CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: FN9K

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

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY	AGENCY	F	acility ID: 00284
1. MEDICARE/MEDICAID PROVIDEI (L1) 245389 2.STATE VENDOR OR MEDICAID NO (L2) 695723400		(L3) LANGTON	COUNTY ROAD		(L6) 55112	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF O	WNERSHIP	7. PROVIDER/SU	PPLIER CATEGORY	Y 09 ESRD	04 13 PTIP	(L7) 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other
6. DATE OF SURVEY 10, 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/25/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIC	CE	FISCAL YEAR ENDING 09/30	DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	99 (L18) 99 (L17)	X A. In Complia Program Re Compliance 1. A B. Not in Com	equirements		2. 3. 4.	Technical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code A*	Following Requirements: 6. Scope of Servi 7. Medical Direct 8. Patient Room S 9. Beds/Room (L12)	or
14. LIC CERTIFIED BED BREAKDOV 18 SNF 18/19 SN 99 (L37) (L38)		ICF (L42)	IID (L43)			1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMA 17. SURVEYOR SIGNATURE	RKS (IF APPLICABLE S	BHOW LTC CANCELI Date:	LATION DATE):		18. STATE:	SURVEY AGENCY API	PROVAL	Date:
Momodou Fat	ty, HFE NE II		10/25/2016	(L19)	Kate J	ohnsTon, Pro	ogram Specialis	10/26/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	EGIONAL	OFFICE C	OR SINGLE STAT	E AGENCY	
DETERMINATION OF ELIGIBILE 1. Facility is Eligible to 2. Facility is not Eligible	Participate		MPLIANCE WITH C HTS ACT:	IVIL	21.		ial Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	-1513)
22. ORIGINAL DATE OF PARTICIPATION 12/01/1986 (L24)	23. LTC AGREEM BEGINNING (L41)		24. LTC AGREEME ENDING DATE (L25)		VOLUNTAE 01-Merger, C 02-Dissatisfa	Closure action W/ Reimbursemer	INVOLUNT 05-Fail to Me	ARY et Health/Safety et Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIV A. Suspension B. Rescind Sus	of Admissions:	(L44) (L45)			ason for Withdrawal	OTHER 07-Provider: 00-Active	Status Change
28. TERMINATION DATE:	20	. INTERMEDIARY/C	CARRIER NO		30. REMAR	KS		
	(L28)	03001		(L31)	D.	110/01/0016 G		
31. RO RECEIPT OF CMS-1539		. DETERMINATION	OF APPROVAL DAT			red 10/31/2016 Co.		
	(L32)			(L33)	DETERM	INATION APPRO	VAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245389 October 26, 2016

Mr. Mathew Bedard, Administrator Langton Place 1910 West County Road D Roseville, MN 55112

Dear Mr. Bedard:

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 October 8, 2016 the above facility is certified for or recommended for:

99 Skilled Nursing Facility Beds

Your facility's Medicare approved area consists of all 99 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.

Langton Place October 26, 2016 Page 2

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered October 26, 2016

Mr. Mathew Bedard, Administrator Langton Place 1910 West County Road D Roseville, MN 55112

RE: Project Number S5389025

Dear Mr. Bedard:

On September 8, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 25, 2016. 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 25, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 25, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 8, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 25, 2016, effective October 8, 2016 and therefore remedies outlined in our letter to you dated September 8, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Langton Place October 26, 2016 Page 2

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

		POST	-CERT	IFICATION	N RE	VISIT RI	EPORT	•				
	R / SUPPLIER / CLIA /	MULTIPLE CONS	TRUCTION							DATE O	F REVISI	Т
245389	CATION NUMBER Y1	A. Building B. Wing							Y2	10/25/2	:016	Y3
NAME OF	FACILITY	1			STREET	Γ ADDRESS, CIT	Y, STATE, ZIF	CODE				
LANGTO	N PLACE				1910 WI	EST COUNTY R	OAD D					
					ROSEV	ILLE, MN 55112						
program, corrected provision	ort is completed by a qual to show those deficienced and the date such corre number and the identificate ey report form).	es previously repo ctive action was a	orted on the ccomplishe	CMS-2567, Statem d. Each deficiency	nent of D should I	eficiencies and be fully identifie	Plan of Cored using either	rection, that er the regula	have b	LSC		
ITE	M	DATE	ITEM			DATE	ITEM				DATE	
Y4		Y5	Y4			Y5	Y4				Y5	
ID Prefix	F0279	Correction	ID Prefix	F0280		Correction	ID Prefix	F0309			Correct	tion
Reg.#	483.20(d), 483.20(k)(1)	Completed	Reg. #	483.20(d)(3), 483.10 (2))(k)	Completed	Reg.#	483.25			Comple	eted
LSC		10/08/2016	LSC			10/08/2016	LSC				10/08/20	016
							-					
ID Prefix	F0329	Correction	ID Prefix	F0441		Correction	ID Prefix				Correct	tion
Reg. #	483.25(I)	Completed	Reg. #	483.65		Completed	Reg. #				Comple	eted
LSC		10/08/2016	LSC			10/08/2016	LSC					
ID Prefix		Correction	ID Prefix			Correction	ID Prefix				Correct	tion
Reg. #		Completed	Reg. #			Completed	Reg. #				Comple	eted
LSC		_	LSC				LSC					
ID Prefix		Correction	ID Prefix			Correction	ID Prefix				Correct	tion
Reg. #		Completed	Reg. #			Completed	Reg.#				Comple	eted
LSC		_	LSC				LSC					
ID Prefix		Correction	ID Prefix			Correction	ID Prefix				Correct	tion

DATE DATE **REVIEWED BY REVIEWED BY** SIGNATURE OF SURVEYOR STATE AGENCY (INITIALS) 10/25/2016 SR/KJ 32984 10/26/2016 DATE TITLE DATE **REVIEWED BY** REVIEWED BY CMS RO (INITIALS) CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF FOLLOWUP TO SURVEY COMPLETED ON

Completed

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

Reg. #

LSC

Reg. #

LSC

Completed

Form CMS - 2567B (09/92) EF (11/06)

Reg. #

LSC

8/25/2016

Page 1 of 1

EVENT ID:

FN9K12

YES NO

Completed



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered October 26, 2016

Mr. Mathew Bedard, Administrator Langton Place 1910 West County Road D Roseville, MN 55112

Re: Reinspection Results - Project Number S5389025

Dear Mr. Bedard:

On October 25, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 25, 2016, with orders received by you on . At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

				STA	ATE FO	ORM: REV	ISIT F	REPORT				
	R / SUPPLIER / CI CATION NUMBER	LIA /	MULTIPLE CONS A. Building B. Wing	STRUCTION						Y2	10/25/2	PF REVISIT
	FACILITY N PLACE						1910 W	T ADDRESS, CIT /EST COUNTY RO /ILLE, MN 55112			1	
corrective	e action was acc tion prefix code p	omplishe	d. Each deficien	cy should be	fully ide	entified usin	ig eithe	r the regulation	or LSC prov	and the date suc ision number and nent on the surve	the	
ITEI	M		DATE	ITEM				DATE	ITEM			DATE
Y4			Y5	Y4				Y5	Y4			Y5
ID Prefix	20560		Correction	ID Prefix	20570			Correction	ID Prefix	20830		Correction
Reg. #	MN Rule 4658.04 Subp. 2	-05	Completed	Reg. #	MN Rul Subp. 4	le 4658.0405		Completed	Reg. #	MN Rule 4658.05 Subp. 1	20	Completed
LSC			10/08/2016	LSC				10/08/2016	LSC			10/08/2016
ID Prefix	21375		Correction	ID Prefix	21800			Correction	ID Prefix	_		Correction
Reg. #	MN Rule 4658.08 Subp. 1	800	Completed	Reg. #	MN St. Subd. 4	Statute144.69	51	Completed	Reg.#			Completed
LSC			10/08/2016	LSC				10/08/2016	LSC			-
ID Prefix			Correction	ID Prefix				Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #				Completed	Reg.#			Completed
LSC			_	LSC				-	LSC			-
ID Prefix			Correction	ID Prefix				Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #				Completed	Reg. #			Completed
LSC			_	LSC				-	LSC			-
ID Prefix			Correction	ID Prefix				Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #				Completed	Reg.#			Completed
LSC			_	LSC				-	LSC			-
REVIEWE STATE AG		REVIEW (INITIAL		10/26/2	2016	SIGNATUR	E OF SI		984		DATE 10	/25/2016
REVIEWE CMS RO	D BY	REVIEW (INITIAL		DATE		TITLE					DATE	
FOLLOW (8/25/2016	FOLLOWUP TO SURVEY COMPLETED ON 3/25/2016			CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?							s 🗌 no	

Page 1 of 1

EVENT ID: FN9K12

0.00

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number 245389		Provider/Supplier I LANGTON PLA					
Type of Survey (select all that apply)	A B C D	Complaint Investigation Dumping Investigation Federal Monitoring Follow-up Visit Other	E F G H	Initial Certification Inspection of Care Validation Life Safety Code	I J K L	Recertification Sanctions/Hearing State License CHOW	
Extent of Survey (select all that apply)	B I C I	Routine/Standard Survey (all pr Extended Survey (HHA or Long Partial Extended Survey (HHA) Other Survey	g Term				

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyo	or ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Le	ader ID								
1.	32984	10/24/2016	10/25/2016	0.25	0.00	0.25	0.00	0.25	0.25
2.	30921	10/24/2016	10/25/2016	0.25	0.00	0.25	0.00	0.25	0.25
3.	34986	10/24/2016	10/25/2016	0.25	0.00	0.25	0.00	0.25	0.25
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13.									
14.									

Total RO Supervisory Review Hours.... Total SA Supervisory Review Hours..... 0.25 0.00 Total RO Clerical/Data Entry Hours.....

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

3.25

Total SA Clerical/Data Entry Hours....

EventID: FN9K12 FORM CMS-670 (12-91) Facility ID: 00284 Page 102000

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: FN9K

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PAKI	1 - 10 BF COM	LEFTED BY I	HE STATI	E SURVEY AGENCY	Facility ID: 00284
MEDICARE/MEDICAID PROVIDER NO. (L1) 245389		3. NAME AND AD (L3) LANGTON I		TY		4. TYPE OF ACTION: <u>2</u> (L8)
2.STATE VENDOR OR MEDICAID NO.		(L4) 1910 WEST	COUNTY ROAD	D		1. Initial 2. Recertification 3. Termination 4. CHOW
(L2) 695723400		(L5) ROSEVILLE	E, MN		(L6) 55112	5. Validation 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OWN	ERSHIP	7. PROVIDER/SUI	PPLIER CATEGOR	Y	<u>04</u> (L7)	
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 08/25/ 2	(L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:			
From (a):		A. In Complian	nce With		And/Or Approved Waivers Of The	Following Requirements:
To (b):		Program Re	•		2. Technical Personnel	6. Scope of Services Limit
		Compliance	Based On:		3. 24 Hour RN	7. Medical Director
12 Tetal Facility Dada	00 (1.19)	1. A	Acceptable POC		4. 7-Day RN (Rural SNF)	8. Patient Room Size
12. Total Facility Beds	99 (L18)	V			5. Life Safety Code	9. Beds/Room
13. Total Certified Beds	99 (L17)		npliance with Program and/or Applied Waiv		* C 1 D*	(L12)
14 LTG CERTIFIED BED DREAMDOWN		Requirements	and/or Applied warv	7015.	* Code: B*	(L12)
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS	a.15)
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
99						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARKS	(IF APPLICABLE S	SHOW LTC CANCELI	LATION DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AP	PROVAL Date:
Sheryl Reed, H	FE NE II		09/19/2016	(L19)	Kate JohnsTon, Pr	rogram Specialist 10/21/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RI	` ′	OFFICE OR SINGLE STAT	
19. DETERMINATION OF ELIGIBILITY		20. COM	MPLIANCE WITH C	CIVIL	21. 1. Statement of Financ	ial Solvency (HCFA-2572)
1. Facility is Eligible to Partic	rinate	RIGI	HTS ACT:		 Ownership/Control I Both of the Above : 	interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	ripute				5. Both of the Above .	
2. Facility is not Engine	(L21)					
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	24. LTC AGREEME	ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	E	VOLUNTARY 00	INVOLUNTARY
12/01/1986					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	nt 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIV	E SANCTIONS			03-Risk of Involuntary Termination	OTHER
20. ETC ETTE (GG), ETTE.	A. Suspension				04-Other Reason for Withdrawal	07-Provider Status Change
			(L44)			00-Active
(L27)	B. Rescind Sus	pension Date:	. ,			
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/C	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DA	TE	Posted 10/28/2016 Co.	
	(L32)			(L33)	DETERMINIATION A PROC	N/A I
	(L34)			(L33)	DETERMINATION APPRO	VAL



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered September 8, 2016

Mr. Mathew Bedard, Administrator Langton Place 1910 West County Road D Roseville, MN 55112

RE: Project Number S5389025

Dear Mr. Bedard:

On August 25, 2016, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. 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>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the

Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor Minnesota Department of Health Licensing and Certification Program Health Regulation Division P.O. Box 64900 85 East Seventh Place, Suite 220 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-3793

Fax: 651-215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 4, 2016, the Department of Health will impose the following remedy:

State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC

must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 25, 2016 (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 25, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 09/19/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED
		245389	B. WING		08/	25/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1910 WEST COUNTY ROAD D ROSEVILLE, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	TS .	F 000			
	INITIAL COMMENTS A recertification survey was conducted August 22, 23, 24, and 25, 2016. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.		F 279			10/8/16
	to be furnished to a highest practicable psychosocial well-b §483.25; and any sebe required under § due to the resident's	describe the services that are ttain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided s exercise of rights under				
_ABORATOR\	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE

