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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: FN9K
Facility ID: 00284

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245389**

2.STATE VENDOR OR MEDICAID NO.
(L2) **695723400**

3. NAME AND ADDRESS OF FACILITY
(L3) **LANGTON PLACE**
(L4) **1910 WEST COUNTY ROAD D**
(L5) **ROSEVILLE, MN** (L6) **55112**

4. TYPE OF ACTION: 7 (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/25/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 04 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **99** (L18)

13.Total Certified Beds **99** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
99				
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Momodou Fatty, HFE NE II — 10/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 10/26/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

Posted 10/31/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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.

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.

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245389	A. Building B. Wing	10/25/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LANGTON PLACE	1910 WEST COUNTY ROAD D ROSEVILLE, MN 55112

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 10/08/2016	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 10/08/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 10/08/2016
ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 10/08/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 10/08/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 10/26/2016	SIGNATURE OF SURVEYOR 32984	DATE 10/25/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/25/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00284 Y1	A. Building B. Wing Y2	10/25/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LANGTON PLACE	1910 WEST COUNTY ROAD D ROSEVILLE, MN 55112

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20560 Reg. # MN Rule 4658.0405 Subp. 2 LSC	Correction Completed 10/08/2016	ID Prefix 20570 Reg. # MN Rule 4658.0405 Subp. 4 LSC	Correction Completed 10/08/2016	ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 10/08/2016
ID Prefix 21375 Reg. # MN Rule 4658.0800 Subp. 1 LSC	Correction Completed 10/08/2016	ID Prefix 21800 Reg. # MN St. Statute144.651 Subd. 4 LSC	Correction Completed 10/08/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 10/26/2016	SIGNATURE OF SURVEYOR 32984	DATE 10/25/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/25/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

FORM APPROVED

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	Provider/Supplier Name
245389	LANGTON PLACE

Type of Survey (select all that apply)

I	D			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
M Other
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor 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 Leader 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 SA Supervisory Review Hours..... 0.25

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 3.25

Total RO Clerical/Data Entry Hours..... 0.00

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: FN9K

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00284

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245389**

2. STATE VENDOR OR MEDICAID NO. (L2) **695723400**

3. NAME AND ADDRESS OF FACILITY
(L3) **LANGTON PLACE**
(L4) **1910 WEST COUNTY ROAD D**
(L5) **ROSEVILLE, MN** (L6) **55112**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **08/25/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12. Total Facility Beds **99** (L18)

13. Total Certified Beds **99** (L17)

10. THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
99				
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Sheryl Reed, HFE NE II 09/19/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 10/21/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

Posted 10/28/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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:

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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
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Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245389	A. BUILDING ______ B. WING ______	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANGTON PLACE	**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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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	F 000		
F 279 SS=D	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. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279		10/8/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE — 09/16/2016

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

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F 279	Continued From page 1 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop a care plan that included non pharmalogical interventions for 1 of 5 residents (R192) who was reviewed for unnecessary medication. Findings include: During random observations during stage one, R192 was observed visiting with his wife in his room. When approached R192 appeared very calm and agreeable but unable to participate in an interview. On 8/24/16 at 2:15 p.m. R192 was sitting in a wheelchair at his doorway to his room. Several staff persons stopped by and spoke to the resident R192 would ask about his wife and 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.	F 279	F279 The facility will continue to ensure that each resident has a plan of care that is developed and revised and reviewed. The policy for Care plan Development has been reviewed and remains in effect. Resident R192 has had his plan of care reviewed and updated. In addition Resident R192 will have a My Best Day completed and available for facility staff to view. This My Best day includes the non pharmacologic interventions for when R192 displays behaviors. In addition all residents during their OBRA RAI process (quarterly, annual and significant change assessments) will have a My best day and/or Care strip updated to ensure non pharmacologic interventions are available to staff. These will be updated following the RAI calendar and with significant 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.	

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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 to take me home, directions to parking lot..." Interventions included allow resident to sleep during the night, however it lacked other non pharmacological interventions identified on the PDA.

During an interview with nursing assistant (NA)-B on 8/24/16 at 2:30 p.m. indicated R192's behavior would be yelling out most of the time and when his wife did not visit, R192 would be yelling for her and refusing cares. R192 would refuse to go to meals as well, and staff would encourage him to attend by telling him what special foods were being served.

On 8/24/16 at 1:45 p.m. the unit clinical nurse coordinator (RN)-B verified the care plan lacked non pharmacological interventions that would

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F 279	Continued From page 3 direct staff techniques to address R192.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the comprehensive care plan to include interventions for skin breakdown and reflect the refusal of care for 1 of 1 resident (R98) reviewed for non pressure related skin concerns. The care plan did not identify risks and benefits explained to the guardian/resident. Findings included:	F 280	F280 The facility will continue to ensure that residents are able to participate in their plan of care and treatment, and that this will be reflected in the residents plan of care. The facility has reviewed the policy on the Resident I Care Plan and it remains in effect. Resident R98 has had their plan of care updated to reflect their choice to refuse cares including repositioning and	10/8/16

