown since admission as it was easier for staff to provide care due to the recent hip fracture. RN-D also reported it probably bothered R69 not to be dressed every day. An interview with social worker (SW)-A was completed on 8/20/14, at 2:18 p.m. SW-A reported she was not aware R69 did not have clothing in her closet. Generally residents wear clothing unless resident/family requests otherwise. SW-A was not aware of any such requests by R69's family. She also indicated the staff were to alert social services to provide clothing for residents.	F 312		

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F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to fully evaluate causative factors for urinary incontinence and develop an individualized toileting program for 2 of 2 residents (R22, R69) reviewed for urinary incontinence. Findings include: R22 was admitted to the facility on 6/13/14. The admission Minimum Data Set (MDS), dated 6/20/14, indicated diagnoses that included hip fracture, arthritis and other fracture (humerus). R22 was occasionally incontinent, required extensive assistance of one staff for toileting, was not on a scheduled toileting program and a trial of a toileting program had not been attempted since admission. R22's Bladder Assessment Form, dated 6/20/14, indicated 4 incontinent bladder episodes, all during the night, during the previous seven days. The form also identified staff would monitor and	F 315	F315D No catheter/prevent UTI, Restore Bladder **RESIDENT:** R 69 has passed away. R22 has been re-assessed for bladder incontinence and care plan has been revised. Resident has shown improvement but is still not at her reported pre-admission baseline of continence. She has transferred to facilities long term care neighborhood. **IDENTIFY OTHERS AFFECTED:** All residents bladder care plans/assessments have been reviewed on this unit for accuracy and effectiveness. Plans of care were adjusted if determined necessary. **INTERVENTIONS:** Caregiver staff has received re-training of facilities Bowel and Bladder Protocol and reinforced documentation expectations for NAR's. Defined 'scheduled' toileting programs for NAR's – where to find in care plan and directed care via Accunurse. Reviewed with licensed staff the protocol following removal of a catheter. **MONITOR:** Random audits will be conducted on unit to assure Bowel Protocol is being followed and facility is evaluating causative factors for urinary incontinence and need for indwelling catheters. Results will be reviewed by Health Care Administrator, Director of Nursing and Quality Assurance IDT.	

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F 315	Continued From page 18 chart bladder incontinence and re-assess the following week to see any improvement or patterns. R22's urinary incontinence/indwelling catheter care area assessment (CAA) dated 6/25/14, indicated a care plan would be developed to regain the previous level of continence and suggested a toileting schedule/elimination pattern, regain weight bearing and independent toileting. R22's care plan, dated 7/27/14, indicated R22 had occasional incontinence but the baseline was continence. The interventions included check for incontinence, clothing easily removed for toileting, evaluate patterns to determine if reassessment was necessary or if a toileting schedule would be beneficial. Put in clothing that is easily removed for toileting. R22 was observed being assisted into the bathroom by occupational therapist (OT)-A on 8/19/14, at 7:06 a.m.. OT-A stated R22 had been incontinent and required a new brief. During interview on 8/20/14, at 8:39 a.m., nursing assistant (NA)-B stated R22 needed assist of one to get to the bathroom due to unsteadiness. R22 normally requested toileting assistance by putting the call light on. R22 was also offered assistance to the bathroom before and after meals. During interview on 8/20/14, at 8:48 a.m., NA-A stated R22 did not have a set schedule for toileting and was assisted to the bathroom only when she put her call light on. Registered nurse (RN)-A, interviewed on 8/20/14,	F 315	**DATES OF COMPLETION:** September 30, 2014 **RESPONSIBLE:** Director of Nursing, Nurse Manager	