09/16/2016

Electronically Signed

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		SURVEY PLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1910 WEST COUNTY ROAD D ROSEVILLE, MN 55112		
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F 279	under §483.10(b)(4) This REQUIREMENT by: Based on record refailed to develop a spharmalogical inter (R192) who was remedication. Findings include: During random obs R192 was observed room. When approcalm and agreeable an interview. On 8 sitting in a wheelch Several staff person the resident R192 was told he had just Afterwards when st continued to sit in the and ask where' A review of R192's physician orders Mevening and Risper	the right to refuse treatment.). NT is not met as evidenced eview and interview, the facility care plan that included non ventions for 1 of 5 residents viewed for unnecessary ervations during stage one, divisiting with his wife in his bached R192 appeared very to but unable to participate in 1/24/16 at 2:15 p.m. R192 was air at his doorway to his room. In stopped by and spoke to would ask about his wife and at gotten off the phone with her. aff had left the area, R192 he area and softly call out help	F 279	F279 The facility will continue to enthat each resident has a plan of car is developed and revised and review The policy for Care plan Developme been reviewed and remains in effect Resident R192 has had his plan of reviewed and updated. In addition Resident R192 will have a My Best completed and available for facility view. This My Best day includes the pharmacologic interventions for whe R192 displays behaviors. In addition residents during their OBRA RAI pro (quarterly, annual and significant chassessments) will have a My best dand/or Care strip updated to ensure pharmacologic interventions are avato staff. These will be updated follow the RAI calendar and with significant changes in behaviors. The staff will receive re-education on non pharmacologic interventions and what these are located as a part of the residents plan of care The facility will complete random at	e that wed. ent has et. care Day staff to e non en all ocess ange lay e non ailable wing at I	
	8/12/16 indicated the receiving an anti pse (Risperidone) for doindicated that non pure currently being use	ig Assessment (PDA) dated ne resident was currently sychotic medication elusional disorder and pharmalogical interventions d for R192 included ation and talking about his wife.		25% of the residents following the Cassessment calendar weekly for the 6 weeks with the results to be report the facility Quality Assurance Common to determine ongoing compliance. Clinical Administrator will be responfor ongoing compliance. Date of Compliance is 10-8-16.	e next ted to nittee The	

	ID PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	` '	E SURVEY MPLETED
		245389	B. WING	····	08.	/25/2016
	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			STREET ADDRESS, CITY, STATE, ZIP CODE 1910 WEST COUNTY ROAD D ROSEVILLE, MN 55112		
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 279	The Psychoactive IR 192 currently was medication for failu included aggressio to bed and refusal "help me" and para pharmacological in used included reas visit, listening to favor to him, calling his whim something to disting the entry way. A review of R192's 12/10/15, identified psychotropic medicantidepressant r/t (behavioral disturbation episodes of refusal bed, yelling kicking withdrawn, little interventions included uring the night, hopharmacological in PDA. During an interview on 8/24/16 at 2:30 would be yelling out his wife did not visitiand refusing cares meals as well, and attend by telling him being served. On 8/24/16 at 1:45 coordinator (RN)-B	Drug Assessment indicated a receiving an anti depressant re to thrive. Target behaviors n, kicking hitting, refusal to go of cares, yelling and calling out anoid statements. Non terventions currently being surance R192's wife would worite radio station, staff talking wife, repositioning and giving lrink. It was noted R192 like to of his room and people watch. Care plan, last revised a focus that read: "I use cations, antipsychotic and related to) Dementia with nnce. Depression, I have of cares, refusal to get out of depressive statement erest in eating, asking for staff directions to parking lot" Ided allow resident to sleep over it lacked other non terventions identified on the	F 279			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245389	B. WING		08/25/2016
	PROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 910 WEST COUNTY ROAD D ROSEVILLE, MN 55112	33,23,23
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 279 F 280 SS=D	483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incompetent or other incapacitated under participate in plannic changes in care and A comprehensive as interdisciplinary teaphysician, a register for the resident, and disciplines as deter and, to the extent put the resident, the resident incapacitation in the resident in the resident incapacitation.	les to address R192. 0(k)(2) RIGHT TO NNING CARE-REVISE CP re right, unless adjudged erwise found to be re the laws of the State, to ing care and treatment or	F 279 F 280		10/8/16
	This REQUIREMENT by: Based on observatoreview, the facility facomprehensive carfor skin breakdown for 1 of 1 resident (pressure related skin breakdown skin breakdown for 1 of 1 resident (pressure related skin breakdown skin breakdo	NT is not met as evidenced tion, interview and document ailed to revise the e plan to include interventions and reflect the refusal of care R98) reviewed for non in concerns. The care plan is and benefits explained to the		F280 The facility will continue to en that residents are able to participate their plan of care and treatment, an this will be reflected in the residents of care. The facility has reviewed the policy Resident I Care Plan and it remains effect. Resident R98 has had their care updated to reflect their choice refuse cares including repositioning	e in d that s plan on the s in plan of

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3)		` /	SURVEY PLETED		
		245389	B. WING			08/2	25/2016
	PROVIDER OR SUPPLIER			19	TREET ADDRESS, CITY, STATE, ZIP CODE 910 WEST COUNTY ROAD D ROSEVILLE, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	On 8/24/16 at 8:24 (NA)-C provided me changing an incontinurse (RN)-D broug R98. RN-D indicate on the buttocks was small open areas a bright red and there Calmoseptine was assisted with dress and was taken to the RN-D indicated the the wound measure wound. RN-D addeduring the day or be R98 had diagnoses disease, demential disturbance, insom moderate protein cafailure to thrive. The (MDS) dated 5/4/16 skin break down, dibut was at risk and associated skin daridentified R98 had sneeded extensive a bed mobility and to incontinent and not annual MDS did no Review of the July Flow Sheet (WAFS had three open are appeared as slit like intact and resolved area identified as median incontinent and resolved area identifi	a.m. the nursing assistant orning cares for R98. After inence pad the registered ght in treatment creams for ed the excoriated open area is less than 1 inch and had two bove it. The open area was a was no drainage. applied to the area. R98 was ing, transferred to wheelchair ne dining room for breakfast. unit clinical coordinator took ements and charted on the ed R98 refuses to lay down a checked and changed.	F 2	280	incontinence management. The p care also reflects interventions for staff to attempt when R98 refuses Resident R98, and her family has received the risks for refusal of carthis has been documented. The physician has also documented this refusal of care. The facility has educated the nursing to report to the nurse when a reside refusing cares to ensure that the faction discusses with the resident and/or responsible party the risks of refusionare, and to ensure the plan of cardiacy developed to address this risk and interventions to mitigate the risk. The facility will complete random at 25% of the residents following the disassessment calendar weekly for the weeks with the results to be report to determine ongoing compliance. Clinical Administrator will be resport ongoing compliance. Date of Compliance is 10-8-16.	es, and s ng staff ent is cility family ng that e is identify udits of OBRA e next rted to mittee The	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	NG	RUCTION 		OMPLETED
		245389	B. WING				08/25/2016
	PROVIDER OR SUPPLIER			1910 WES	DRESS, CITY, STATE, ZIP CODE T COUNTY ROAD D .LE, MN 55112		
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F 280	scant serosanguine of calmoseptine and used. On 8/25/16 the was 4.8 x 2.0 with 9 Calmoseptine creat to cover. The note practitioner had becarea. The current care plaidentified the resided down and had a his moisture associated.	ated tissue. The wound had cous drainage. Pass treatment d covered with mepiplex was he WAFS indicated the wound 90% hard red raised skin. The wound would be with mepiplex was applied with mepiplex	F 2	80			
	one staff for repositincontinent products of approaches to repositioned and character plan lacked ever fusals of cares have resident/family. 8/24/16 at approximations in the wheeled table pulled close to	ioning and changing of s, however it lacked direction sident's refusal of being lecked for incontinence. The idence risks and benefits of ad been explained to hately 1:00 p.m. R98 was chair in her room with a tray of the chair and a glass of					
	repositioned R98 at brief, but R98 refus NA-C attempted to wheelchair. NA-C i lay R98 down in the refused. NA-C veri wheelchair since 8: same incontinence	p.m. NA-C reported she fter breakfast and checked the ed and would not lay down. reposition R98 in the ndicated she also offered to afternoon and again R98 fied R98 had been in the 30 a.m. and was still in the brief.					
	On 8/24/16 at appro	oximately 2:45 p.m. RN-D					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245389	B. WING		08/25/2016
NAME OF PROVID				STREET ADDRESS, CITY, STATE, ZIP CODE 1910 WEST COUNTY ROAD D ROSEVILLE, MN 55112	
	EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
reporto lay On 8 clinical areas had journely refuse RN-0 behave and in order famile A color breat proving SS=D F 309 SS=D Each proving or more mention account of the state of the stat	y down in bed to 1/24/16 at 1:45 cal coordinator is on the buttoo fust healed in Journing since Fivounds kept rentinence of bow cals to lay down country of continuation of continuation of continuation of the first had been of the second of	refused to be repositioned or this shift. p.m. the registered nurse (RN)-C verified the open less were reoccurring and they luly. The area had been rebruary 2016. RN-C reported turning due to resident's well and bladder and ongoing and to be repositioned. The area had been refusals of identified cares refusals and standard risks and refusals and skin refusals and skin refusals refusals and skin refusals refusal	F 2		y care

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		` ,	(X3) DATE SURVEY COMPLETED	
		245389	B. WING			/25/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CIT 1910 WEST COUNTY ROSEVILLE, MN 5	Y, STATE, ZIP CODE ROAD D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	plan of care and m prevent further bre resident reviewed f facility also failed to resident/family regardings include: On 8/24/16 at 8:24 (NA)-C provided m changing an incontinurse (RN)-D brough R98. RN-D indicated on the buttocks was small open areas a bright red and there Calmoseptine (moist the area. R98 was transferred to wheed dining room for breunit clinical coordinates are to wheed dining room for breunit clinical coordinates are as a bright red and there Calmoseptine (moist clinical coordinates are an added R98 refuses be checked and changes are to thrive. The (MDS) dated 5/4/16 pressure ulcer but moisture associate MDS identified R98 cognition, needed transfers, bed mobalways incontinent	and treatments identified in the odified the interventions to akdown in skin for 1 of 1 (R98) or skin break down. The explain risks and benefits to arding refusal of care. a.m. the nursing assistant orning cares for R98. After inence pad the registered ght in treatment creams for ed the excoriated open area is less than 1 inch and had two above it. The open area was e was no drainage. Sture barrier) was applied to assisted with dressing, elchair and was taken to the eakfast. RN-D indicated the lator took the wound dicharted on the wound. RN-D is to lay down during the day or langed.	F 3	highest practical The facility has Resident I Care effect. Resident care updated to refuse cares incincontinence made care also reflects staff to attempt Resident R98, a received the rist this has been done physician has a refusal of care. The facility has to report to the refusing cares to discusses with the responsible paracare, and to enside developed to accompany to the facility will care assessment cales weeks with the facility Quality to determine on Clinical Adminis	reviewed the policy on the e Plan and it remains in at R98 has had their plan of the reflect their choice to cluding repositioning and anagement. The plan of the interventions for the when R98 refuses cares, and her family has ks for refusal of cares, and ocumented. The also documented this educated the nursing staff nurse when a resident is to ensure that the facility the resident and/or family the risks of refusing that sure the plan of care is address this risk and identify mitigate the risk. Complete random audits of dents following the OBRA lendar weekly for the next are results to be reported to lity Assurance Committee agoing compliance. The strator will be responsible appliance. Date of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245389	B. WING		 	08/	25/2016
	PROVIDER OR SUPPLIER	•		1	STREET ADDRESS, CITY, STATE, ZIP CODE 910 WEST COUNTY ROAD D ROSEVILLE, MN 55112	,	
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F 309	with severe impairs pressure ulcers, diextensive assist for toileting. No behave A review of the monotes dated 6/16/1 wound and was get A review of body at the resident's button progress note by the referred to body at and groin. Review of the July Flow Sheet (WAFS had three open are appeared as slit liking intact and resolved area identified as redamage (MASD) of and 100% grant scant serosanguin of calmoseptine are used. On 8/25/16 was 4.8 x 2.0 with Calmoseptine creato cover. The notes	s, dated 8/1/16 identified R98 ed cognition, at risk for d have MASD, and needed r all turning repositioning and	F3	809			
	assessment comp as a moderate risk assessment indica mattress and cush	skin risk and braden leted on 8/23/16 identified R98 for skin breakdown, The ted the resident had an air ion in wheelchair, had a turn edule of 2 -21/2 hours and had					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 1910 WEST COUNTY ROAD D ROSEVILLE, MN 55112	•	
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F 309	a check and changincontinence. The resident did not have resistance to a partindicated intervention repositioning and packed led turning a change, pressure recalmoseptine crear further breakdown. Interventions indicate excoriation to coccy on left buttock with no indication of refu	e schedule for urinary assessment indicated the ve any preferences or icular position. The summary ons as specific turning and ressure reducing devices, a and repositioning check and eliving air mattress in and dressing to prevent. The evaluation of ted resident had a history of yx/buttocks. Excoriation noted minimal bleeding. There was usal of turning/repositioning eking and changing of	F3	309		
	identified the resided down and had a his moisture associated identified R98 needs one staff for reposition incontinent product of approaches to repositioned and character plan lacked ever fusals of cares have resident/family. 8/24/16 at approximation sitting in the wheels pulled close to the obeverage was near On 8/24/16 at 2:15 repositioned R98 at	an, reviewed on 8/23/16, ent was at risk for skin break story of pressure ulcers and d skin damage. The care plan led extensive assistance from tioning and changing of s, however it lacked direction esident's refusal of being necked for incontinence. The ridence risks and benefits of ad been explained to the explained to the explained at large table chair and a glass of orange by. p.m. NA-C reported she fiter breakfast and to check and would not lay down.				