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F 280	Continued From page 4 On 8/24/16 at 8:24 a.m. the nursing assistant (NA)-C provided morning cares for R98. After changing an incontinence pad the registered nurse (RN)-D brought in treatment creams for R98. RN-D indicated the excoriated open area on the buttocks was less than 1 inch and had two small open areas above it. The open area was bright red and there was no drainage. Calmoseptine was applied to the area. R98 was assisted with dressing, transferred to wheelchair and was taken to the dining room for breakfast. RN-D indicated the unit clinical coordinator took the wound measurements and charted on the wound. RN-D added R98 refuses to lay down during the day or be checked and changed. R98 had diagnoses that included Alzheimer's disease, dementia without behavioral disturbance, insomnia, anorexia, anemia, moderate protein calorie malnutrition and adult failure to thrive. The annual minimum data set (MDS) dated 5/4/16 indicated R98 was at risk for skin break down, did not have a pressure ulcer but was at risk and did have a moisture associated skin damage (MASD). The MDS identified R98 had severe impaired cognition, needed extensive assist of one for all transfers, bed mobility and toileting, and was always incontinent and not on a toileting program. The annual MDS did not identify any behaviors. Review of the July 1, 2016 Wound Assessment Flow Sheet (WAFS) progress note indicated R98 had three open areas on the buttocks, the areas appeared as slit like openings. The areas were intact and resolved on 7/22/16. On 8/23/16 an area identified as moisture acquired skin damage(MASD) on the left buttocks that was .6 x	F 280	incontinence management. The plan of care also reflects interventions for the staff to attempt when R98 refuses cares. Resident R98, and her family has received the risks for refusal of cares, and this has been documented. The physician has also documented this refusal of care. The facility has educated the nursing staff to report to the nurse when a resident is refusing cares to ensure that the facility discusses with the resident and/or family responsible party the risks of refusing that care, and to ensure the plan of care is developed to address this risk and identify interventions to mitigate the risk. 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.	

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.6 and 100% granulated tissue. The wound had scant serosanguineous drainage. Pass treatment of calmoseptine and covered with mepiplex was used. On 8/25/16 the 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 indicated 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 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 her 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 repositioned R98 after breakfast and checked the brief, but R98 refused and would not lay down. NA-C attempted to reposition R98 in the wheelchair. NA-C indicated she also offered to lay R98 down in the afternoon and again R98 refused. NA-C verified R98 had been in the wheelchair since 8:30 a.m. and was still in the same incontinence brief.

On 8/24/16 at approximately 2:45 p.m. RN-D

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F 280	Continued From page 6 reported R98 had refused to be repositioned or to lay down in bed this shift. On 8/24/16 at 1:45 p.m. the registered nurse clinical coordinator (RN)-C verified the open areas on the buttocks were reoccurring and they had just healed in July. The area had been reoccurring since February 2016. RN-C reported the wounds kept returning due to resident's incontinence of bowel and bladder and ongoing refusals to lay down and to be repositioned. RN-C verified the care plan did not address the behavior of continued refusals of identified cares and repositioning. RN-C also indicated there was no documentation that indicated risks and benefits had been discussed with the resident or family. A copy of a policy for care plans and skin breakdown were requested however, not provided.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview the facility failed to ensure a resident identified at risk for skin breakdown consistently	F 309	F 309 The facility will continue to ensure that residents receive the necessary care and services to attain or maintain their	10/8/16

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F 309	Continued From page 7 received services and treatments identified in the plan of care and modified the interventions to prevent further breakdown in skin for 1 of 1 (R98) resident reviewed for skin break down. The facility also failed to explain risks and benefits to resident/family regarding refusal of care. Findings include: On 8/24/16 at 8:24 a.m. the nursing assistant (NA)-C provided morning cares for R98. After changing an incontinence pad the registered nurse (RN)-D brought in treatment creams for R98. RN-D indicated the excoriated open area on the buttocks was less than 1 inch and had two small open areas above it. The open area was bright red and there was no drainage. Calmoseptine (moisture barrier) was applied to the area. R98 was assisted with dressing, transferred to wheelchair and was taken to the dining room for breakfast. RN-D indicated the unit clinical coordinator took the wound measurements and charted on the wound. RN-D added R98 refuses to lay down during the day or be checked and changed. R98 had diagnoses that included Alzheimer's disease, dementia without behavioral disturbance, insomnia, anorexia, anemia, moderate protein calorie malnutrition and adult failure to thrive. The annual minimum data set (MDS) dated 5/4/16 indicated R98 did not have a pressure ulcer but was at risk and did have a moisture associated skin damage (MASD). The MDS identified R98 had severe impaired cognition, needed extensive assist of one for all transfers, bed mobility and toileting, and was always incontinent and not on a toileting program. The annual MDS did not identify any behaviors.	F 309	highest practicable level. . The facility has reviewed the policy on the Resident I Care Plan and it remains in effect. Resident R98 has had their plan of care updated to reflect their choice to refuse cares including repositioning and incontinence management. The plan of care also reflects interventions for the staff to attempt when R98 refuses cares. Resident R98, and her family has received the risks for refusal of cares, and this has been documented. The physician has also documented this refusal of care. The facility has educated the nursing staff to report to the nurse when a resident is refusing cares to ensure that the facility discusses with the resident and/or family responsible party the risks of refusing that care, and to ensure the plan of care is developed to address this risk and identify interventions to mitigate the risk. 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.	