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F 315	Continued From page 19 at 9:13 a.m., stated R22 let staff know when she needed to use the bathroom. R22 was on an every two hour toileting program when she was admitted, but not now. During interview on 8/20/14, at 12:37 p.m., RN-C stated the MDS staff nurses completed bowel and bladder assessments on admission and quarterly thereafter. RN-C stated she could not locate any bowel and bladder assessments after 6/20/14, to indicate R22's bladder continence had been re-assessed. RN-C stated her co-worker, RN-B completed the 6/20/14 assessment. Staff used a standard every two hour toileting protocol for residents not able to get to the bathroom independently, sometimes they would do an every three hour program. R22 had been added to an every two to three hour toileting program effective 7/1/14, according to the electronic medical record (EMR) task instructions. Regarding individualized toileting programs, RN-C stated that unit nursing staff were responsible for re-evaluations between quarterly MDS assessments. During interview on 8/20/14, at 12:58 p.m., RN-B stated there had been no bladder re-assessment since 6/20/14. During interview on 8/21/14, at 8:25 a.m. the director of nursing (DON) verified the lack of a toileting program for R22. The facility policy, entitled Bowel and Bladder Management (Care Plan Protocols section), last revised 9/1/10, directed the facility shall develop and utilize Bowel and Bladder toileting programs and care delivery protocols. These care planning protocols will then be individualized for each resident.	F 315		

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F 315	Continued From page 20 R69 was admitted to the facility on 8/6/14. The admission MDS competed on 8/19/14, indicated diagnosis that included pathologic fracture of hip, aphasia (inability to speak), and dementia. The MDS indicated acute change in mental status. R69 required extensive staff assistance for bed mobility, transfers, dressing, toilet use and personal hygiene. R69 was wheelchair bound, had an indwelling urinary catheter and was occasionally incontinent of urine. The care area assessments (CAAs) dated 8/18/14, indicated urinary incontinence. R69's indwelling catheter had been removed. R69 was incontinent of urine, was unable to sit on a commode due to poor upper body strength, required two staff assistance for transfer, and staff were to anticipate her needs. The current care plan, established on 8/14/14, directed complete set-up and extensive assistance of two (2) staff for bed mobility, positioning, bathing, grooming and toileting. A Hoyer lift was to be used for all transfers into the wheelchair for meals. Staff were instructed to check for incontinence and change every two hours; dress R69 in clothing that was easily removed for toileting; provide hygiene after voiding and bowel movements to prevent skin breakdown; and to apply moisture barriers. R69 was observed 8/18/14, at 4:56 p.m. lying in her bed with an odor of urine detected. R69's personal cares were observed on 8/20/14, at 9:10 a.m. by nursing assistant (NA)-A and NA-C. NA-C reported R69 had been incontinent of urine and her continence product was changed. NA-C and NA-A stated they check for	F 315		

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F 315	Continued From page 21 urinary incontinence every two hours. All facility residents are checked every two hours if incontinent. Registered nurse (RN)-A , interviewed on 8/20/14, at approximately 9:30 a.m., stated R69 was admitted for hospice services but improved and hospice services were discontinued on 8/12/14. The urinary catheter was discontinued on 8/12/14. RN-A reported R69 was considered to be incontinent of urine and was currently checked and changed every two hours. RN-A stated it was a facility standard of practice for residents to be checked/changed every two hours. RN-A stated a bladder assessment should have been completed when the catheter was removed to determine an appropriate check/change schedule.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and implement interventions to prevent falls for 1 of 3 residents (R22) reviewed for accidents.. Findings include:	F 323	F323 Free of accident Hazards/supervision/devices **RESIDENT:** R22 has been reassessed; fall interventions have been reviewed and updated to minimize the risk of further falls. Resident has not had a fall since 8/16/14. She has improved to weight bearing as tolerated status and has shown improvement in urinary continence. She has moved to our long term neighborhood. **IDENTIFY OTHERS AFFECTED:** Reviewed effectiveness of interventions for current residents on this unit who have with falls in the last 30 days. Verified interventions are in place as recommended to minimize risk of further falls.	