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONS	TRUCTION			E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO ROSS-REFERENCED TO THE APP DEFICIENCY)	OULD	BE	(X5) COMPLETION DATE
F 309	wheelchair. NA-C i lay R98 down in the refused. NA-C veri wheelchair since 8: same incontinence On 8/24/16 at approreported R98 had it to lay down in bed to lay down areas on the buttoo had just healed in Joureoccurring since F the wounds kept reincontinence of bow refusals to lay down RN-C verified the cobehavior of continuand repositioning. In the latest to lay down the latest to lay down RN-C verified the cobehavior of continuand repositioning. In the latest la	reposition R98 in her ndicated she also offered to afternoon and again R98 fied R98 had been in the 30 a.m. and was still in the brief. Eximately 2:45 p.m. RN-C refused to be repositioned or his shift. p.m. the registered nurse (RN)-C verified the open ks were reoccurring and they uly. The area had been ebruary 2016. RN-C reported turning due to resident's vel and bladder and ongoing and to be repositioned. The area had been ed refusals of identified cares RN-C also indicated there was hat indicated risks and discussed with the resident or approximately 9:00 a.m. R98 st in main dining room and	F3	09				
	was taken to her ro her room in the whe opened. The nursin wanted to lay down nursing assistant to At 10:13 a.m. the cl assistant and the nur room and spoke to asked R98 if she co refused. The RN-C	om at 9:42 a.m. R98 sat in selchair with window shade g assistant asked if she and R98 declined. The ld R98 she would return later. inical coordinator, the nursing arse practitioner entered the R98. The nursing assistant ould lay her down, and R98 explained because the d, the nurse practitioner was						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 1910 WEST COUNTY ROAD D ROSEVILLE, MN 55112	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD	BE	(X5) COMPLETION DATE
F 309	On 8/25/16 at approreported the wound practitioner, however provided. The care indicate new interversks and benefits hand guardian. A copy of the nurse	area. Because R98 refused, try at a later time. Eximately 2:00 p.m. the RN-C was assessed by the nurse er documentation was never a plan had been updated to entions developed as well as and been explained to resident practitioner note and a policy skin breakdown were	F3	309			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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F 309	Continued From pa	ge 12	F3	09		
F 329 SS=D	UNNECESSARY D Each resident's dru unnecessary drugs drug when used in e duplicate therapy); without adequate m indications for its us adverse consequent should be reduced e combinations of the Based on a compre resident, the facility who have not used given these drugs ut therapy is necessar as diagnosed and de record; and residen drugs receive gradu	g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or onitoring; or without adequate se; or in the presence of ices which indicate the dose or discontinued; or any	F3	29		10/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245389	B. WING		08/25	5/2016
	PROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 910 WEST COUNTY ROAD D ROSEVILLE, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	drugs.	ge 13 an effort to discontinue these NT is not met as evidenced	F 329			
	by: Based on observarinterview, the facility pharmalogical intersof psychoactive medications. Findings include: During random obsective room. When approcalm and agreeable an interview. On 8, sitting in a wheelch Several staff persothe resident R192 was told he had just Afterwards when strontinued to sit in the me and ask where' A review of R192's physician orders Mevening and Risperson.	tion, document review and y failed to develop non ventions for the continual use edication for 1 of 5 residents viewed for unnecessary ervations during stage one, divisiting with his wife in his eached R192 appeared very but unable to participate in 24/16 at 2:15 p.m. R192 was air at his doorway to his room. In stopped by and spoke to would ask about his wife and to gotten off the phone with her. aff had left the area, R192 ne area and softly call out help		F 329 The facility will continue to end that residents who receive psychotr medications have non pharmacologinterventions identified on the reside plan of care. The facility has reviewed the policy Unnecessary Medications and it renin effect. Resident R192 has had hof care reviewed and updated. In a Resident R192 will have a My Best completed and available for facility view. This My Best day includes the pharmacologic interventions for whe R192 displays behaviors. In addition residents during their OBRA RAI pro (quarterly, annual and significant chassessments) will have a My best dand/or Care strip updated to ensure pharmacologic interventions are avato staff. These will be updated follow the RAI calendar and with significant changes in behaviors. The staff will receive re-education on non pharmacologic interventions and what these are located as a part of the residents plan of care.	opic gic ent s on mains is plan ddition Day staff to e non en en all occess ange ay e non ailable wing at t	
		ng Assessment (PDA) dated ne resident was currently		The facility will complete random au 25% of the residents following the C assessment calendar weekly for the	DBRA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245389	B. WING _			08/25/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 1910 WEST COUNTY ROAD D ROSEVILLE, MN 55112	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
F 329	(Risperidone) for dindicated that non particular currently being use reassurance, validated. The Psychoactive R192 currently was medication for failure included aggression to bed and refusal "help me" and parapharmacological in used included reast visit, listening to favor to him, calling his whim something to sit in the entry way. A review of R192's 12/10/15, identified psychotropic medicantidepressant r/t (behavioral disturbated antidepressant r/t	age 14 sychotic medication elusional disorder and charmalogical interventions ad for R192 included ation and talking about his wife. Drug Assessment indicated a receiving an anti depressant are to thrive. Target behaviors n, kicking hitting, refusal to go of cares, yelling and calling out anoid statements. Non terventions currently being surance R192's wife would vorite radio station, staff talking vife, repositioning and giving drink. It was noted R192 like to of his room and people watch. care plan, last revised I a focus that read: "I use cations, antipsychotic and related to) Dementia with ance. Depression, I have I of cares, refusal to get out of a depressive statement erest in eating, asking for staff directions to parking lot" ded allow resident to sleep owever it lacked other non terventions identified on the with nursing assistant (NA)-B p.m. indicated R192's behavior at most of the time and when t. R192 would be yelling for would refuse to go to meals rould encourage him to attend t the special foods that were	F 3:	6 weeks with the results to the facility Quality Assurance to determine ongoing comp Clinical Administrator will be for ongoing compliance. Do Compliance is 10-8-16.	ce Committed liance. The e responsible	e

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245389	B. WING		08/	25/2016
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 910 WEST COUNTY ROAD D ROSEVILLE, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	coordinator (RN)-B non pharmacologic	ge 15 p.m. the unit clinical nurse verified the care plan lacked al interventions that would eniques to address R192's	F 329			
F 441 SS=D	behaviors.	I CONTROL, PREVENT	F 441			10/8/16
	Infection Control Pr safe, sanitary and o	tablish and maintain an ogram designed to provide a omfortable environment and development and transmission ction.				
	Program under which (1) Investigates, continuous in the facility; (2) Decides what proshould be applied to	tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective				
	determines that a reprevent the spread isolate the resident. (2) The facility must communicable dise from direct contact direct contact will tr. (3) The facility must	ion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	(X3) DATE SURVEY COMPLETED		
		245389	B. WING		08/25/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1910 WEST COUNTY ROAD D ROSEVILLE, MN 55112	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 441	transport linens so infection. This REQUIREMED by: Based on observareview, the facility for to prevent the spreglucose monitoring observed who requand failed to ensure measures were management of the spregular observed who requand failed to ensure measures were management.	•	F 44	F441 The facility will continue to entitat there is an Infection Control Proin place to provide a safe, sanitary a comfortable environment. The facility has reviewed the Infection Control policies of Blood Glucose Machine Cleaning and Use of Glove these both remain in effect. The facility has reviewed wipes from use 8/25/16 and reviewed all remaining to the second control policies.	gram nd on s, and cility e on
	R346 received blood glucose monitoring on 9/22/16, in the evening and registered nurse (RN)-A did not properly clean it between each residents use. On 8/22/16, at 7:10 p.m. registered nurse (RN)-A indicated she was going to check R346's blood sugar (test performed on residents who are diagnosed with diabetes). RN-A retrieved a blood glucose monitor and supplies from the medication cart and went into R346's room. At the completion of the blood glucose test, RN-A took the blood glucose monitor, brought it back to the medication cart, set it on top, and stated she would clean it when finished documenting. On 8/22/16, at 7:23 p.m. RN-A obtained and			to ensure they were not expired on 8/25/16. The facility has provided education to staff on Infection Control, and specification on the cleaning of Blood Glucose Machines and Glove use. In addition education was provided to staff on the chemical expiration dates. The facility will complete random author to ensure infection control progration place weekly for the next 6 weeks the results to be reported to the facility Quality Assurance Committee to determine ongoing compliance. The Clinical Administrator will be responsifor ongoing compliance. Date of Compliance is 10-8-16.	rically n ne dits um is with ity

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245389	B. WING			08/2	25/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 1910 WEST COUNTY ROAD D ROSEVILLE, MN 55112	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 441	walked back to the removed the blood of the cart and walk Sani-cloth bleach conurse's station. RN-monitor, stating she seconds. RN-A furtiget it clean when wibleach container was expiration date of 6. On 8/23/16, at 8:18 expectation with gluit with bleach wipes let it air dry between On 8/25/16, at 12:5 (DON) stated blood cleaned after each multi-use glucometrollow manufacturer monitor with wipes, minutes, and then leanother patient. DO use the gold top Sanitated 2015 indicated to clean and disinfed are shared between manufacturer's guiddisinfecting of glucomanufacturer to dei procedures, specific should be adhered	dministration for R346 and medication cart. RN-A glucose monitor from the top ted down the hall to the ontainer located near the A wiped the blood glucose wipes the monitor for 30 her stated she makes sure to iping it for 30 seconds. The as observed to have an /2016. a.m. RN-B stated her accometer cleaning was to wrap for three to five minutes and a patients. 8 p.m. the director of nursing glucose monitors should be use because they are ers. DON stated staff should r's guidelines, wipe the wrap it for three to four et it air dry before use on only further stated staff should ni-cloth bleach wipes. fection control general policies ecting blood glucose meters that a residents." "11. Follow delines for cleaning and one meters Consult with termine which cleaning coto glucose meter sharing, to glucose meter sharing,	F 4	.41			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		245389	B. WING _		08	/25/2016	
NAME OF PROVIDER OR SUPPLIER LANGTON PLACE				STREET ADDRESS, CITY, STATE, ZIP CO 1910 WEST COUNTY ROAD D ROSEVILLE, MN 55112			
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 441	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 44	.1			
	director of nursing that all staff should should remove glo	on 8/25/16, at 1:27 p.m. stated her expectation was know when to use gloves, wes when finished exposure to ect hands by washing hands or					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245389	B. WING		08/	/25/2016	
NAME OF PROVIDER OR SUPPLIER LANGTON PLACE				STREET ADDRESS, CITY, STATE, ZIP CO 1910 WEST COUNTY ROAD D ROSEVILLE, MN 55112			
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLÉTION		
F 441	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 4	41			

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

Printed: 08/30/2016 FORM APPROVED OMB NO. 0938-0391

08/24/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 (X3) DATE SURVEY COMPLETED

245389

LANGTON PLACE

STREET ADDRESS, CITY, STATE, ZIP CODE 1910 WEST COUNTY ROAD D

B. WING_

DOCEVILLE MN 55412

	ROSEV	ILLE, MN	55112	Û
(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		K 000	DEFICIENCY)	
	ORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIG	CMATLIDE	TITLE	(X6) DATE

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

TITLE

(X6) DATE

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

	OF ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY				
NO HARM WI FOR SNFs AN	ITH ONLY A POTENTIAL FOR MINIMAL HARM D NFs	245389	A. BUILDING:B. WING	COMPLETE: 8/25/2016				
NAME OF PRO	OVIDER OR SUPPLIER N PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1910 WEST COUNTY ROAD D ROSEVILLE, MN						
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIE	NCIES						
F 156	483.10(b)(5) - (10), 483.10(b)(1) NOT							
	The facility must inform the resident behis or her rights and all rules and regular in the facility. The facility must also punder §1919(e)(6) of the Act. Such no resident's stay. Receipt of such inform	ations governing re rovide the resident stification must be re ation, and any ame	esident conduct and responsibilities dur with the notice (if any) of the State de- made prior to or upon admission and du- endments to it, must be acknowledged in	ring the stay veloped uring the n writing.				
	The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.							
	The facility must inform each resident resident's stay, of services available in services not covered under Medicare o	the facility and of	charges for those services, including an					
	The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;							
	A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.							
	A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.							
	The facility must inform each resident for his or her care.	The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.						
	The facility must prominently display i applicants for admission oral and writte benefits, and how to receive refunds for	en information abo	out how to apply for and use Medicare a					

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

The above isolated deficiencies pose no actual harm to the residents

Event ID: FN9K11 If continuation sheet 1 of 2

TATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM		PROVIDER #	MULTIPLE CONSTRUCTION A. BUILDING:	DATE SURVEY			
FOR SNFs AN		245389	B. WING	COMPLETE: 8/25/2016			
NAME OF PR	OVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 1910 WEST COUNTY ROAD D ROSEVILLE, MN					
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIE	NCIES					
F 156	Continued From Page 1						
	This REQUIREMENT is not met as e Based on document review and intervi beneficiary for 1 of 3 residents (R34) I Findings include:	ew, the facility did r		are			
	Record review for R34 revealed a Trandischarged on 7/9/16. A Physician Cer	nsfer/Discharge Report showing that R34 was admitted on 6/17/16 and rtification and Recertification form, signed by a provider on 6/23/16, lled nursing facility services after inpatient hospital services and timated 30 day period.					
	When a surveyor requested a denial let director of health information manager located. This HIM director went on to form was given to the social worker or could not be found.	ment (HIM) stated the explain that R34 ha	nat a denial letter or liability notice cond been covered by Medicare for there	uld not be apies, a denial			



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted September 8, 2016

Mr. Mathew Bedard, Administrator Langton Place 1910 West County Road D Roseville, MN 55112

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5389025

Dear Mr. Bedard:

The above facility was surveyed on August 22, 2016 through August 25, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Langton Place September 8, 2016 Page 2

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susanne Reuss, Unit Supervisor at (651) 201-3793.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00284	B. WING		08/25/2016
NAME OF D	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE ZID CODE	1 00/25/2010
			ST COUNTY RO		
LANGTON	IPLACE	ROSEVII	LE, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
2 000	Initial Comments		2 000		
	****ATTEN	TION*****			
	NH LICENSING CO	ORRECTION ORDER			
	144A.10, this correction pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart Determination of where corrected requires correquirements of the runumber and MN Rule	ther a violation has been mpliance with all			
	comply with any of the lack of compliance. L re-inspection with any result in the assessment	e items will be considered ack of compliance upon item of multi-part rule will ent of a fine even if the item ing the initial inspection was			
	that may result from norders provided that a	earing on any assessments con-compliance with these witten request is made to a 15 days of receipt of a for non-compliance.			
	surveyors of this Depa above provider and the orders are issued. Ple electronic plan of corr	through August 25, 2016, artment's staff visited the se following correction ease indicate in your ection that you have s, and identify the date when			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

09/16/16 **Electronically Signed**

TITLE

Minnesota Department of Health

WIIIIICSOL	a Department of Health					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		= IED
		00284	B. WING	B. WING		5/2016
	20//255 05 0//55//55		DE00 0171/ 074	TE 710 0005	, , ,	0.2010
NAME OF PI	ROVIDER OR SUPPLIER		ORESS, CITY, STA			
LANGTON	PLACE		T COUNTY RO	AD D		
		ROSEVILL	E, MN 55112			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	NEGOE/WORL ONE		TAG	DEFICIENCY)		
2 000	Continued From page	2 1	2 000			
	The facility is enrolled	I in ePOC and therefore a				
	•	red at the bottom of the first				
	•	though no plan of correction				
	is required, it is requir					
		of the electronic documents.				
	p.					
2 560	MNI Dula 4659 0405 9	Subp. 2 Comprehensive	2 560			10/8/16
2 300	Plan of Care; Content	•	2 300			10/6/10
	Flati of Care, Content	.5				
	Subp. 2. Contents of	nlan of care. The				
		of care must list measurable				
		bles to meet the resident's				
	-	goals for medical, nursing,				
		nosocial needs that are				
	identified in the comp					
		nprehensive plan of care				
		ridual abuse prevention plan				
		a Statutes, section 626.557,				
	subdivision 14, parag	тарії (b).				
	This MN Requirement	t is not met as evidenced				
	by:	t is not met as evidenced				
	,	ew and interview, the facility		The policy for Care plan Development	has	
		re plan that included non		been reviewed and remains in effect.	iius	
		ntions for 1 of 5 residents		Resident R192 has had his plan of cal	re	
	(R192) who was revie			reviewed and updated. In addition		
	medication.	wed for difficuous ary		Resident R192 will have a My Best Da	av.	
	modioation.			completed and available for facility sta	-	
	Findings include:			view. This My Best day includes the r		
				pharmacologic interventions for when		
	During random observ	vations during stage one,		R192 displays behaviors. In addition a	all	
	•	risiting with his wife in his		residents during their OBRA RAI proce		
		thed R192 appeared very		(quarterly, annual and significant chan		
		out unable to participate in		assessments) will have a My best day		
		1/16 at 2:15 p.m. R192 was		and/or Care strip updated to ensure no		
		at his doorway to his room.		pharmacologic interventions are availa		
		stopped by and spoke to		to staff. These will be updated following		
		uld ask about his wife and		the RAI calendar and with significant	5	