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The quarterly MDS, dated 8/1/16 identified R98 with severe impaired cognition, at risk for pressure ulcers, did have MASD, and needed extensive assist for all turning repositioning and toileting. No behaviors were noted.

A review of the most current medical doctor's notes dated 6/16/16 indicated R98 had a coccyx wound and was getting Calmoseptine to the area.

A review of body audit forms for 8/21/16 indicated the resident's buttock was red and excoriated. A progress note by the dietician dated 8/22/16 referred to body audit and excoriated buttocks and groin.

Review of the July 1, 2016 Wound Assessment Flow Sheet (WAFS) progress note indicated R98 had three open areas on the buttocks, the areas appeared as slit like openings. The areas were intact and resolved on 7/22/16. On 8/23/16 an area identified as moisture acquired skin damage(MASD) on the left buttocks that was .6 x .6 and 100% granulated tissue. The wound had scant serosanguineous drainage. Pass treatment of calmoseptine and covered with mepiplex was used. On 8/25/16 the 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 indicated the nurse practitioner had been requested to assess the area.

The most current skin risk and braden assessment completed on 8/23/16 identified R98 as a moderate risk for skin breakdown, The assessment indicated the resident had an air mattress and cushion in wheelchair, had a turn and reposition schedule of 2 -21/2 hours and had

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a check and change schedule for urinary incontinence. The assessment indicated the resident did not have any preferences or resistance to a particular position. The summary indicated interventions as specific turning and repositioning and pressure reducing devices, a scheduled turning and repositioning check and change, pressure reliving air mattress calmoseptine cream and dressing to prevent further breakdown. The evaluation of interventions indicated resident had a history of excoriation to coccyx/buttocks. Excoriation noted on left buttock with minimal bleeding. There was no indication of refusal of turning/repositioning schedule or of checking and changing of incontinent products,

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 repositioned R98 after breakfast and to check her, but R98 refused and would not lay down.

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NA-C attempted to reposition R98 in her wheelchair. NA-C indicated she also offered to lay R98 down in the afternoon and again R98 refused. NA-C verified R98 had been in the wheelchair since 8:30 a.m. and was still in the same incontinence brief.

On 8/24/16 at approximately 2:45 p.m. RN-C reported R98 had refused to be repositioned or to lay down in bed this shift.

On 8/24/16 at 1:45 p.m. the registered nurse clinical coordinator (RN)-C verified the open areas on the buttocks were reoccurring and they had just healed in July. The area had been reoccurring since February 2016. RN-C reported the wounds kept returning due to resident's incontinence of bowel and bladder and ongoing refusals to lay down and to be repositioned. RN-C verified the care plan did not address the behavior of continued refusals of identified cares and repositioning. RN-C also indicated there was no documentation that indicated risks and benefits had been discussed with the resident or family.

On 8/25/16 from approximately 9:00 a.m. R98 was eating breakfast in main dining room and was taken to her room at 9:42 a.m. R98 sat in her room in the wheelchair with window shade opened. The nursing assistant asked if she wanted to lay down and R98 declined. The nursing assistant told R98 she would return later. At 10:13 a.m. the clinical coordinator, the nursing assistant and the nurse practitioner entered the room and spoke to R98. The nursing assistant asked R98 if she could lay her down, and R98 refused. The RN-C explained because the wound had changed, the nurse practitioner was

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F 309	Continued From page 11	F 309		

going to assess the area. Because R98 refused, the team agreed to try 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 practitioner note and a policy for care plans and skin breakdown were requested however, not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245389	A. BUILDING ______ B. WING ______	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANGTON PLACE	**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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329		10/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245389	A. BUILDING ______ B. WING ______	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 13 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to develop non pharmalogical interventions for the continual use of psychoactive medication for 1 of 5 residents (R192) who was reviewed for unnecessary medications. Findings include: During random observations during stage one, R192 was observed visiting with his wife in his room. When approached R192 appeared very calm and agreeable but unable to participate in an interview. On 8/ 24/16 at 2:15 p.m. R192 was sitting in a wheelchair at his doorway to his room. Several staff persons stopped by and spoke to the resident R192 would ask about his wife and 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 0.25 milligram (mg) once a day and 0.5 mg twice a day for delusional disorder. A Psychoactive Drug Assessment (PDA) dated 8/12/16 indicated the resident was currently	F 329	F 329 The facility will continue to ensure that residents who receive psychotropic medications have non pharmacologic interventions identified on the resident s plan of care. The facility has reviewed the policy on Unnecessary Medications and it remains in effect. Resident R192 has had his plan of care reviewed and updated. In addition Resident R192 will have a My Best Day completed and available for facility staff to view. This My Best day includes the non pharmacologic interventions for when R192 displays behaviors. In addition all residents during their OBRA RAI process (quarterly, annual and significant change assessments) will have a My best day and/or Care strip updated to ensure non pharmacologic interventions are available to staff. These will be updated following the RAI calendar and with significant 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	

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	245389	A. BUILDING ______ B. WING ______	08/25/2016

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LANGTON PLACE	**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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 14	F 329		

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. 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 to take me home, directions to parking lot..." Interventions included allow resident to sleep during the night, however it lacked other non pharmacological interventions identified on the PDA.