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F 323	Continued From page 22 R22 was admitted to the facility on 6/13/14. The admission Minimum Data Set (MDS), dated 6/20/14, included hip fracture, arthritis and other fracture (humerus). Additionally, the MDS identified that R22 had intact cognition, had experienced falls since admission with no injury, had impaired balance during walking and sitting and required extensive assistance for toileting and transfers. R22's Bladder Assessment dated 6/20/14, indicated R22 had 4 incontinent bladder episodes the previous week, all diring the night. Staff were to monitor and chart episodes or bladder incontinence and reassess the next week to determine improvement or patterns. There was no evidence of follow up to the bladder assessment dated 6/20/14. R22's Care Area Assessments (CAAs), dated 6/25/14, revealed R22 experienced urge incontinence that could contribute to her fall risk. R22's care plan, dated 7/3/14, revealed R22 was at risk for falls due to urinary incontinence with a goal of no falls/fall-related injury by next review. Interventions included anticipate needs, assess for physical needs, repositioning, toileting, a drink of warter, constipation, pain, etc. R22's incident reports and Post Fall Assessments revealed the following information: -Fall on 6/19/14 at 4:20 a.m., cause was unknown/resident unable to express, interventions included positioning resident more in center of bed.	F 323	**INTERVENTIONS:** Reviewed Fall Protocol at mandatory Caregiver meetings. All residents to be referred to therapy following first fall in facility and prn as appropriate with recurrent falls. Nursing re-educated regarding completion of Post Fall assessment and effectiveness of interventions – not repeating an intervention if resident has another fall. Brainstormed on possible interventions for different fall scenarios. Will continue with daily 'stand up' meetings and more detailed weekly IDT meetings to discuss and review falls and appropriateness of fall interventions **MONITOR:** Random audits will be conducted on unit to assure all falls have an effective intervention in place based on the findings of the Root Cause Analysis of fall. Audits will be reviewed at weekly IDT meeting and evaluated by Quality Assurance IDT. **DATES OF COMPLETION:** September 30, 2014 **RESPONSIBLE:** Director of Nursing, Nurse Managers, and Health Care Administrator	

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F 323	Continued From page 23 -Fall on 6/30/14 at 10:30 p.m., cause was trying to self-transfer to commode, interventions included re-education on use of the call light and implement a toileting schedule. Last prior time toileted was marked not applicable (N/A). A Post Fall Assessment, dated 6/30/14 revealed R22 was instructed not to get out of bed without assistance and given her call light. -A Post Fall Assessment, dated 7/2/14, indicated a history of previous falls, forgets to use call light, check positioning and put to bed. -Fall on 8/9/14 at 5:10 a.m., cause was going to bathroom. Last time toileted marked as N/A, interventions included call light within reach and instruction. A Post Fall Assessment, dated 8/9/14, revealed follow up interventions of check positioning/seating, put to bed and circumstances surrounding the fall of resident seems to have been trying to transfer herself to the bathroom unassisted. -A Post Fall Assessment, dated 8/12/14, identified a pattern of falls in the last 90 days with interventions of checking positioning and putting to bed. -Fall on 8/16/14 at 10:36 p.m., cause was trying to go to the bathroom, last time toileted marked as N/A, interventions included call light in reach and instruction. Observation on 8/20/14, at 7:06 a.m. revealed R22 had her call light on and was trying to sit up on the edge of the bed. Registered nurse (RN)-D came to assist R22 back to bed and find out which nursing assistant (NA) was assigned to her for the day. RN-D told R22 that occupational therapist (OT)-A was assigned to get her up and left the room. OT-A entered the room and R22 stated she needed to use the bathroom. OT-A	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING _____ B. WING _____	08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL ACRES HEALTH CARE CTR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 24	F 323		

proceeded to assist R22 with cares and to the toilet. R22 was observed to be unsteady and required the use of a transfer belt and physical support for walking and pivot transfers. OT-A transferred R22 onto the toilet, and stated R22's incontinent brief had been soiled.