Minnesota Department of Health

STATE FORM FN9K11 If continuation sheet 2 of 22

Minnesota Department of Health

MILLIESOL	a Department of Fleatti	<u> </u>				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
				_		
		00004	B. WING		00/0	= (00.40
		00284	2. WING		08/2	25/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		1910 WES	COUNTY RO	AD D		
LANGTON	IPLACE	ROSEVILL	E, MN 55112			
(V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	I.D.	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
2 560	Continued From page	2	2 560			
	. •					
		gotten off the phone with her.		changes in behaviors. The staff will		
		f had left the area, R192		receive re-education on non		
	continued to sit in the	area and softly call out help		pharmacologic interventions and when	е	
	me and ask where's r	ny wife.		these are located as a part of the		
				residents plan of care		
	A review of R192's me	edical record indicated		The facility will complete random audi	ts of	
	physician orders Mirta	azapine 7.5 mg every		25% of the residents following the OB	RA	
	evening and Risperide	one .25 mg once a day and		assessment calendar weekly for the n	ext	
	.5 mg twice a day for	delusional disorder.		6 weeks with the results to be reported	d to	
				the facility Quality Assurance Commit	iee	
	A Psychoactive Drug	Assessment (PDA) dated		to determine ongoing compliance. Th	е	
	8/12/16 indicated the	resident was currently		Clinical Administrator will be responsil	ole	
	receiving an anti psyc	chotic medication		for ongoing compliance. Date of		
	(Risperidone) for delu	isional disorder and		Compliance is 10-8-16		
		armalogical interventions				
	currently being used f	_				
		on and talking about his wife.				
		ug Assessment indicated				
		eceiving an anti depressant				
		to thrive. Target behaviors				
		kicking hitting, refusal to go				
		cares, yelling and calling out				
	"help me" and parano					
		ventions currently being				
		rance R192's wife would				
		ite radio station, staff talking				
		e, repositioning and giving				
		ik. It was noted R192 like to				
	•	his room and people watch.				
	Sit in the entry way or	The room and people water.				
	A review of R192's ca	re plan. last revised				
		focus that read: "I use				
	· ·	ions, antipsychotic and				
		ated to) Dementia with				
		e. Depression, I have				
		cares, refusal to get out of				
	bed, yelling kicking de					
		est in eating, asking for staff				
		ections to parking lot"				
		d allow resident to sleep				
			1	I .		

Minnesota Department of Health

STATE FORM 6899 FN9K11 If continuation sheet 3 of 22

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00284	B. WING		30	3/25/2016
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATI			
LANGTON	N PLACE		ST COUNTY ROA LLE, MN 55112	D D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 560	pharmacological inter PDA. During an interview w on 8/24/16 at 2:30 p.r would be yelling out rhis wife did not visit, Fand refusing cares. Fmeals as well, and stattend by telling him vbeing served. On 8/24/16 at 1:45 p. coordinator (RN)-B very possible production of the possible production of the possible production of the productio	ever it lacked other non ventions identified on the vith nursing assistant (NA)-B m. indicated R192's behavior nost of the time and when R192 would be yelling for her R192 would refuse to go to aff would encourage him to what special foods were m. the unit clinical nurse erified the care plan lacked interventions that would	2 560			
	review, the facility fail comprehensive care p for skin breakdown ar for 1 of 1 resident (RS	plan included interventions nd reflect the refusal of care 98) reviewed for non concerns and did not				

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STATE FORM 6899 FN9K11 If continuation sheet 4 of 22

Minnesota Department of Health

MILLIESOL	a Department of Fleatti	<u> </u>				
STATEMENT	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		00284	B. WING		08/2	25/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE ZIP CODE		
TO WILL OF TH	TO VIDER ON OUT FEILING		, ,	·		
LANGTON	I PLACE		T COUNTY RO	AD D		
		ROSEVILI	.E, MN 55112			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
				BEI IOIEITOT)		
2 560	Continued From page	2.4	2 560			
	Continuou i rom page					
	On 8/24/16 at 8:24 a.	m. the nursing assistant				
	(NA)-C provided morr	ning cares for R98. After				
		ence pad the registered				
		t in treatment creams for				
		the excoriated open area				
		•				
		ess than 1 inch and had two				
	•	ve it. The open area was				
	bright red and there w	•				
		plied to the area. R98 was				
	assisted with dressing	g, transferred to wheelchair				
	and was taken to the	dining room for breakfast.				
	RN-D indicated the ur	nit clinical coordinator took				
	the wound measurem	ents and charted on the				
		R98 refuses to lay down				
		checked and changed.				
	during the day of be c	checked and changed.				
	R08 had diagnoses th	nat included Alzheimer's				
	disease, dementia wit					
	disturbance, insomnia					
	•	orie malnutrition and adult				
		annual minimum data set				
		ndicated R98 was at risk for				
	skin break down, did	not have a pressure ulcer				
	but was at risk and di	d have a moisture				
	associated skin dama	ige (MASD). The MDS				
	identified R98 had se	vere impaired cognition,				
		sist of one for all transfers,				
	bed mobility and toile	•				
		n a toileting program. The				
		dentify any behaviors.				
	annual MDS did not it	dentity arry behaviors.				
	Davious of the July 1	2016 Wound Assessment				
		2016 Wound Assessment				
		progress note indicated R98				
		on the buttocks, the areas				
		ppenings. The areas were				
	intact and resolved or	n 7/22/16. On 8/23/16 an				
	area identified as moi	sture acquired skin				
		ne left buttocks that was .6 x				
		ed tissue. The wound had				

Minnesota Department of Health

STATE FORM 6899 FN9K11 If continuation sheet 5 of 22

Minnesota Department of Health

MILLIESUL	a Department of Health	<u> </u>				
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUF					
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			D WING			
		00284	B. WING		08/2	25/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
LANGTON	I PLACE		T COUNTY RO	ADD		
		ROSEVILL	.E, MN 55112			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORT OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	MAIE	DAIL
				- ,		
2 560	Continued From page	e 5	2 560			
	. •					
		us drainage. Pass treatment				
	•	covered with mepiplex was				
		e WAFS indicated the wound				
	was 4.8 x 2.0 with 90°	% hard red raised skin.				
	Calmoseptine cream	was applied with mepiplex				
	to cover. The note in	dicated the nurse				
	practitioner had been	requested to assess the				
	area.					
	The current care plan	, reviewed on 8/23/16,				
	identified the resident	was at risk for skin break				
	down and had a histo	ry of pressure ulcers and				
		skin damage. The care plan				
		d extensive assistance from				
	one staff for reposition					
	-	however it lacked direction				
		dent's refusal of being				
		cked for incontinence. The				
	•	ence risks and benefits of				
	refusals of cares had					
		been explained to				
	resident/family.					
	0/04/40	t-1. 1.00 D00				
		tely 1:00 p.m. R98 was				
	•	air in her room with a tray				
	•	he chair and a glass of				
	orange beverage was	s near by.				
		m. NA-C reported she				
	•	r breakfast and checked the				
	brief, but R98 refused	l and would not lay down.				
	NA-C attempted to re	position R98 in the				
	wheelchair. NA-C inc	dicated she also offered to				
	lay R98 down in the a	afternoon and again R98				
		ed R98 had been in the				
		a.m. and was still in the				
	same incontinence br					
	22					
	On 8/24/16 at approx	imately 2:45 p.m. RN-D				
		fused to be repositioned or				
	to lay down in bed this					
	to lay down in bed till	o ornic.	1			1

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STATE FORM 6899 FN9K11 If continuation sheet 6 of 22

Minnesot	a Department of Health	า				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	=150
		00004	B. WING		00/0	NE (0040
		00284	B. WIIVO		08/2	25/2016
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
LANGTON	I PLACE		T COUNTY RO .E, MN 55112	AD D		
0/0.15	STIMMADA ST.	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	.1	0/5)
(X4) ID PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	JATE	DATE
0.500			0.500			
2 560	Continued From page	e 6	2 560			
	0.0/04/40 14.45					
		m. the registered nurse RN)-C verified the open				
	,	s were reoccurring and they				
	-	y. The area had been				
	•	oruary 2016. RN-C reported				
		rning due to resident's I and bladder and ongoing				
		and to be repositioned.				
	RN-C verified the care	e plan did not address the				
		I refusals of identified cares				
	no documentation that	N-C also indicated there was				
		cussed with the resident or				
	family.					
	A copy of a policy for					
	breakdown were requ	uested however, not				
	provided.					
	SUCCESTED METH	OD OF CORRECTION:				
		g (DON) or designee, could				
		ent policies and procedures				
		sive care plans. The DON				
		ovide training for all nursing ation documented on the of				
		ation documented on the or assessment and assurance				
	committee could perfe					
	ensure compliance.					
	TIME PERIOD FOR (CORRECTION;				
	Thwenty-one (21) day	ys .				
2 570		Subp. 4 Comprehensive	2 570			10/8/16
	Plan of Care; Revisio	n				

Minnesota Department of Health

Subp. 4. Revision. A comprehensive plan of

STATE FORM 6899 FN9K11 If continuation sheet 7 of 22

Minnesot	a Department of Healtl	า				
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00284	B. WING		08/25/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
		1910 WES	T COUNTY RO	OAD D		
LANGTON	I PLACE		LE, MN 55112			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PRÉFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		
TAG	REGULATORT OR I	130 IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	MATE	
		_	0.550			
2 570	Continued From page	2 7	2 570			
	care must be reviewe	ed and revised by an				
		that includes the attending				
		d nurse with responsibility				
	, , ,	other appropriate staff in				
		ined by the resident's needs,				
	and, to the extent pra	-				
	participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of					
the comprehensive resident by part 4658.0400, subpart		_				
	<i>by</i> part 1000.0100, 0	aspart of item 5.				
	This MAN Descriptions	t is not meet as suideneed				
	_ ·	t is not met as evidenced				
	by:	intonious and decument		The facility has reviewed the relieve	- th	
		n, interview and document		The facility has reviewed the policy or		
	review, the facility fail			Resident I Care Plan and it remains in		
		plan to include interventions		effect. Resident R98 has had their place		
		nd reflect the refusal of care		care updated to reflect their choice to		
	for 1 of 1 resident (RS	The state of the s		refuse cares including repositioning a		
	1 -	concerns. The care plan		incontinence management. The plan		
	· ·	and benefits explained to the		care also reflects interventions for the	stan	
	guardian/resident.			to attempt when R98 refuses cares.	a is cond	
	Cindings included:			Resident R98, and her family has reco		
	Findings included:			the risks for refusal of cares, and this		
	On 9/24/16 of 9:24 a	m the pureing assistant		been documented. The physician ha	5	
		m. the nursing assistant			-1-ff	
		ning cares for R98. After		The facility has educated the nursing		
		ence pad the registered		to report to the nurse when a resident		
		t in treatment creams for		refusing cares to ensure that the facili		
		the excoriated open area		discusses with the resident and/or fan		
		ess than 1 inch and had two		responsible party the risks of refusing		
	-	ove it. The open area was		care, and to ensure the plan of care is		
	bright red and there v			developed to address this risk and ide	entiry	
		oplied to the area. R98 was		interventions to mitigate the risk.		
	1	g, transferred to wheelchair		The facility will complete random audi		
		dining room for breakfast.		25% of the residents following the OB		
		nit clinical coordinator took		assessment calendar weekly for the n		
	the wound measurem	nents and charted on the		6 weeks with the results to be reporte	d to	

Minnesota Department of Health

wound. RN-D added R98 refuses to lay down

STATE FORM 6899 FN9K11 If continuation sheet 8 of 22

the facility Quality Assurance Committee

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLI					
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		COMIL	LILD
		00284	B. WING		08/2	25/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
LANGTON	I PLACE		COUNTY RO E, MN 55112	AD D		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	IATE	DATE
2 570	Continued From page	8	2 570			
		checked and changed.		to determine ongoing compliance. The Clinical Administrator will be responsite		
	disease, dementia wit	nat included Alzheimer's thout behavioral		for ongoing compliance. Date of Compliance is 10-8-16		
	disturbance, insomnia	a, anorexia, anemia,				
	•	orie malnutrition and adult annual minimum data set				
		ndicated R98 was at risk for				
		not have a pressure ulcer				
	but was at risk and di- associated skin dama	ge (MASD). The MDS				
		vere impaired cognition,				
		sist of one for all transfers,				
	bed mobility and toile	ting, and was always n a toileting program. The				
		dentify any behaviors.				
	Review of the July 1,	2016 Wound Assessment				
		progress note indicated R98				
		on the buttocks, the areas				
		n 7/22/16. On 8/23/16 an				
	area identified as moi	•				
		ne left buttocks that was .6 x ed tissue. The wound had				
	-	us drainage. Pass treatment				
	·	covered with mepiplex was				
		WAFS indicated the wound % hard red raised skin.				
		was applied with mepiplex				
	to cover. The note in					
	•	requested to assess the				
	area.					
	The current care plan	, reviewed on 8/23/16,				
		was at risk for skin break				
		ry of pressure ulcers and				
		skin damage. The care plan dextensive assistance from				
	one staff for reposition					

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00284	B. WING		08	3/25/2016
NAME OF P	ROVIDER OR SUPPLIER	1910 WE	DDRESS, CITY, STATE ST COUNTY ROAI LLE, MN 55112			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 570	of approaches to resire positioned and chercare plan lacked evid refusals of cares had resident/family. 8/24/16 at approxima sitting in the wheelchatable pulled close to torange beverage was On 8/24/16 at 2:15 p. repositioned R98 after brief, but R98 refused NA-C attempted to rewheelchair. NA-C includy R98 down in the arefused. NA-C verified wheelchair since 8:30 same incontinence brown reported R98 had refused to lay down in bed thi On 8/24/16 at 1:45 p. clinical coordinator (Rareas on the buttockshad just healed in Jul reoccurring since Febthe wounds kept returnincontinence of bowerefusals to lay down a RN-C verified the carbehavior of continued and repositioning. Rino documentation that	however it lacked direction dent's refusal of being cked for incontinence. The ence risks and benefits of been explained to tely 1:00 p.m. R98 was air in her room with a tray he chair and a glass of a near by. m. NA-C reported she are breakfast and checked the drand would not lay down. position R98 in the dicated she also offered to afternoon and again R98 and R98 had been in the drand. The dicated she also offered to afternoon and was still in the rief. imately 2:45 p.m. RN-D fused to be repositioned or shift. m. the registered nurse RN)-C verified the open are were reoccurring and they by The area had been or any 2016. RN-C reported roing due to resident's I and bladder and ongoing and to be repositioned. The plan did not address the I refusals of identified cares N-C also indicated there was	2 570			