During an interview with nursing assistant (NA)-B on 8/24/16 at 2:30 p.m. indicated R192's behavior would be yelling out most of the time and when his wife did not visit. R192 would be yelling for he, refusing cares, would refuse to go to meals as well, and staff would encourage him to attend by telling him about the special foods that were

Provider's plan of correction (F 329):

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245389	A. BUILDING ______ B. WING ______	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANGTON PLACE	**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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 15 being served. On 8/24/16 at 1:45 p.m. the unit clinical nurse coordinator (RN)-B verified the care plan lacked non pharmacological interventions that would direct staff with techniques to address R192's behaviors.	F 329		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		10/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245389	A. BUILDING ______ B. WING ______	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANGTON PLACE	**1910 WEST COUNTY ROAD D** **ROSEVILLE, MN 55112**

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F 441	Continued From page 16 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement procedures to prevent the spread of infection during blood glucose monitoring for 1 of 3 residents (R346) observed who required blood glucose monitoring and failed to ensure appropriate infection control measures were maintained for 1 of 1 residents (R209) observed for activities of daily living. Findings include: 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	F 441	F441 The facility will continue to ensure that there is an Infection Control Program in place to provide a safe, sanitary and comfortable environment. The facility has reviewed the Infection Control policies of Blood Glucose Machine Cleaning and Use of Gloves, and these both remain in effect. The facility removed the expired wipes from use on 8/25/16 and reviewed all remaining wipes to ensure they were not expired on 8/25/16. The facility has provided education to all staff on Infection Control, and specifically 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 audits for to ensure infection control program is in place 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245389	A. BUILDING ______ B. WING ______	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANGTON PLACE	**1910 WEST COUNTY ROAD D ROSEVILLE, MN 55112**

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F 441		F 441		

F 441 Continued From page 17
completed insulin administration for R346 and walked back to the medication cart. RN-A removed the blood glucose monitor from the top of the cart and walked down the hall to the Sani-cloth bleach container located near the 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 that are shared between residents." "11. Follow manufacturer's guidelines for cleaning and 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245389	A. BUILDING ______ B. WING ______	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 18	F 441		

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.
*Please note, what looks visibly wet on one surface type may look different on another surface type. Evaporation rates are affected by room humidity, temperature and air flow. These factors must be taken into consideration when following label directions.

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.

On 8/22/16, at 12:53 p.m. NA-Z acknowledged walking in the hallway with gloves on and not washing hands or using hand sanitizer after removing the gloves, prior to opening the clean linen room and NA-Z stated, was supposed to wash hands or use hand sanitizer after removing gloves.

When interviewed on 8/25/16, at 1:27 p.m. director of nursing stated her expectation was that all staff should know when to use gloves, should remove gloves when finished exposure to bodily fluids, disinfect hands by washing hands or

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	245389	A. BUILDING ______ B. WING ______	08/25/2016

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LANGTON PLACE	1910 WEST COUNTY ROAD D ROSEVILLE, MN 55112

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F 441	Continued From page 19 using hand sanitizer upon removing gloves, before entering, leaving the room and after doing cares to prevent contaminating clean surfaces. DON, added, Staff should not wear gloves in the hallway unless actively cleaning up bodily fluids. Policy and procedure titled INFECTION CONTROL STANDARD PRECAUTIONS dated 2015, indicated, "Perform hand hygiene: 20. After performing your personal hygiene (hand washing with soap and water); 21. After removing gloves or aprons ... After removing gloves. Wash hands with non-antimicrobial soap and water or with antimicrobial soap and water." Further revealed, "Remove gloves after contact with a patient, bodily fluids/excretions, and/or the surrounding environment (including medical equipment) using proper technique to prevent hand contamination. Do not wear the same pair of gloves for the care of more than one patient. Do not wash gloves for the purpose of reuse since this practice has been associated with transmission of pathogens."	F 441		

F5389025

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245389	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	08/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANGTON PLACE	1910 WEST COUNTY ROAD D ROSEVILLE, MN 55112

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Langton Place was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This 2-story building was determined to be of Type II(222) construction. It has a partial basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 101 beds and had a census of 78 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245389	MULTIPLE CONSTRUCTION A. BUILDING: ________ B. WING ________	DATE SURVEY COMPLETE: 8/25/2016
NAME OF PROVIDER OR SUPPLIER **LANGTON PLACE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1910 WEST COUNTY ROAD D ROSEVILLE, MN**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in 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 before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. 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 of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

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

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245389	A. BUILDING: ____ B. WING ____	8/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANGTON PLACE	**1910 WEST COUNTY ROAD D** **ROSEVILLE, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	Continued From Page 1

Continued From Page 1

This REQUIREMENT is not met as evidenced by:
Based on document review and interview, the facility did not provide liability notice to a Medicare beneficiary for 1 of 3 residents (R34) reviewed for liability notice.