During interview on 8/20/14, at 7:32 a.m., OT-A stated R22 had been working primarily with her on independence with dressing and activities of daily living (ADLs). OT-A had not worked with R22 on any specific interventions for falls. Nursing staff was to let therapy know if they had concerns regarding falls.

During interview on 8/20/14, at 8:39 a.m., NA-B stated R22 normally put on her call light for assistance and was not on a scheduled toileting program. R22 was unsteady on her feet and required assistance of one staff for transfers.

During interview on 8/20/14, at 8:48 a.m., NA-A stated R22 was not on a scheduled toileting program. R22 was unsteady on her feet, her legs would sometimes give way during transfers. Physical therapy assistant (PTA)-B was present at the nursing station and stated a lot of R22's falls were because she tried to self-transfer, therapy had worked with her on teaching her to wait for staff, however she did not consistently follow instructions. PTA stated there was a meeting on Tuesdays where falls were discussed, but could not recall any specific fall interventions for R22.

During interview on 8/20/14, at 9:13 a.m., RN-A stated R22 tried to self transfer to the bathroom. RN-A stated interventions currently in use to reduce R22's falls included reminding her to wait

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING _____ B. WING _____	08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL ACRES HEALTH CARE CTR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 25 for help, lowering the bed and trying to keep an eye on her. During interview on 8/20/14, at 12:37 a.m., RN-C stated R22 was not on an individualized toileting plan. She was awere R22 had falls, however was unsure of the frequency and did not complete post fall assessments. During interview on 8/20/14, at 12:58 p.m., RN-B stated he attended the IDT meeting and had not heard anything specifically regarding falls interventions for R22. During interview on 8/21/14, at 8:25 a.m., the director of nursing (DON) stated the IDT team had discussed R22's falls and removed the bedside commode on 8/14/14. The facility policy entitled Fall Prevention and Management, dated 9/1/10, indicated Covenant Retirement Communities health care facilities will have in place a Fall Management protocol utilizing assessments and interventions to minimize the risk of falling for residents. All disciplines will participate in the identification of such residents, evaluation of causative factors, implementation of interventional strategies, and evaluation of efficacy of these strategies and their implementation.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING _____ B. WING _____	08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL ACRES HEALTH CARE CTR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

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F 371	Continued From page 26 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to monitor safe dishwashing temperatures. This had the potential to affect 22 of 22 residents in the facility who received food/fluids out of the facility kitchen. Findings include: During tour on 8/18/14, at 1:30 p.m. with dietary manager (DM) a dishwasher run was observed. Dietary aid (DA)-A stated the temperature was 160° for the wash and 165° for the rinse. She indicated the temperature would go up after about a half an hour. DM stated the gauges on the dishwasher were replaced last month, and verified she had not checked the temperatures after this. Manufacturer directions for operation for Model C-44 dishwasher, provided by DM, verified, "Wash thermometer should register 160° F. Rinse thermometer should register 180° or more during rinsing operation. These temperatures are necessary for proper dishwashing." Dishwashing/Warewashing Machine Temperature Log for June 2014, noted the following: Wash temperatures- four below 160° two not documented Rinse temperatures- zero at or above 180°	F 371	F371 F Food procure, store/prepare/serve – sanitary **IDENTIFY OTHERS AFFECTED:** On the first day of the survey, a plumber inspected the dishwasher and concluded that temperatures were adequate and temperature gauges were recording accurately. **INTERVENTIONS:** The dishwasher temperature log form will be reviewed and revised as necessary. Dietary staff will be educated on the form and procedure for temperature recording and the notification process if temperatures are not within acceptable ranges. **MONITOR:** Random audits will be done to assure accuracy of the recording of dishwasher temperatures. **DATE OF COMPLETION:** September 30, 2014 **RESPONSIBLE:** Dining Services Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING _____ B. WING _____	08/21/2014

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COLONIAL ACRES HEALTH CARE CTR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