Minnesota Department of Health STATE FORM

Minnesot	<u>a Department of Healtr</u>	1				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
		00284	B. WING		08/2	25/2016
NAME OF B	20,455, 05, 01,55, 155	070557.40		TE 710.000E		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	, and the second		
LANGTON PLACE		T COUNTY RO	AD D			
		ROSEVIL	LE, MN 55112			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG	,	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
2 570	Continued From page	10	2 570			
2 37 0	Continued From page	: 10	2 370			
	A copy of a policy for					
	breakdown were requ	ested however, not				
	provided.					
	SUGGESTED METH	OD OF CORRECTION:				
	The director of nursing (DON) or designee, could develop and implement policies and procedures					
	related to care plan re					
		de training for all nursing				
	staff related to the tim	•				
		assessment and assurance				
	committee could perform ensure compliance.	onn random addits to				
	crisure compliance.					
	TIME PERIOD FOR (CORRECTIONS:				
	Twenty-one (21) days	3				
2 830	MN Rule 4658.0520 S		2 830			10/8/16
	Proper Nursing Care;	General				
	0.1					
		eneral. A resident must				
	receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and					
	•	home resident must be out				
	•	ssible unless there is a				
		attending physician that the				
		in bed or the resident				
	prefers to remain in b	ed.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00284	B. WING		08/25/2016	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA			
LANGTON	I PLACE		ΓCOUNTY RO E, MN 55112	AD D		
		ROSEVILL	E, IVIN 55112			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
2 830	Continued From page	: 11	2 830			
	This MN Requirement by: Based on observation interview the facility faidentified at risk for sk received services and plan of care and modiprevent further breakd resident reviewed for facility also failed to e resident/family regard. Findings include: On 8/24/16 at 8:24 a. (NA)-C provided morrochanging an incontine nurse (RN)-D brought R98. RN-D indicated on the buttocks was keep small open areas about bright red and there we Calmoseptine (moistuthe area. R98 was as transferred to wheeled dining room for break unit clinical coordinate measurements and cladded R98 refuses to be checked and chan R98 had diagnoses the disease, dementia with disturbance, insomnia moderate protein calcalaliure to thrive. The a (MDS) dated 5/4/16 in	t is not met as evidenced a, document review and ailed to ensure a resident tin breakdown consistently a treatments identified in the offied the interventions to down in skin for 1 of 1 (R98) skin break down. The explain risks and benefits to be ing refusal of care. The nursing assistant and particular and the excoriated open area areas than 1 inch and had two are barrier) was applied to assisted with dressing, anair and was taken to the fast. RN-D indicated the fast. RN-D indicated the fast. RN-D indicated the fast and was taken to the fast. RN-D indicated the fast and was taken to the fast. RN-D indicated the fast and was taken to the fast. RN-D indicated the fast and was taken to		The facility has reviewed the policy or Resident I Care Plan and it remains ir effect. Resident R98 has had their pla care updated to reflect their choice to refuse cares including repositioning a incontinence management. The plan care also reflects interventions for the to attempt when R98 refuses cares. Resident R98, and her family has received the risks for refusal of cares, and this been documented. The physician has also documented this refusal of care. The facility has educated the nursing to report to the nurse when a resident refusing cares to ensure that the facility discusses with the resident and/or fan responsible party the risks of refusing care, and to ensure the plan of care is developed to address this risk and ide interventions to mitigate the risk. The facility will complete random audi 25% of the residents following the OB assessment calendar weekly for the not weeks with the results to be reported the facility Quality Assurance Committed to determine ongoing compliance. The Clinical Administrator will be responsited for ongoing compliance. Date of Compliance is 10-8-16	an of an of of staff eived has s staff is ty nilly that entify ts of RA ext d to dee e	
	pressure ulcer but wa	s at risk and did have a skin damage (MASD). The				

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MDS identified R98 had severe impaired

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
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			B 14/11/0			
		00284	B. WING		08/2	25/2016
NAME OF D	ROVIDER OR SUPPLIER	STREET ADE	DECC CITY CTA	TE ZID CODE		
NAIVIE OF P	ROVIDER OR SUPPLIER		ORESS, CITY, STA			
LANGTON	LANGTON PLACE		T COUNTY RO	AD D		
		ROSEVILL	E, MN 55112			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V	(X5)
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				DEFICIENCY)		
2 830	Continued Frame name	12	2 830			
2 030	Continued From page	÷ 12	2 030			
	cognition, needed ex	tensive assist of one for all				
		y and toileting, and was				
		nd not on a toileting program.				
	_	not identify any behaviors.				
		lated 8/1/16 identified R98				
	with severe impaired					
	l •	nave MASD, and needed				
		II turning repositioning and				
	toileting. No behaviors were noted.					
A review of the most current medical doctor's						
	notes dated 6/16/16 in	ndicated R98 had a coccyx				
	wound and was getting	ng Calmoseptine to the area.				
		3				
	A review of body audi	it forms for 8/21/16 indicated				
	_	was red and excoriated. A				
		dietician dated 8/22/16				
	' -					
	_	and excoriated buttocks				
	and groin.					
		2016 Wound Assessment				
	, , , , , , , , , , , , , , , , , , , ,	progress note indicated R98				
	had three open areas	on the buttocks, the areas				
	appeared as slit like of	penings. The areas were				
	intact and resolved or	n 7/22/16. On 8/23/16 an				
	area identified as moi					
		ne left buttocks that was .6 x				
		ted tissue. The wound had				
		us drainage. Pass treatment				
		•				
		covered with mepiplex was				
		e WAFS indicated the wound				
		% hard red raised skin.				
	T	was applied with mepiplex				
	to cover. The note in					
	practitioner had been	requested to assess the				
	area.					
	The most current skin	risk and braden				
		ed on 8/23/16 identified R98				
		r skin breakdown, The				
	as a moderate risk lui	i oniii bicanaowii, IIIC	1			1

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Minnesot	a Department of Health	n				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00284	B. WING		08/2	5/2016
					1 00/2	5/2016
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
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	QUILLEN OT		.E, MN 55112			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	Continued From page	÷ 13	2 830			
	mattress and cushion and reposition schedulated intervention repositioning and prescheduled turning and change, pressure relical moseptine cream a further breakdown. Tinterventions indicate excoriation to coccyxon left buttock with m	any preferences or ular position. The summary as as specific turning and assure reducing devices, a d repositioning check and ving air mattress and dressing to prevent the evaluation of d resident had a history of //buttocks. Excoriation noted inimal bleeding. There was al of turning/repositioning				
	The current care plan, reviewed on 8/23/16, identified the resident was at risk for skin break down and had a history of pressure ulcers and moisture associated skin damage. The care plan identified R98 needed extensive assistance from one staff for repositioning and changing of incontinent products, however it lacked direction of approaches to resident's refusal of being repositioned and checked for incontinence. The care plan lacked evidence risks and benefits of refusals of cares had been explained to resident/family. 8/24/16 at approximately 1:00 p.m. R98 was sitting in the wheelchair in room with a tray table pulled close to the chair and a glass of orange beverage was near by.					

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On 8/24/16 at 2:15 p.m. NA-C reported she

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION ((X3) DATE SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		COMPLETED	
		00284	B. WING	B. WING		5/2016	
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LANGTON	I PLACE		LE, MN 55112	. = =			
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2 830	Continued From page	e 14	2 830				
2 830	repositioned R98 after her, but R98 refused in NA-C attempted to rewheelchair. NA-C inclay R98 down in the arefused. NA-C verifies wheelchair since 8:30 same incontinence by On 8/24/16 at approximate reported R98 had refused to lay down in bed this On 8/24/16 at 1:45 publication of the wounds kept return incontinence of bower refusals to lay down a RN-C verified the care behavior of continued and repositioning. RN no documentation that benefits had been disfamily. On 8/25/16 from approximate and reposition of the documentation that benefits had been disfamily.	r breakfast and to check and would not lay down. position R98 in her dicated she also offered to afternoon and again R98 and R98 had been in the a.m. and was still in the rief. imately 2:45 p.m. RN-C fused to be repositioned or shift. m. the registered nurse and they be were reoccurring and they be were reoccurring and they be repositioned or shift. The area had been be repositioned and bladder and ongoing and to be repositioned. The plan did not address the larefusals of identified cares N-C also indicated there was	2 830				
	nursing assistant told At 10:13 a.m. the clini assistant and the nurs room and spoke to RS	nd R98 declined. The R98 she would return later. ical coordinator, the nursing se practitioner entered the 98. The nursing assistant ld lay her down, and R98					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
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		ROSEVIL	LE, MN 55112			
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2 830	Continued From page	2 15	2 830			
		the nurse practitioner was rea. Because R98 refused, y at a later time.				
	On 8/25/16 at approximately 2:00 p.m. the RN-C reported the wound was assessed by the nurse practitioner, however documentation was never provided. The care plan had been updated to indicate new interventions developed as well as risks and benefits had been explained to resident and guardian.					
	A copy of the nurse properties for care plans and ski requested however, n					
	SUGGESTIVE METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for non- pressure related skin beakdown to assure they are receiving the necessary treatment/services to prevent skin breakdown from developing and to identify risks and benefits of treatment. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for skin breakdown to occur.					
	TIME PERIOD FOR (Twwenty-one (21) day					
21375	MN Rule 4658.0800 S Program	Subp. 1 Infection Control;	21375			10/8/16
	Subpart 1. Infection	control program. A nursing				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
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		ROSEVILL	E, MN 55112			
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TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE DATE	
				DETIGIENCT)		_
21375	Continued From page	e 16	21375			
	home must establish	and maintain an infection				
	control program designed to provide a safe and sanitary environment.					
	•					
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document					
				The facility has reviewed the Infection		
		ed to implement procedures		Control policies of Blood Glucose Mad	hine	
		of infection during blood		Cleaning and Use of Gloves, and thes		
	glucose monitoring for 1 of 3 residents (R346)				-	
	9	` ,		both remain in effect. The facility		
	observed who required blood glucose monitoring			removed the expired wipes from use of		
		appropriate infection control		8/25/16 and reviewed all remaining wi	pes	
		tained for 1 of 1 residents		to ensure they were not expired on		
	(R209) observed for a	activities of daily living.		8/25/16.		
				The facility has provided education to	all	
	Findings include:			staff on Infection Control, and specific	ally	
				on the cleaning of Blood Glucose		
	R346 received blood	glucose monitoring on		Machines and Glove use. In addition		
	9/22/16, in the evening	ig and registered nurse		education was provided to staff on the		
		ly clean it between each		chemical expiration dates.		
	residents use.	.,		The facility will complete random audit	s for	
				to ensure infection control program is	I	
	On 8/22/16 at 7:10 n	.m. registered nurse (RN)-A		place weekly for the next 6 weeks with		
		ing to check R346's blood		results to be reported to the facility Qu	I	
		3		Assurance Committee to determine	anty	
		l on residents who are				
	_	tes). RN-A retrieved a blood		ongoing compliance. The Clinical		
	•	supplies from the medication		Administrator will be responsible for		
	cart and went into R3			ongoing compliance. Date of Complia	nce	
		od glucose test, RN-A took		is 10-8-16.		
		nitor, brought it back to the				
		on top, and stated she				
	would clean it when fi	inished documenting.				
	On 8/22/16, at 7:23 p	.m. RN-A obtained and				
	completed insulin adr	ninistration for R346 and				
	walked back to the me					
	removed the blood all	ucose monitor from the top				
	of the cart and walked					

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Sani-cloth bleach container located near the