Findings include:

Record review for R34 revealed a Transfer/Discharge Report showing that R34 was admitted on 6/17/16 and discharged on 7/9/16. A Physician Certification and Recertification form, signed by a provider on 6/23/16, described R34 as needing inpatient skilled nursing facility services after inpatient hospital services and needing daily skilled therapy for an estimated 30 day period.

When a surveyor requested a denial letter or liability notice for this resident on 8/25/16, at 8:33 a.m. the director of health information management (HIM) stated that a denial letter or liability notice could not be located. This HIM director went on to explain that R34 had been covered by Medicare for therapies, a denial form was given to the social worker on this resident's unit to complete, but a completed denial letter form could not be found.

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

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

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

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

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

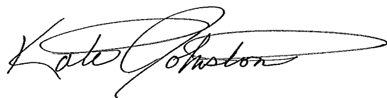
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00284	A. BUILDING: ______ B. WING ______	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANGTON PLACE	**1910 WEST COUNTY ROAD D ROSEVILLE, MN 55112**

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On August 22, 2016 through August 25, 2016, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

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2 000	Continued From page 1 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on record review and interview, the facility failed to develop a care plan that included non pharmalogical interventions for 1 of 5 residents (R192) who was reviewed for unnecessary medication. Findings include: During random observations during stage one, R192 was observed visiting with his wife in his room. When approached R192 appeared very calm and agreeable but unable to participate in an interview. On 8/24/16 at 2:15 p.m. R192 was sitting in a wheelchair at his doorway to his room. Several staff persons stopped by and spoke to the resident R192 would ask about his wife and	2 560	The policy for Care plan Development has been reviewed and remains in effect. Resident R192 has had his plan of care reviewed and updated. In addition Resident R192 will have a My Best Day completed and available for facility staff to view. This My Best day includes the non pharmacologic interventions for when R192 displays behaviors. In addition all residents during their OBRA RAI process (quarterly, annual and significant change assessments) will have a My best day and/or Care strip updated to ensure non pharmacologic interventions are available to staff. These will be updated following the RAI calendar and with significant	10/8/16

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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.

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. 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 to take me home, directions to parking lot..." Interventions included allow resident to sleep

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

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2 560	Continued From page 3	2 560		

during the night, however it lacked other non pharmacological interventions identified on the PDA.

During an interview with nursing assistant (NA)-B on 8/24/16 at 2:30 p.m. indicated R192's behavior would be yelling out most of the time and when his wife did not visit, R192 would be yelling for her and refusing cares. R192 would refuse to go to meals as well, and staff would encourage him to attend by telling him what special foods were being served.

On 8/24/16 at 1:45 p.m. the unit clinical nurse coordinator (RN)-B verified the care plan lacked non pharmacological interventions that would direct staff techniques to address R192.

Based on observation, interview and document review, the facility failed to assure the comprehensive care plan included interventions for skin breakdown and reflect the refusal of care for 1 of 1 resident (R98) reviewed for non pressure related skin concerns and did not identify risks and benefits explained to the guardian/resident.

Findings included:

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2 560	Continued From page 4 On 8/24/16 at 8:24 a.m. the nursing assistant (NA)-C provided morning cares for R98. After changing an incontinence pad the registered nurse (RN)-D brought in treatment creams for R98. RN-D indicated the excoriated open area on the buttocks was less than 1 inch and had two small open areas above it. The open area was bright red and there was no drainage. Calmoseptine was applied to the area. R98 was assisted with dressing, transferred to wheelchair and was taken to the dining room for breakfast. RN-D indicated the unit clinical coordinator took the wound measurements and charted on the wound. RN-D added R98 refuses to lay down during the day or be checked and changed. R98 had diagnoses that included Alzheimer's disease, dementia without behavioral disturbance, insomnia, anorexia, anemia, moderate protein calorie malnutrition and adult failure to thrive. The annual minimum data set (MDS) dated 5/4/16 indicated R98 was at risk for skin break down, did not have a pressure ulcer but was at risk and did have a moisture associated skin damage (MASD). The MDS identified R98 had severe impaired cognition, needed extensive assist of one for all transfers, bed mobility and toileting, and was always incontinent and not on a toileting program. The annual MDS did not identify any behaviors. Review of the July 1, 2016 Wound Assessment Flow Sheet (WAFS) progress note indicated R98 had three open areas on the buttocks, the areas appeared as slit like openings. The areas were intact and resolved on 7/22/16. On 8/23/16 an area identified as moisture acquired skin damage(MASD) on the left buttocks that was .6 x .6 and 100% granulated tissue. The wound had	2 560		

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2 560	Continued From page 5	2 560		

scant serosanguineous drainage. Pass treatment of calmoseptine and covered with mepiplex was used. On 8/25/16 the 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 indicated 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 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 her 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 repositioned R98 after breakfast and checked the brief, but R98 refused and would not lay down. NA-C attempted to reposition R98 in the wheelchair. NA-C indicated she also offered to lay R98 down in the afternoon and again R98 refused. NA-C verified R98 had been in the wheelchair since 8:30 a.m. and was still in the same incontinence brief.