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F 371	Continued From page 27 two not documented Final rinse none documented/no column on the form Dishwashing/Warewashing Machine Temperature Log for July 2014, noted the following: Wash temperatures- 11 below 160° three not documented Rinse temperatures- one at or above 180° three not documented Final rinse 12 documented with each one below 180° Dishwashing/Warewashing Machine Temperature Log for August 2014, noted the following: Wash temperatures- four below 160° three not documented Rinse temperatures- five at or above 180° three not documented Final rinse two documented with each one below 180° When interviewed on 8/18/14, at 3:35 p.m. DM stated the gauges on the dishwasher were broken last month and weren't reading correctly. DM verified the gauges had been replaced. She also verified it was a hot water sanitizing system. She stated she was aware the staff were not reading the temperatures correctly, and when she asked about the low temperatures, staff informed her the gauges were broken.. She indicated when reviewing the temperatures for June, she noted the low temperatures, and went in to test the dishwasher with a thermometer, which revealed the temperatures were within normal limits, and got an order for the gauges to be	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING _____ B. WING _____	08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 28 checked. This was middle of July, which was verified with a receipt from Hobart Service from 7/14/14, and 7/15/14. When interviewed on 8/18/14, at 5:15 p.m. DM stated she expects that staff report any low temperatures. She verified the low temperatures had not been reported in July, and she felt the staff were reading the temperatures incorrectly. DM verified she had not reviewed the temperatures after the gauges were replaced, and discovered today the temperatures remained low. DM tested with thermometer and found the temperatures within normal limits. She stated at this time she felt confident the temperatures were correct and the dishes were safe for use by the residents. When interviewed on 8/20/14, at 8:43 a.m., DM stated there was a lack of monitoring the system with the dishwasher temperatures. She indicated there are various forms which are being utilized by staff, and she plans to make one standard form. DM verified staff should record a final rinse temperature and this had not been done. Facility policy titled Dietary/Food Handling implementation date 7/1/09, noted, "Dishwashing units with automatic detergent dispenser must be operated using the following specification: Wash temperature (140°-165°F) - forty-five (45) seconds. Rinse temperature (160°-180°F) - twelve (12) seconds."	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 29 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure prescription medications were secured for 1 of 22 residents (R129) residing in the facility.	F 431	F431 D Drug records, label/store drugs & biologicals **RESIDENT:** R129 has successfully met goals and discharged. **IDENTIFY OTHERS AFFECTED:** Nurse Manager on unit/or designee interviewed all current residents and/or families to assure that no medications from home were being kept in resident room. Rounds were completed and all resident areas were visually observed **INTERVENTIONS:** Admission Consent Form has been modified to include statement that no medications can be kept in resident's room and all medications from home must be locked in medication room until family can take them home. Staff training at Caregiver meetings regarding reporting, removal, and appropriate secure storage of medications found in residents room to be reported to nurse. **MONITOR:** Random audits will be conducted on unit to assure all Admission Consent Forms are filled out completely and timely. Audits will be reviewed and evaluated by Quality Assurance IDT. **DATES OF COMPLETION:** September 30, 2014 **RESPONSIBLE:** Director of Nursing, Nurse Managers, and Health Care Administrator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING _____ B. WING _____	08/21/2014

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F 431	Continued From page 30 Findings include: R129 was admitted to the facility on 8/8/14. Physician's orders printed 8/21/14, did not include orders for self-administration of medications. R129 was observed on 8/18/14, at 3:47 p.m. to have an Albuterol inhaler on the nightstand and a bottle of Delsym (cough syrup) on the bedside table. At 3:52 p.m., a shaving bag was observed in the bathroom with a bottle of Tramadol (narcotic-like analgesic) inside. Registered nurse (RN)-A, interviewed on 8/18/14, at 8:09 p.m., observed R129's shaving case in the bathroom with a note taped to it directing the family to take it home. The bag contained the following medications: Refresh lubricating eye drops Delsym cough syrup - approximately 90 cubic centimeters (cc) (1) Ventolin inhaler (a bronchodilator) Zantac 150 mg tablets (an antacid), approximately 20 tablets Tramadol 50 mg po - (2) bottles with greater than 50 tablets each Advair Discus inhaler 250/50 micrograms (mcg) Citalopram 10 mg tablets (antidepressant) - approximately 30 tablets Ketoprofen Lidocaine ointment - 1/3 bottle (analgesic cream) (1) Proventil inhaler (a bronchodilator) Voltaren 1% gel 100 grams (topical anti-inflammatory) RN-A stated she did not know R129 had the medications in his room or how long the medications had been there. RN-A secured the	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING _____ B. WING _____	08/21/2014