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE 1910 WEST COUNTY ROAD D ROSEVILLE, NN 55112 (A4) ID PRETEX TAG (IRACH DEPICIENCY MUST BE PRECEDED BY PUL. PRECIL ATORY OR LSC IDENTIFYING INFORMATION) 21375 Continued From page 17 nurse's station. RN-A wiped the blood glucose monitor, stating she wipes the monitor for 30 seconds. RN-A further stated she makes sure to get it clean when wiping it for 30 seconds. The bleach container was observed to have an expiration date of 6/2016. On 8/23/16, at 8:18 a.m. RN-B stated her expectation with glucometer cleaning was to wrap it with bleach wipes for three to five minutes and let it air dry between patients. On 8/25/16, at 12:58 p.m. the director of nursing (IDON) stated blood glucose monitors should be cleaned after each use because they are multi-use glucometers. DON stated staff should follow manufacturer's guidelines, wipe the monitor with wipes, wrap it for three to four minutes, and then let it air dry before use on another patient. DON further stated staff should use the gold top Sani-cloth bleach wipes. Review of facility infection control general policies cleaning and disinfecting blood glucose meters dated 2015 indicated: "It is the policy of the facility to clean and disinfect blood glucose meters that are shared between residents." "11. Follow manufacturer's guidelines for cleaning and	STATEMENT	A Department of Healtr FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER TAGY SUMMARY STATEMENT OF DEFICIENCY TAGY SUMMARY STATEMENT OF DEFICIENCY TAGY SUMMARY STATEMENT OF DEFICIENCY RESULATORY OR LSC IDENTIFYING INFORMATION) PROPERTY TAGY CONTINUED FROM page 17 nurse's station. RN-A wiped the blood glucose monitor, stating she wipes the monitor for 30 seconds. RN-A further stated she makes sure to get it clean when wiping it for 30 seconds. The bleach container was observed to have an expiration date of 6/2016. On 8/23/16, at 8:18 a.m. RN-B stated her expectation with glucometer cleaning was to wrap it with bleach wipes for three to five minutes and let it air dry between patients. On 8/25/16, at 12:58 p.m. the director of nursing (DON) stated blood glucose monitors should be cleaned after each use because they are multi-use glucometers. DON stated staff should follow manufacturer's guidelines, wipe the monitor with wipes, wrap it for three to four minutes, and then let it air dry before use on another patient. DON further stated staff should use the gold top Sani-cloth bleach wipes. Review of facility infection control general policies cleaning and disinfecting blood glucose meters dated 2015 indicated: "It is the policy of the facility to clean and disinfect blood glucose meters dated 2015 indicated:" "It is the policy of the facility to clean and disinfect blood glucose meters that are shared between residents." "11. Follow								
In the state of facility infection control general policies cleaning and disinfecting blood glucose meters dated 2015 indicated: "It is the policy of the facility to clean and disinfecting blood glucose meters dated 2015 indicated: "It is the policy of the facility to clean and disinfecting blood glucose meters dated 2015 indicated: "It is the policy of the facility to clean and disinfecting blood glucose meters dated 2015 indicated: "It is the policy of the facility to clean and disinfecting blood glucose meters that are shared between residents." "11. Follow			00284	B. WING		08/2	25/2016	
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PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 21375 Continued From page 17 nurse's station. RN-A wiped the blood glucose monitor, stating she wipes the monitor for 30 seconds. RN-A further stated she makes sure to get it clean when wiping it for 30 seconds. RN-B further stated she makes sure to get it dean with glucometer cleaning was to wrap it with bleach wipes for three to five minutes and let it air dry between patients. On 8/23/16, at 12:58 p.m. the director of nursing (DON) stated blood glucose monitors should be cleaned after each use because they are multi-use glucometers. DON stated staff should follow manufacturer's guidelines, wipe the monitor with wipes, wrap it for three to four minutes, and then let it air dry before use on another patient. DON further stated staff should use the gold top Sani-cloth bleach wipes. Review of facility infection control general policies cleaning and disinfecting blood glucose meters dated 2015 indicated: "It is the policy of the facility to clean and disinfect blood glucose meters that are shared between residents." "11. Follow	LANGTON PLACE			AD D				
nurse's station. RN-A wiped the blood glucose monitor, stating she wipes the monitor for 30 seconds. RN-A further stated she makes sure to get it clean when wiping it for 30 seconds. The bleach container was observed to have an expiration date of 6/2016. On 8/23/16, at 8:18 a.m. RN-B stated her expectation with glucometer cleaning was to wrap it with bleach wipes for three to five minutes and let it air dry between patients. On 8/25/16, at 12:58 p.m. the director of nursing (DON) stated blood glucose monitors should be cleaned after each use because they are multi-use glucometers. DON stated staff should follow manufacturer's guidelines, wipe the monitor with wipes, wrap it for three to four minutes, and then let it air dry before use on another patient. DON further stated staff should use the gold top Sani-cloth bleach wipes. Review of facility infection control general policies cleaning and disinfecting blood glucose meters that are shared between residents." "11. Follow	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	COMPLETE	
disinfecting of glucose meters Consult with manufacturer to determine which cleaning procedures, specific to glucose meter sharing, should be adhered to. Sani-cloth bleach manufacturer general guidelines for use dated 2011 indicated: "4. Treated surface must remain visibly wet for a full four (4) minutes*. Use additional wipe (s) if needed to assure continuous four (4) minute wet contact time. Allow to air dry.	21375	nurse's station. RN-A monitor, stating she was econds. RN-A further get it clean when wipi bleach container was expiration date of 6/20. On 8/23/16, at 8:18 a expectation with glucorit with bleach wipes for let it air dry between proceedings of the state of the sta	wiped the blood glucose vipes the monitor for 30 or stated she makes sure to fing it for 30 seconds. The observed to have an 1016. I.M. RN-B stated her cometer cleaning was to wrap for three to five minutes and obtains. I.M. The director of nursing lucose monitors should be see because they are so. DON stated staff should guidelines, wipe the grap it for three to four it air dry before use on further stated staff should ecloth bleach wipes. It is the policy of the facility blood glucose meters that residents." "11. Follow blood glucose meters that residents." "11. Follow lines for cleaning and the meters Consult with remine which cleaning to glucose meter sharing, or glucose meters and glu	21375				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		00284	B. WING		08/25/2016	
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21375	Continued From page	e 18	21375			
	room humidity, tempe	ation rates are affected by erature and air flow. These n into consideration when				
	R209, during observations on 8/22/16, the following was observed during the initial tour observation on second floor long term care unit: At 12:47 p.m. observed nursing assistant (NA)-Z leaving R209's room with gloves on walking down the hallway toward the clean linen room. NA-Z took the gloves off and opened the clean linen room without washing hands or using hand sanitizer and went in and grabbed a clean night gown. NA-Z returned to R209's room by opening the door without washing hands or use of hand sanitizer.					
	walking in the hallway washing hands or usi removing the gloves, linen room and NA-Z	p.m. NA-Z acknowledged with gloves on and not ng hand sanitizer after prior to opening the clean stated, was supposed to and sanitizer after removing				
	that all staff should kn should remove gloves bodily fluids, disinfect using hand sanitizer u before entering, leavi cares to prevent cont DON, added, Staff sh	8/25/16, at 1:27 p.m. ated her expectation was now when to use gloves, is when finished exposure to hands by washing hands or upon removing gloves, ing the room and after doing aminating clean surfaces. In the ly cleaning up bodily fluids.				

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Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT					
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		COMPLETED	
		00284	B. WING	B. WING		08/25/2016	
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
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			LE, MN 55112				
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21375	Continued From page	e 19	21375				
	2015, indicated, "Perf performing your person with soap and water); or aprons After rem with non-antimicrobial antimicrobial soap an "Remove gloves after bodily fluids/excretion environment (includin proper technique to p Do not wear the same of more than one patithe purpose of reuse	titled INFECTION RD PRECAUTIONS dated form hand hygiene: 20. After conal hygiene (hand washing 21. After removing gloves noving gloves. Wash hands I soap and water or with d water." Further revealed, contact with a patient, s, and/or the surrounding g medical equipment) using revent hand contamination. e pair of gloves for the care ent. Do not wash gloves for since this practice has been mission of pathogens."					
	The director of nursin policies and procedur control, specific to cle machines and hand w monitor to assure pro utilized. The director could conduct randon	OD OF CORRECTION: g or designee, could review res related to infection raning of blood glucose vashing, train staff and per techiniques are being of nursing or designee, n audits of the delivery of priate care and services are					
	TIME PERIOD FOR (one (21) days	CORRECTIONS: Twenty					
21800	MN St. Statute144.65 Residents of HC Fac.		21800			10/8/16	
	residents shall, at adr	on about rights. Patients and mission, be told that there eir protection during their					

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PRINTED: 10/21/2016

Minneso	ta Department of Health	1			FORM	1 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00284	B. WING		08/2	25/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE		
LANCTO	N DI ACE	1910 WE	ST COUNTY RO	OAD D		
LANGTON PLACE ROSEVII		LE, MN 55112				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21800	stay at the facility or t treatment and mainte that these are describ written statement of the responsibilities set for case of patients admin as defined in section statement shall also operson 16 years old operson years and organ advocacy and legal seridential programs. accommodations shad communication impais speak a language oth facility policies, inspellocal health authoritie the written statement to patients, residents, chosen representative to the administrator operson, consistent with Practices Act, and sevulnerable adults. This MN Requirement by: Based on document refacility did not provided.	hroughout their course of nance in the community and ped in an accompanying the applicable rights and with in this section. In the section that the ted to residential programs 253C.01, the written describe the right of a per older to request release as 63B.04, subdivision 2, and and telephone numbers of services for patients in	21800	The policy for Determination of Medic Benefits on Continued Stay has been reviewed and remains in effect. The Resident Services staff and Health Information Director will receive eduction this on 9/16/16.		

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Record review for R34 revealed a

Transfer/Discharge Report showing that R34 was

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The facility will complete random audits of

25% of the residents who end Medicare

coverage weekly for 6 weeks with the

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00284	B. WING		08/25	/2016	
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE			
LANGTON PLACE		T COUNTY RO .E, MN 55112	AD D			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
Physician Certificat signed by a provide as needing inpatier services after inpatineeding daily skille day period. When a surveyor reliability notice for that a.m. the director of management (HIM) liability notice could director went on to covered by Medica was given to the sounit to complete, but form could not be form administrator of the administrator of appropriate staff or The administrator of monitoring systems compliance.	and discharged on 7/9/16. A ion and Recertification form, or on 6/23/16, described R34 at skilled nursing facility ient hospital services and discharge for an estimated 30 equested a denial letter or is resident on 8/25/16, at 8:33 health information a stated that a denial letter or into the located. This HIM explain that R34 had been refor therapies, a denial form cial worker on this resident's at a completed denial letter bund. THOD OF CORRECTION: or designee could develop, see policies and procedures to functed on the appropriate rovide residents at the end of and to ensure resident rights appropriately and acted upon. In designee could educate all the policies and procedures. In designee could develop	21800	results being reported to the facility Quassurance Committee to determine ongoing compliance. The Director of Resident Services will be responsible ongoing compliance. Date of complia is 10-8-16.	for		

Minnesota Department of Health STATE FORM

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(X6) DATE

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF		00284		OTATE ZID OODE	08/2	5/2016
	PROVIDER OR SUPPLIER		T COUNTY	STATE, ZIP CODE ROAD D		
LANGIC	ON PLACE		LE, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated ducorrected.	nether a violation has been				
	that may result from orders provided tha the Department with	nearing on any assessments non-compliance with these tawritten request is made to hin 15 days of receipt of a ent for non-compliance.				
	surveyors of this De above provider and orders are issued. electronic plan of co	6 through August 25, 2016, epartment's staff visited the the following correction Please indicate in your prrection that you have ers, and identify the date when				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

09/16/16 **Electronically Signed**

TITLE

STATE FORM 6899 If continuation sheet 1 of 22 FN9K11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	ID DI AN OF CORRECTION IN INDER IN INDER		` '	TIPLE CONSTRUCTION (X:		X3) DATE SURVEY COMPLETED	
	A. BOILDING.						
		00284	B. WING		08/2	5/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
LANGTO	N PLACE		ST COUNTY LE, MN 5511				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION				(X5) COMPLETE DATE		
2 000	Continued From pa	ge 1	2 000				
	signature is not req page of state form. is required, it is req	ed in ePOC and therefore a uired at the bottom of the first Although no plan of correction uired that the facility of the electronic documents.					
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents					10/8/16	
	comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The con must include the inc	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, rchosocial needs that are aprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).					
	by: Based on record refailed to develop a opharmalogical inter (R192) who was remedication. Findings include: During random obs R192 was observed room. When approcalm and agreeable an interview. On 8/sitting in a wheelch. Several staff person	view and interview, the facility care plan that included non ventions for 1 of 5 residents viewed for unnecessary ervations during stage one, divisiting with his wife in his eached R192 appeared very but unable to participate in 24/16 at 2:15 p.m. R192 was air at his doorway to his room. In stopped by and spoke to would ask about his wife and		The policy for Care plan Developmen reviewed and remains in effer Resident R192 has had his plan of reviewed and updated. In addition Resident R192 will have a My Best completed and available for facility view. This My Best day includes the pharmacologic interventions for wresidents during their OBRA RAI programments (quarterly, annual and significant cassessments) will have a My best and/or Care strip updated to ensurpharmacologic interventions are a to staff. These will be updated for the RAI calendar and with significations.	ect. f care n t Day y staff to he non hen ion all process change day re non vailable lowing		

Minnesota Department of Health

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1910 WEST COUNTY ROAD D ROSEVILLE, MN 55112 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 560 Continued From page 2 was told he had just gotten off the phone with her. Afterwards when staff had left the area, R192 continued to sit in the area and softly call out help me and ask where's my wife. A review of R192's medical record indicated physician orders Mirtazapine 7.5 mg every evening and Risperidone .25 mg once a day and .5 mg twice a day for delusional disorder. A Psychoactive Drug Assessment (PDA) dated 8/12/16 indicated the resident was currently receiving an anti psychotic medication (Risperidone) for delusional disorder and indicated that non pharmalogical interventions currently being used for R192 included reassurance, validation and talking about his wife.	STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMPLETE	
NAME OF PROVIDER OR SUPPLIER LANGTON PLACE 1910 WEST COUNTY ROAD D ROSEVILLE, MN 55112 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 560 Continued From page 2 was told he had just gotten off the phone with her. Afterwards when staff had left the area, R192 continued to sit in the area and softly call out help me and ask where's my wife. A review of R192's medical record indicated physician orders Mirtazapine 7.5 mg every evening and Risperidone .25 mg once a day and .5 mg twice a day for delusional disorder. A Psychoactive Drug Assessment (PDA) dated 8/12/16 indicated the resident was currently receiving an anti psychotic medication (Risperidone) for delusional disorder and indicated that non pharmalogical interventions currently being used for R192 included reassurance, validation and talking about his wife.			00284	B. WING		08/2	5/2016
SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES CACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG CEACH CORRECTIVE ACTION SHOULD BE CHOSS-REFERENCED TO THE APPROPRIATE CACH CORRECTIVE ACTION SHOULD BE CHOSS-REFERENCED TO THE APPROPRIATE DATE 2 560 Continued From page 2 2 560 Was told he had just gotten off the phone with her. Afterwards when staff had left the area, R192 Continued to sit in the area and softly call out help me and ask where's my wife. Changes in behaviors. The staff will receive re-education on non pharmacologic interventions and where these are located as a part of the residents plan of care The facility will complete random audits of 25% of the residents following the OBRA assessment calendar weekly for the next 6 weeks with the results to be reported to the facility Quality Assurance Committee to determine ongoing compliance. The Clinical Administrator will be responsible for ongoing compliance. Date of Compliance is 10-8-16	NAME OF	PROVIDER OR SUPPLIER		<u> </u>		1 00/2	<u> </u>
(X4) ID PREFIX TAG (X5) Description (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 560 Continued From page 2 was told he had just gotten off the phone with her. Afterwards when staff had left the area, R192 continued to sit in the area and softly call out help me and ask where's my wife. A review of R192's medical record indicated physician orders Mirtazapine 7.5 mg every evening and Risperidone .25 mg once a day and .5 mg twice a day for delusional disorder. A Psychoactive Drug Assessment (PDA) dated 8/12/16 indicated the resident was currently receiving an anti psychotic medication (Risperidone) for delusional disorder and indicated that non pharmalogical interventions currently being used for R192 included reassurance, validation and talking about his wife.							
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 560 Continued From page 2 was told he had just gotten off the phone with her. Afterwards when staff had left the area, R192 continued to sit in the area and softly call out help me and ask where's my wife. A review of R192's medical record indicated physician orders Mirtazapine 7.5 mg every evening and Risperidone .25 mg once a day and .5 mg twice a day for delusional disorder. A Psychoactive Drug Assessment (PDA) dated 8/12/16 indicated the resident was currently receiving an anti psychotic medication (Risperidone) for delusional disorder and indicated that non pharmalogical interventions currently being used for R192 included reassurance, validation and talking about his wife.	LANGIC	ON PLACE	ROSEVILI	_E, MN 5511	12		
was told he had just gotten off the phone with her. Afterwards when staff had left the area, R192 continued to sit in the area and softly call out help me and ask where's my wife. A review of R192's medical record indicated physician orders Mirtazapine 7.5 mg every evening and Risperidone .25 mg once a day and .5 mg twice a day for delusional disorder. A Psychoactive Drug Assessment (PDA) dated 8/12/16 indicated the resident was currently receiving an anti psychotic medication (Risperidone) for delusional disorder and indicated that non pharmalogical interventions currently being used for R192 included reassurance, validation and talking about his wife.	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
Afterwards when staff had left the area, R192 continued to sit in the area and softly call out help me and ask where's my wife. A review of R192's medical record indicated physician orders Mirtazapine 7.5 mg every evening and Risperidone .25 mg once a day and .5 mg twice a day for delusional disorder. A Psychoactive Drug Assessment (PDA) dated 8/12/16 indicated the resident was currently receiving an anti psychotic medication (Risperidone) for delusional disorder and indicated that non pharmalogical interventions currently being used for R192 included reassurance, validation and talking about his wife.	2 560	Continued From pa	ge 2	2 560		ļ	
The Psychoactive Drug Assessment indicated R192 currently was receiving an anti depressant medication for failure to thrive. Target behaviors included aggression, kicking hitting, refusal to go to bed and refusal of cares, yelling and calling out "help me" and paranoid statements. Non pharmacological interventions currently being used included reassurance R192's wife would visit, listening to favorite radio station, staff talking to him, calling his wife, repositioning and giving him something to drink. It was noted R192 like to sit in the entry way of his room and people watch. A review of R192's care plan, last revised 12/10/15, identified a focus that read: "I use psychotropic medications, antipsychotic and antidepressant r/t (related to) Dementia with behavioral disturbance. Depression, I have episodes of refusal of cares, refusal to get out of bed, yelling kicking depressive statement withdrawn, little interest in eating, asking for staff	2 560	was told he had just Afterwards when st continued to sit in the me and ask where's physician orders Milevening and Risper .5 mg twice a day for A Psychoactive Drught 12/16 indicated the receiving an anti psychoactive Indicated that non pure currently being use reassurance, validated The Psychoactive In R192 currently was medication for failured aggression to bed and refusal of the me" and parapharmacological introduced included reast visit, listening to favor to him, calling his whim something to disting the entry way are view of R192's 12/10/15, identified psychotropic medicantidepressant r/t (to behavioral disturbate pisodes of refusal bed, yelling kicking	t gotten off the phone with her. aff had left the area, R192 ne area and softly call out help is my wife. medical record indicated intazapine 7.5 mg every ridone .25 mg once a day and or delusional disorder. In g Assessment (PDA) dated ne resident was currently eychotic medication relusional disorder and charmalogical interventions of for R192 included receiving an anti depressant re to thrive. Target behaviors not kicking hitting, refusal to go of cares, yelling and calling out noid statements. Non reterventions currently being surance R192's wife would reventions currently being surance R192's wife would revention station, staff talking rife, repositioning and giving rink. It was noted R192 like to of his room and people watch. care plan, last revised a focus that read: "I use rations, antipsychotic and related to) Dementia with nece. Depression, I have of cares, refusal to get out of depressive statement	2 560	receive re-education on non pharmacologic interventions and with these are located as a part of the residents plan of care. The facility will complete random a 25% of the residents following the assessment calendar weekly for the facility Quality Assurance Complete to determine ongoing compliance. Clinical Administrator will be responded to the complete complete complete complete.	where audits of OBRA he next orted to nmittee The	