On 8/24/16 at approximately 2:45 p.m. RN-D reported R98 had refused to be repositioned or to lay down in bed this shift.

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2 560	Continued From page 6	2 560		

On 8/24/16 at 1:45 p.m. the registered nurse clinical coordinator (RN)-C verified the open areas on the buttocks were reoccurring and they had just healed in July. The area had been reoccurring since February 2016. RN-C reported the wounds kept returning due to resident's incontinence of bowel and bladder and ongoing refusals to lay down and to be repositioned. RN-C verified the care plan did not address the behavior of continued refusals of identified cares and repositioning. RN-C also indicated there was no documentation that indicated risks and benefits had been discussed with the resident or family.

A copy of a policy for care plans and skin breakdown were requested however, not provided.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee, could develop and implement policies and procedures related to comprehensive care plans. The DON or designee, could provide training for all nursing staff related to information documented on the of care plan. The quality assessment and assurance committee could perform random audits to ensure compliance.

TIME PERIOD FOR CORRECTION;
Thwenty-one (21) days

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2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision	2 570		10/8/16

Subp. 4. Revision. A comprehensive plan of

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2 570	Continued From page 7 care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the 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 assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the comprehensive care plan to include interventions for skin breakdown and reflect the refusal of care for 1 of 1 resident (R98) reviewed for non pressure related skin concerns. The care plan did not identify risks and benefits explained to the guardian/resident. Findings included: On 8/24/16 at 8:24 a.m. the nursing assistant (NA)-C provided morning cares for R98. After changing an incontinence pad the registered nurse (RN)-D brought in treatment creams for R98. RN-D indicated the excoriated open area on the buttocks was less than 1 inch and had two small open areas above it. The open area was bright red and there was no drainage. Calmoseptine was applied to the area. R98 was assisted with dressing, transferred to wheelchair and was taken to the dining room for breakfast. RN-D indicated the unit clinical coordinator took the wound measurements and charted on the wound. RN-D added R98 refuses to lay down	2 570	The facility has reviewed the policy on the Resident I Care Plan and it remains in effect. Resident R98 has had their plan of care updated to reflect their choice to refuse cares including repositioning and incontinence management. The plan of care also reflects interventions for the staff to attempt when R98 refuses cares. Resident R98, and her family has received the risks for refusal of cares, and this has been documented. The physician has also documented this refusal of care. The facility has educated the nursing staff to report to the nurse when a resident is refusing cares to ensure that the facility discusses with the resident and/or family responsible party the risks of refusing that care, and to ensure the plan of care is developed to address this risk and identify interventions to mitigate the risk. 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	

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2 570	Continued From page 8	2 570		

during the day or be checked and changed.

R98 had diagnoses that included Alzheimer's disease, dementia without behavioral disturbance, insomnia, anorexia, anemia, moderate protein calorie malnutrition and adult failure to thrive. The annual minimum data set (MDS) dated 5/4/16 indicated R98 was at risk for skin break down, did not have a pressure ulcer but was at risk and did have a moisture associated skin damage (MASD). The MDS identified R98 had severe impaired cognition, needed extensive assist of one for all transfers, bed mobility and toileting, and was always incontinent and not on a toileting program. The annual MDS did not identify any behaviors.

Review of the July 1, 2016 Wound Assessment Flow Sheet (WAFS) progress note indicated R98 had three open areas on the buttocks, the areas appeared as slit like openings. The areas were intact and resolved on 7/22/16. On 8/23/16 an area identified as moisture acquired skin damage(MASD) on the left buttocks that was .6 x .6 and 100% granulated tissue. The wound had scant serosanguineous drainage. Pass treatment of calmoseptine and covered with mepiplex was used. On 8/25/16 the 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 indicated the nurse practitioner had been requested to assess the area.

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Provider's plan of correction (continued):

to determine ongoing compliance. The Clinical Administrator will be responsible for ongoing compliance. Date of Compliance is 10-8-16

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2 570	Continued From page 9	2 570		

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 her 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 repositioned R98 after breakfast and checked the brief, but R98 refused and would not lay down. NA-C attempted to reposition R98 in the wheelchair. NA-C indicated she also offered to lay R98 down in the afternoon and again R98 refused. NA-C verified R98 had been in the wheelchair since 8:30 a.m. and was still in the same incontinence brief.

On 8/24/16 at approximately 2:45 p.m. RN-D reported R98 had refused to be repositioned or to lay down in bed this shift.

On 8/24/16 at 1:45 p.m. the registered nurse clinical coordinator (RN)-C verified the open areas on the buttocks were reoccurring and they had just healed in July. The area had been reoccurring since February 2016. RN-C reported the wounds kept returning due to resident's incontinence of bowel and bladder and ongoing refusals to lay down and to be repositioned. RN-C verified the care plan did not address the behavior of continued refusals of identified cares and repositioning. RN-C also indicated there was no documentation that indicated risks and benefits had been discussed with the resident or family.