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F 431	Continued From page 31 medications in a locked med room. R129 stated he had not taken any of the medications and was not sure how long they had been in his room. During interview on 8/19/14, at 11:15 a.m., RN-D stated she was unaware R129 had the medication in his room and all resident medications should be stored in the med cart. The director of nurses (DON), interviewed on 8/20/14, at 3:03 p.m., stated R129's medications should have been locked in a medication room. The facility policy entitled Self-Administration of Medication, dated 7/1/09, directed a resident may not be permitted to administer or retain any medication in his/her room unless so ordered, in writing, by the attending physician.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/09/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL ACRES HEALTH CARE CTR	**5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Colonial Acres Health Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The Colonial Acres Health Care Center is made up of two buildings that are attached. The original building is 1 story without a basement and was constructed in 1961. It was determined to be of Type II(000) construction and is fully fire sprinkler protected. In 1982 an addition was built to the north of the original building, is a 1 story building without a basement. It was determined to be of Type V (111) construction, is fully fire sprinkler protected and is separated with at least a 2 hour fire barrier from the original building. This building house State Licensed only beds. This building had additions to it in 2000 of the same construction type and fully fire sprinkler protected. The buildings are divided into 5 smoke zones. The facility has a fire alarm system with smoke detection in the corridor system and in all common areas. The fire alarm system is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 95 beds and had a census of 80 at the time of the survey. Of these beds only 39 are	K 000		

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: EKCK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00183

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245322**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **COLONIAL ACRES HEALTH CARE CTR**
(L4) **5825 ST CROIX AVENUE**
(L5) **GOLDEN VALLEY, MN** (L6) **55422**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/13/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 04 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
01/31

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

12.Total Facility Beds **88** (L18)

13.Total Certified Beds **39** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
39				
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Jessica Sellner, Unit Supervisor 10/13/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 10/14/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 10/30/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245322

October 14, 2014

Mr. Todd Carsen, Administrator
Colonial Acres Health Care Center
5825 St Croix Avenue
Golden Valley, Minnesota 55422

Dear Mr. Carsen:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective the above facility is certified for or recommended for:

39 Skilled Nursing Facility Beds

Your facility's Medicare approved area consists of all 39 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

October 14, 2014

Mr. Todd Carsen, Administrator
Colonial Acres Health Care Center
5825 St Croix Avenue
Golden Valley, Minnesota 55422

RE: Project Number S5521023

Dear Mr. Carsen:

On September 8, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 21, 2014. This survey found the most serious deficiencies 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 October 13, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 21, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 30, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 21, 2014, effective September 30, 2014 and therefore remedies outlined in our letter to you dated September 8, 2014, will not be imposed.

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

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,

Kate Johnston

Kate Johnston, Program Specialist
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Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245322	A. Building B. Wing	10/13/2014

Name of Facility	Street Address, City, State, Zip Code
COLONIAL ACRES HEALTH CARE CTR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

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 **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **09/30/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **09/30/2014**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **09/30/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/30/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **09/30/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **09/30/2014**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **09/30/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/30/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **09/30/2014**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **09/30/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	10/14/2014	29249	10/13/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/21/2014			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/09/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL ACRES HEALTH CARE CTR	**5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Medicaid/Medicare certified, 25 of these were occupied at the time of the survey. For this survey, only the 39 bed section (see sketch) and the associated exiting system are covered under this report as a single building. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		