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STATE FORM FN9K11 If continuation sheet 3 of 22

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND DUAN OF CODDECTION DEPT DESCRIPTION AND DE			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00284	B. WING		08/2	5/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LANGTO	N PLACE		ST COUNTY LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 3	2 560			
		wever it lacked other non erventions identified on the				
	on 8/24/16 at 2:30 p would be yelling out his wife did not visit and refusing cares. meals as well, and	with nursing assistant (NA)-B o.m. indicated R192's behavior t most of the time and when R192 would be yelling for her R192 would refuse to go to staff would encourage him to what special foods were				
	coordinator (RN)-B non pharmacologic	p.m. the unit clinical nurse verified the care plan lacked al interventions that would les to address R192.				
	review, the facility facomprehensive care for skin breakdown for 1 of 1 resident (I pressure related sk	on, interview and document ailed to assure the e plan included interventions and reflect the refusal of care R98) reviewed for non in concerns and did not enefits explained to the				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7 20.25 10.1			
		00284	B. WING		08/2	5/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LANGTO	ON PLACE		ST COUNTY LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	Continued From pa	ige 4	2 560			
	On 8/24/16 at 8:24 (NA)-C provided mochanging an incontinurse (RN)-D brougen R98. RN-D indicated on the buttocks was small open areas a bright red and there Calmoseptine was assisted with dress and was taken to the RN-D indicated the the wound measure wound. RN-D addeduring the day or be R98 had diagnoses disease, demential disturbance, insom moderate protein of failure to thrive. The (MDS) dated 5/4/16 skin break down, disturbance as trisk and associated skin daridentified R98 had ineeded extensive a bed mobility and to incontinent and not annual MDS did not review of the July Flow Sheet (WAFS) had three open are appeared as slit like intact and resolved area identified as mothers.	a.m. the nursing assistant orning cares for R98. After inence pad the registered ght in treatment creams for ed the excoriated open area is less than 1 inch and had two bove it. The open area was e was no drainage. applied to the area. R98 was ing, transferred to wheelchair he dining room for breakfast. unit clinical coordinator took ements and charted on the ed R98 refuses to lay down e checked and changed.				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00284	B. WING		08/2	5/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	_	
LANGTO	N PLACE		ST COUNTY LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 560	scant serosanguine of calmoseptine and used. On 8/25/16 t was 4.8 x 2.0 with 9 Calmoseptine creat to cover. The note practitioner had becarea. The current care plaidentified the reside down and had a his moisture associated identified R98 need one staff for repositincontinent products of approaches to rerepositioned and characteristic plan lacked ever fusals of cares have resident/family. 8/24/16 at approximation sitting in the wheeled table pulled close to orange beverage wheeled to wheelchair. NA-C is lay R98 down in the refused. NA-C veriwheelchair since 8: same incontinence.	cous drainage. Pass treatment of covered with mepiplex was he WAFS indicated the wound 20% hard red raised skin. In was applied with mepiplex indicated the nurse en requested to assess the enterprise and distinct and a glass of as near by. p.m. NA-C reported she iter breakfast and checked the ed and would not lay down. reposition R98 in the noticated she also offered to a field R98 had been in the 30 a.m. and was still in the	2 560			

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Minnesota Department of Health

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00284	B. WING		08/2	5/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE		
LANGTO	N PLACE		T COUNTY			
040.15	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	_E, MN 551	PROVIDER'S PLAN OF CORRECTION	ON!	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 6	2 560			
	clinical coordinator areas on the buttoo had just healed in J reoccurring since F the wounds kept reincontinence of bow refusals to lay down RN-C verified the cabehavior of continuand repositioning. In o documentation to benefits had been of family. A copy of a policy for	p.m. the registered nurse (RN)-C verified the open ks were reoccurring and they uly. The area had been ebruary 2016. RN-C reported turning due to resident's vel and bladder and ongoing and to be repositioned. are plan did not address the ed refusals of identified cares RN-C also indicated there was hat indicated risks and discussed with the resident or or care plans and skin quested however, not				
	The director of nursing develop and implementated to comprehe or designee, could a staff related to information care plan. The quality of the country of the	THOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures ensive care plans. The DON provide training for all nursing mation documented on the of ity assessment and assurance erform random audits to				
	TIME PERIOD FOR Thwenty-one (21) d	,				
2 570	MN Rule 4658.0405 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			10/8/16
	Subp. 4. Revision.	A comprehensive plan of				

Minnesota Department of Health

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Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00284	B. WING 08/2		08/2	5/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LANGTO	N PLACE		ST COUNTY LE, MN 551			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 7	2 570			
	interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within	resident, the resident's legal representative at least seven days of the revision of resident assessment required				
	by: Based on observati review, the facility facomprehensive car for skin breakdown for 1 of 1 resident (pressure related sk	ent is not met as evidenced on, interview and document ailed to revise the e plan to include interventions and reflect the refusal of care R98) reviewed for non in concerns. The care plan s and benefits explained to the		The facility has reviewed the police Resident I Care Plan and it remain effect. Resident R98 has had their care updated to reflect their choice refuse cares including repositionin incontinence management. The care also reflects interventions for to attempt when R98 refuses care Resident R98, and her family has the risks for refusal of cares, and the risks for refusal of cares.	ns in r plan of e to ig and plan of the staff s. received	
	On 8/24/16 at 8:24 (NA)-C provided mochanging an incontinurse (RN)-D broug R98. RN-D indicate on the buttocks was small open areas a bright red and there Calmoseptine was assisted with dress and was taken to the RN-D indicated the the wound measure	a.m. the nursing assistant orning cares for R98. After nence pad the registered ght in treatment creams for ed the excoriated open area is less than 1 inch and had two bove it. The open area was a was no drainage. Applied to the area. R98 was ing, transferred to wheelchair the dining room for breakfast. Unit clinical coordinator took ements and charted on the ed R98 refuses to lay down		been documented. The physiciar also documented this refusal of car also documented this refusal of car also documented this refusal of car the facility has educated the nurs to report to the nurse when a resider fusing cares to ensure that the fuscusses with the resident and/or responsible party the risks of refusions care, and to ensure the plan of car developed to address this risk and interventions to mitigate the risk. The facility will complete random a 25% of the residents following the assessment calendar weekly for the facility Quality Assurance Com	n has are. ing staff dent is acility family sing that re is I identify audits of OBRA ne next orted to	

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STATE FORM FN9K11 If continuation sheet 8 of 22

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00284	B. WING		08/2	5/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/2	5/2010
	ON PLACE		T COUNTY			
LANGIC			_E, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 8	2 570			
	during the day or be R98 had diagnoses disease, demential disturbance, insommoderate protein cafailure to thrive. The (MDS) dated 5/4/16 skin break down, dibut was at risk and associated skin daridentified R98 had sneeded extensive abed mobility and toi incontinent and not annual MDS did noon Review of the July Flow Sheet (WAFS had three open are appeared as slit like intact and resolved area identified as mage(MASD) on 6 and 100% granus scant serosanguine of calmoseptine and used. On 8/25/16 twas 4.8 x 2.0 with SCalmoseptine creat to cover. The note	e checked and changed. It that included Alzheimer's without behavioral nia, anorexia, anemia, alorie malnutrition and adult e annual minimum data set indicated R98 was at risk for d not have a pressure ulcer did have a moisture mage (MASD). The MDS severe impaired cognition, assist of one for all transfers, leting, and was always on a toileting program. The tridentify any behaviors. 1, 2016 Wound Assessment programs on the buttocks, the areas e openings. The areas were on 7/22/16. On 8/23/16 an noisture acquired skin the left buttocks that was .6 x lated tissue. The wound had yous drainage. Pass treatment do covered with mepiplex was the WAFS indicated the wound 20% hard red raised skin. In was applied with mepiplex		to determine ongoing compliance. Clinical Administrator will be respondent of the compliance of the co		
	identified the reside down and had a his moisture associated identified R98 need	an, reviewed on 8/23/16, ent was at risk for skin break story of pressure ulcers and d skin damage. The care plan ed extensive assistance from ioning and changing of				

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STATE FORM FN9K11 If continuation sheet 9 of 22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00284	B. WING		08/2	5/2016
NAME OF PROV	VIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
LANGTON P	LANGTON PLACE 1910 WE ROSEVII			ROAD D 12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
inc of a rep car refir res 8/2 sitt tab ora On rep brick NA who lay refir who sar On clir are had red the inc refir RN bel and no ber	approaches to re- cositioned and che re plan lacked evi- fusals of cares has sident/family. 24/16 at approximating in the wheelch cole pulled close to cange beverage was a 8/24/16 at 2:15 prositioned R98 af ef, but R98 refuse A-C attempted to a cositioned R98 af ef, but R98 refuse A-C attempted to a cositioned R98 af el, but R98 refuse A-C attempted to a cositioned R98 af a 8/24/16 at approximation a 8/24/16 at approximation beautiful at a 1:45 process and a 1:45	s, however it lacked direction sident's refusal of being ecked for incontinence. The idence risks and benefits of d been explained to rately 1:00 p.m. R98 was hair in her room with a tray the chair and a glass of as near by. D.m. NA-C reported she ter breakfast and checked the ed and would not lay down. reposition R98 in the indicated she also offered to afternoon and again R98 fied R98 had been in the 30 a.m. and was still in the brief.	2 570			

6899

		(X1) PROVIDER/SUPPLIER/CLIA				TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		00284	B. WING		08/2	5/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
LANGTO	N PLACE	1910 WES	T COUNTY	ROAD D			
LANGIC	IN PLACE	ROSEVILI	LE, MN 551	12			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 570	Continued From pa	ge 10	2 570				
	A copy of a policy for	or care plans and skin quested however, not					
	The director of nursing develop and implementated to care pland designee, could prostaff related to the trevisions. The quality	THOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures revisions. The DON or ovide training for all nursing timeliness of care plan ity assessment and assurance erform random audits to					
	TIME PERIOD FOR Twenty-one (21) da						
2 830	MN Rule 4658.0520 Proper Nursing Car	3 Subp. 1 Adequate and e; General	2 830			10/8/16	
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.					