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2 570	Continued From page 10 A copy of a policy for care plans and skin breakdown were requested however, not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. 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 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		10/8/16

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2 830	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, document review and interview the facility failed to ensure a resident identified at risk for skin breakdown consistently received services and treatments identified in the plan of care and modified the interventions to prevent further breakdown in skin for 1 of 1 (R98) resident reviewed for skin break down. The facility also failed to explain risks and benefits to resident/family regarding refusal of care. Findings include: On 8/24/16 at 8:24 a.m. the nursing assistant (NA)-C provided morning cares for R98. After changing an incontinence pad the registered nurse (RN)-D brought in treatment creams for R98. RN-D indicated the excoriated open area on the buttocks was less than 1 inch and had two small open areas above it. The open area was bright red and there was no drainage. Calmoseptine (moisture barrier) was applied to the area. R98 was assisted with dressing, transferred to wheelchair and was taken to the dining room for breakfast. RN-D indicated the unit clinical coordinator took the wound measurements and charted on the wound. RN-D added R98 refuses to lay down during the day or be checked and changed. R98 had diagnoses that included Alzheimer's disease, dementia without behavioral disturbance, insomnia, anorexia, anemia, moderate protein calorie malnutrition and adult failure to thrive. The annual minimum data set (MDS) dated 5/4/16 indicated R98 did not have a pressure ulcer but was at risk and did have a moisture associated skin damage (MASD). The MDS identified R98 had severe impaired	2 830	The facility has reviewed the policy on the Resident I Care Plan and it remains in effect. Resident R98 has had their plan of care updated to reflect their choice to refuse cares including repositioning and incontinence management. The plan of care also reflects interventions for the staff to attempt when R98 refuses cares. Resident R98, and her family has received the risks for refusal of cares, and this has been documented. The physician has also documented this refusal of care. The facility has educated the nursing staff to report to the nurse when a resident is refusing cares to ensure that the facility discusses with the resident and/or family responsible party the risks of refusing that care, and to ensure the plan of care is developed to address this risk and identify interventions to mitigate the risk. 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	

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2 830	Continued From page 12	2 830		

cognition, needed extensive assist of one for all transfers, bed mobility and toileting, and was always incontinent and not on a toileting program. The annual MDS did not identify any behaviors. The quarterly MDS, dated 8/1/16 identified R98 with severe impaired cognition, at risk for pressure ulcers, did have MASD, and needed extensive assist for all turning repositioning and toileting. No behaviors were noted.

A review of the most current medical doctor's notes dated 6/16/16 indicated R98 had a coccyx wound and was getting Calmoseptine to the area.

A review of body audit forms for 8/21/16 indicated the resident's buttock was red and excoriated. A progress note by the dietician dated 8/22/16 referred to body audit and excoriated buttocks and groin.

Review of the July 1, 2016 Wound Assessment Flow Sheet (WAFS) progress note indicated R98 had three open areas on the buttocks, the areas appeared as slit like openings. The areas were intact and resolved on 7/22/16. On 8/23/16 an area identified as moisture acquired skin damage(MASD) on the left buttocks that was .6 x .6 and 100% granulated tissue. The wound had scant serosanguineous drainage. Pass treatment of calmoseptine and covered with mepiplex was used. On 8/25/16 the 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 indicated the nurse practitioner had been requested to assess the area.

The most current skin risk and braden assessment completed on 8/23/16 identified R98 as a moderate risk for skin breakdown, The

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assessment indicated the resident had an air mattress and cushion in wheelchair, had a turn and reposition schedule of 2 -21/2 hours and had a check and change schedule for urinary incontinence. The assessment indicated the resident did not have any preferences or resistance to a particular position. The summary indicated interventions as specific turning and repositioning and pressure reducing devices, a scheduled turning and repositioning check and change, pressure reliving air mattress calmoseptine cream and dressing to prevent further breakdown. The evaluation of interventions indicated resident had a history of excoriation to coccyx/buttocks. Excoriation noted on left buttock with minimal bleeding. There was no indication of refusal of turning/repositioning schedule or of checking and changing of incontinent products,

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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Continued From page 14

repositioned R98 after breakfast and to check her, but R98 refused and would not lay down. NA-C attempted to reposition R98 in her wheelchair. NA-C indicated she also offered to lay R98 down in the afternoon and again R98 refused. NA-C verified R98 had been in the wheelchair since 8:30 a.m. and was still in the same incontinence brief.

On 8/24/16 at approximately 2:45 p.m. RN-C reported R98 had refused to be repositioned or to lay down in bed this shift.

On 8/24/16 at 1:45 p.m. the registered nurse clinical coordinator (RN)-C verified the open areas on the buttocks were reoccurring and they had just healed in July. The area had been reoccurring since February 2016. RN-C reported the wounds kept returning due to resident's incontinence of bowel and bladder and ongoing refusals to lay down and to be repositioned. RN-C verified the care plan did not address the behavior of continued refusals of identified cares and repositioning. RN-C also indicated there was no documentation that indicated risks and benefits had been discussed with the resident or family.