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00284	B. WING		08/2	08/25/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, §	STATE, ZIP CODE			
LANGTO	N DI ACE	1910 WES	ST COUNTY	ROAD D			
LANGTON PLACE ROSEVIL		ROSEVILI	LE, MN 5511	12			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 11	2 830				
2 830	This MN Requirements: Based on observation interview the facility identified at risk for received services a plan of care and may prevent further break resident reviewed facility also failed to resident/family regards. Findings include: On 8/24/16 at 8:24 (NA)-C provided may changing an incontinurse (RN)-D broug R98. RN-D indicate on the buttocks was small open areas a bright red and there Calmoseptine (moist the area. R98 was transferred to wheeld dining room for break breaked and changed the checked the checked and changed the checked and changed the checked t	ent is not met as evidenced ion, document review and if failed to ensure a resident skin breakdown consistently and treatments identified in the odified the interventions to akdown in skin for 1 of 1 (R98) or skin break down. The o explain risks and benefits to arding refusal of care. a.m. the nursing assistant orning cares for R98. After inence pad the registered ght in treatment creams for ed the excoriated open area is less than 1 inch and had two bove it. The open area was is was no drainage. Sture barrier) was applied to assisted with dressing, elchair and was taken to the akfast. RN-D indicated the ator took the wound I charted on the wound. RN-D to lay down during the day or anged. it that included Alzheimer's	2 830	The facility has reviewed the policing Resident I Care Plan and it remaineffect. Resident R98 has had theicare updated to reflect their choice refuse cares including repositioning incontinence management. The care also reflects interventions for to attempt when R98 refuses care Resident R98, and her family has the risks for refusal of cares, and to been documented. The physician also documented this refusal of care also documented this refusal of care also documented this refusal of care also documented the nurse to report to the nurse when a residence refusing cares to ensure that the foliacusses with the resident and/or responsible party the risks of refusions and to ensure the plan of care developed to address this risk and interventions to mitigate the risk. The facility will complete random a 25% of the residents following the assessment calendar weekly for the facility Quality Assurance Com to determine ongoing compliance. Clinical Administrator will be response for ongoing compliance. Date of Compliance is 10-8-16	ns in a plan of the staff s. received this has a reciing staff dent is acility family sing that re is a lidentify audits of OBRA ne next orted to imittee The		
		d skin damage (MASD). The				ı	

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MDS identified R98 had severe impaired

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00284	B. WING		08/2	25/2016
	LANGTON PLACE		DRESS, CITY, S BT COUNTY I LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	cognition, needed of transfers, bed mobilialways incontinent at The annual MDS did The quarterly MDS, with severe impaire pressure ulcers, did extensive assist for toileting. No behave A review of the most notes dated 6/16/16 wound and was get A review of body author resident's button progress note by the referred to body author and groin. Review of the July Flow Sheet (WAFS had three open area appeared as slit like intact and resolved area identified as modamage (MASD) on .6 and 100% granul scant serosanguine of calmoseptine and used. On 8/25/16 to was 4.8 x 2.0 with 90 Calmoseptine creat to cover. The note practitioner had becarea. The most current slit.	extensive assist of one for all lity and toileting, and was and not on a toileting program. d not identify any behaviors. dated 8/1/16 identified R98 d cognition, at risk for I have MASD, and needed all turning repositioning and iors were noted. It current medical doctor's indicated R98 had a coccyx ting Calmoseptine to the area. Idit forms for 8/21/16 indicated ck was red and excoriated. A de dietician dated 8/22/16 dit and excoriated buttocks If 2016 Wound Assessment oprogress note indicated R98 as on the buttocks, the areas de openings. The areas were on 7/22/16. On 8/23/16 and insisture acquired skin the left buttocks that was .6 x lated tissue. The wound had yous drainage. Pass treatment of covered with mepiplex was the WAFS indicated the wound 20% hard red raised skin. In was applied with mepiplex indicated the nurse en requested to assess the	2 830			
		eted on 8/23/16 identified R98 for skin breakdown, The				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00284	B. WING		08/2	25/2016
	PROVIDER OR SUPPLIER	1910 WES	DRESS, CITY, S ST COUNTY I LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	assessment indicated mattress and cushical and reposition scheus a check and change incontinence. The resident did not have resistance to a part indicated intervention repositioning and proceedings of the scheduled turning a change, pressure recalmoseptine cream further breakdown, interventions indicated excoriation to coccy on left buttock with no indication of refuschedule or of check	ed the resident had an air on in wheelchair, had a turn adule of 2 -21/2 hours and had a schedule for urinary assessment indicated the re any preferences or icular position. The summary ons as specific turning and ressure reducing devices, a and repositioning check and eliving air mattress in and dressing to prevent. The evaluation of the resident had a history of resident had a history of resident had a history of minimal bleeding. There was usal of turning/repositioning eking and changing of	2 830			
	The current care plan, reviewed on 8/23/16, identified the resident was at risk for skin break down and had a history of pressure ulcers and moisture associated skin damage. The care plan identified R98 needed extensive assistance from one staff for repositioning and changing of incontinent products, however it lacked direction of approaches to resident's refusal of being repositioned and checked for incontinence. The care plan lacked evidence risks and benefits of refusals of cares had been explained to resident/family. 8/24/16 at approximately 1:00 p.m. R98 was sitting in the wheelchair in room with a tray table pulled close to the chair and a glass of orange beverage was near by. On 8/24/16 at 2:15 p.m. NA-C reported she					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00284	B. WING		08/2	25/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LANGTO	ON PLACE		ST COUNTY LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 830	repositioned R98 at her, but R98 refuse NA-C attempted to wheelchair. NA-C ilay R98 down in the refused. NA-C veri wheelchair since 8: same incontinence. On 8/24/16 at approreported R98 had to lay down in bed to lay down RN-C verified the continence of bown in the wounds kept responsible to lay down RN-C verified the continence of bown in the continence of lay down land repositioning. In documentation to benefits had been of family. On 8/25/16 from approximate to lay down nursing assistant to lay down nursing assistant to lay down nursing assistant and the nursing and spoke to lay some and spoke to lay down and s	fter breakfast and to check d and would not lay down. reposition R98 in her ndicated she also offered to afternoon and again R98 fied R98 had been in the 30 a.m. and was still in the brief.	2 830			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00284	B. WING	B. WING		5/2016	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	00/2	3/2010	
LANGTO	LANGTON PLACE 1910 WE ROSEVIL						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 830	wound had changed going to assess the the team agreed to On 8/25/16 at approreported the wound practitioner, however provided. The care indicate new interverisks and benefits hand guardian. A copy of the nurse for care plans and serequested however. SUGGESTIVE MET The director of nurse all residents at risk beakdown to assure necessary treatment breakdown from deand benefits of treator designee, could delivery of care; to designee, could delivery of care; to designe to the control of the contro	d, the nurse practitioner was area. Because R98 refused, try at a later time. Distribution of the commentation was never a plan had been updated to entions developed as well as ad been explained to resident practitioner note and a policy skin breakdown were, not provided. THOD OF CORRECTION: sing or designee, could review for non- pressure related sking they are receiving the ent/services to prevent sking eveloping and to identify risks timent. The director of nursing conduct random audits of the ensure appropriate care and nented; to reduce the risk for occur.	2 830				
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375			10/8/16	
	Subpart 1. Infection	n control program. A nursing					

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED	
AND I LAN	OF CONTILCTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMP	LLILD
		00284	B. WING		08/25/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LANCTO	N PLACE	1910 WES	T COUNTY	ROAD D		
LANGIC	IN PLACE	ROSEVILI	LE, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 16	21375			
	home must establis	th and maintain an infection signed to provide a safe and				
	by: Based on observati review, the facility for the spread glucose monitoring observed who reques and failed to ensure measures were man (R209) observed for Findings include: R346 received blood 9/22/16, in the ever (RN)-A did not proporesidents use. On 8/22/16, at 7:10 indicated she was going sugar (test perform diagnosed with diaking glucose monitor and cart and went into Findication cart, see would clean it where on 8/22/16, at 7:23	lood glucose test, RN-A took nonitor, brought it back to the tit on top, and stated she if finished documenting. p.m. RN-A obtained and		The facility has reviewed the Infect Control policies of Blood Glucose Cleaning and Use of Gloves, and both remain in effect. The facility removed the expired wipes from u 8/25/16 and reviewed all remaining to ensure they were not expired or 8/25/16. The facility has provided education staff on Infection Control, and specon the cleaning of Blood Glucose Machines and Glove use. In addit education was provided to staff on chemical expiration dates. The facility will complete random at to ensure infection control program place weekly for the next 6 weeks results to be reported to the facility Assurance Committee to determine ongoing compliance. The Clinical Administrator will be responsible for ongoing compliance. Date of Comis 10-8-16.	Machine these se on g wipes in to all cifically ion the audits for is in with the v Quality ie	
	walked back to the removed the blood of the cart and walk	dministration for R346 and medication cart. RN-A glucose monitor from the top led down the hall to the container located near the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00284	B. WING		08/2	25/2016	
NAME OF PROVIDER OR SUPI	IER STREET AL	DDRESS, CITY, S	STATE, ZIP CODE	•		
LANGTON PLACE		ST COUNTY .LE, MN 5511				
PREFIX (EACH DEFIC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
monitor, statin seconds. RN-get it clean who bleach contain expiration date. On 8/23/16, at expectation with with bleach volet it air dry be. On 8/25/16, at (DON) stated cleaned after of multi-use glucted follow manufarmonitor with with wind minutes, and the another patient use the gold to. Review of facion cleaning and of dated 2015 independent of the clean and down are shared be manufacturer disinfecting of manufacturer procedures, syshould be adh. Sani-cloth blead guidelines for Treated surfaction (4) minute needed to assocontact time.	RN-A wiped the blood glucose she wipes the monitor for 30 further stated she makes sure to n wiping it for 30 seconds. The r was observed to have an of 6/2016. 8:18 a.m. RN-B stated her a glucometer cleaning was to wrap pes for three to five minutes and ween patients. 12:58 p.m. the director of nursing ood glucose monitors should be ach use because they are meters. DON stated staff should urer's guidelines, wipe the bes, wrap it for three to four en let it air dry before use on DON further stated staff should a Sani-cloth bleach wipes. 12:58 p.m. the director of nursing ood glucose monitors should be ach use because they are meters. DON stated staff should urer's guidelines, wipe the bes, wrap it for three to four en let it air dry before use on DON further stated staff should a Sani-cloth bleach wipes. 12:58 p.m. the director of nursing one let it air dry before use on DON further stated staff should urer's guidelines, wipe the best of the facility infection control general policies sated: "It is the policy of the facility infect blood glucose meters that ween residents." "11. Follow guidelines for cleaning and lucose meters Consult with determine which cleaning ecific to glucose meter sharing, ared to. 13:50 the manufacturer general are dated 2011 indicated: "4. 14. In must remain visibly wet for a full are continuous four (4) minute wet the contin					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00284	B. WING		08/2	25/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LANGTO	N PLACE		ST COUNTY LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	surface type may lo surface type. Evapo room humidity, tem	ook different on another oration rates are affected by perature and air flow. These en into consideration when	21375			
	following was obsert observation on second 12:47 p.m. obsert leaving R209's room the hallway toward took the gloves off a room without washis sanitizer and went it gown. NA-Z returned	vations on 8/22/16, the rved during the initial tour and floor long term care unit: rved nursing assistant (NA)-Z m with gloves on walking down the clean linen room. NA-Z and opened the clean linen ng hands or using hand n and grabbed a clean night at to R209's room by opening shing hands or use of hand				
	walking in the hallw washing hands or u removing the gloved linen room and NA-	3 p.m. NA-Z acknowledged ay with gloves on and not using hand sanitizer after s, prior to opening the clean Z stated, was supposed to hand sanitizer after removing				
	director of nursing s that all staff should should remove glov bodily fluids, disinfe using hand sanitize before entering, lea cares to prevent co DON, added, Staff s	on 8/25/16, at 1:27 p.m. stated her expectation was know when to use gloves, res when finished exposure to ect hands by washing hands or rupon removing gloves, wing the room and after doing ntaminating clean surfaces. should not wear gloves in the rely cleaning up bodily fluids.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00284	B. WING		08/2	5/2016	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
LANGTO	N PLACE		T COUNTY LE, MN 5511				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
21375	CONTROL STAND 2015, indicated, "Perperforming your perwith soap and water or aprons After rewith non-antimicrobial soap a "Remove gloves after bodily fluids/excretic environment (include proper technique to Do not wear the said of more than one pathe purpose of reus associated with transcript suggestions of the purpose of reus associated with transcript suggestions."	ge 19 re titled INFECTION ARD PRECAUTIONS dated erform hand hygiene: 20. After resonal hygiene (hand washing r); 21. After removing gloves emoving gloves. Wash hands bial soap and water or with and water." Further revealed, there contact with a patient, ons, and/or the surrounding ling medical equipment) using a prevent hand contamination. The pair of gloves for the care attent. Do not wash gloves for the since this practice has been as mission of pathogens." THOD OF CORRECTION: Sing or designee, could review lures related to infection	21375				
	machines and hand monitor to assure p utilized. The directo could conduct rand care; to ensure app implemented.	cleaning of blood glucose washing, train staff and proper techiniques are being or of nursing or designee, om audits of the delivery of propriate care and services are a CORRECTIONS: Twenty					
21800	MN St. Statute144. Residents of HC Fa	651 Subd. 4 Patients & ac.Bill of Rights	21800			10/8/16	
	residents shall, at a	tion about rights. Patients and dmission, be told that there their protection during their					

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Minneso	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00284	B. WING		08/2	5/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
I ANGTON PLACE			ST COUNTY LE, MN 551			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON SHOULD BE COMPLET E APPROPRIATE DATE	
21800	Continued From pa	ige 20	21800			
	treatment and main that these are desc written statement or responsibilities set case of patients ad as defined in section statement shall also person 16 years old provided in section shall list the names individuals and orga advocacy and legal residential program accommodations scommunication imposeak a language of facility policies, insplocal health authorithe written stateme to patients, residen chosen representate to the administrator person, consistent	r throughout their course of stenance in the community and cribed in an accompanying of the applicable rights and forth in this section. In the mitted to residential programs on 253C.01, the written of describe the right of a dor older to request release as 253B.04, subdivision 2, and and telephone numbers of anizations that provide a services for patients in as. Reasonable services for those with pairments and those who other than English. Current pection findings of state and ties, and further explanation of ant of rights shall be available to their guardians or their tives upon reasonable request or or other designated staff with chapter 13, the Data section 626.557, relating to				
	by:	ent is not met as evidenced		The policy for Determination of Me	edicare	
	facility did not provi	de liability notice to a Medicare 3 residents (R34) reviewed for		Benefits on Continued Stay has be reviewed and remains in effect. T Resident Services staff and Healtl	een 'he h	
	Findings include:			Information Director will receive ed on this on 9/16/16. The facility will complete random a		
	Record review for F Transfer/Discharge	R34 revealed a Report showing that R34 was		25% of the residents who end Meccoverage weekly for 6 weeks with	dicare	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00284	B. WING		08/2	5/2016	
LANGTON PLACE 1910 WEST				RESS, CITY, STATE, ZIP CODE T COUNTY ROAD D E, MN 55112			
	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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLETE		
admitter Physicis signed as nee service needin day pe When a liability a.m. the manage liability director covere was given unit to form consumer liability Medical are consumer liability. Medical are consumer liability medical are consumer liability. Medical are consumer liability medical are consumer liability. It may be administrated as a service was given be administrated as a service needs as a serv	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		21800	results being reported to the facility Assurance Committee to determine ongoing compliance. The Director Resident Services will be responsionated on the facility of the property of the prope	ne facility Quality determine Director of responsible for		

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