On 8/25/16 from approximately 9:00 a.m. R98 was eating breakfast in main dining room and was taken to her room at 9:42 a.m. R98 sat in her room in the wheelchair with window shade opened. The nursing assistant asked if she wanted to lay down and R98 declined. The nursing assistant told R98 she would return later. At 10:13 a.m. the clinical coordinator, the nursing assistant and the nurse practitioner entered the room and spoke to R98. The nursing assistant asked R98 if she could lay her down, and R98 refused. The RN-C explained because the

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wound had changed, the nurse practitioner was going to assess the area. Because R98 refused, the team agreed to try 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 practitioner note and a policy for care plans and skin breakdown were requested however, not provided.

SUGGESTIVE METHOD OF CORRECTION:
The director of nursing or designee, could review all residents at risk for non- pressure related skin breakdown 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 CORRECTIONS:
Twwenty-one (21) days

21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program	21375		10/8/16

Subpart 1. Infection control program. A nursing

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21375	Continued From page 16 home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement procedures to prevent the spread of infection during blood glucose monitoring for 1 of 3 residents (R346) observed who required blood glucose monitoring and failed to ensure appropriate infection control measures were maintained for 1 of 1 residents (R209) observed for activities of daily living. Findings include: 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 completed insulin administration for R346 and walked back to the medication cart. RN-A removed the blood glucose monitor from the top of the cart and walked down the hall to the Sani-cloth bleach container located near the	21375	The facility has reviewed the Infection Control policies of Blood Glucose Machine Cleaning and Use of Gloves, and these both remain in effect. The facility removed the expired wipes from use on 8/25/16 and reviewed all remaining wipes to ensure they were not expired on 8/25/16. The facility has provided education to all staff on Infection Control, and specifically 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 audits for to ensure infection control program is in place 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.	

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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 that are shared between residents." "11. Follow manufacturer's guidelines for cleaning and 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.
*Please note, what looks visibly wet on one

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surface type may look different on another surface type. Evaporation rates are affected by room humidity, temperature and air flow. These factors must be taken into consideration when following label directions.

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.

On 8/22/16, at 12:53 p.m. NA-Z acknowledged walking in the hallway with gloves on and not washing hands or using hand sanitizer after removing the gloves, prior to opening the clean linen room and NA-Z stated, was supposed to wash hands or use hand sanitizer after removing gloves.

When interviewed on 8/25/16, at 1:27 p.m. director of nursing stated her expectation was that all staff should know when to use gloves, should remove gloves when finished exposure to bodily fluids, disinfect hands by washing hands or using hand sanitizer upon removing gloves, before entering, leaving the room and after doing cares to prevent contaminating clean surfaces. DON, added, Staff should not wear gloves in the hallway unless actively cleaning up bodily fluids.

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21375	Continued From page 19 Policy and procedure titled INFECTION CONTROL STANDARD PRECAUTIONS dated 2015, indicated, "Perform hand hygiene: 20. After performing your personal hygiene (hand washing with soap and water); 21. After removing gloves or aprons ... After removing gloves. Wash hands with non-antimicrobial soap and water or with antimicrobial soap and water." Further revealed, "Remove gloves after contact with a patient, bodily fluids/excretions, and/or the surrounding environment (including medical equipment) using proper technique to prevent hand contamination. Do not wear the same pair of gloves for the care of more than one patient. Do not wash gloves for the purpose of reuse since this practice has been associated with transmission of pathogens." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review policies and procedures related to infection control, specific to cleaning of blood glucose machines and hand washing, train staff and monitor to assure proper techiniques are being utilized. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTIONS: Twenty one (21) days	21375		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their	21800		10/8/16

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stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.

This MN Requirement is not met as evidenced by:
Based on document review and interview, the facility did not provide liability notice to a Medicare beneficiary for 1 of 3 residents (R34) reviewed for liability notice.

Findings include:

Record review for R34 revealed a Transfer/Discharge Report showing that R34 was

Provider's Plan of Correction:

The policy for Determination of Medicare Benefits on Continued Stay has been reviewed and remains in effect. The Resident Services staff and Health Information Director will receive education on this on 9/16/16.
The facility will complete random audits of 25% of the residents who end Medicare coverage weekly for 6 weeks with the

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21800	Continued From page 21 admitted on 6/17/16 and discharged on 7/9/16. A Physician Certification and Recertification form, signed by a provider on 6/23/16, described R34 as needing inpatient skilled nursing facility services after inpatient hospital services and needing daily skilled therapy for an estimated 30 day period. When a surveyor requested a denial letter or liability notice for this resident on 8/25/16, at 8:33 a.m. the director of health information management (HIM) stated that a denial letter or liability notice could not be located. This HIM director went on to explain that R34 had been covered by Medicare for therapies, a denial form was given to the social worker on this resident's unit to complete, but a completed denial letter form could not be found. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure staff are educated on the appropriate liability notices to provide residents at the end of Medicare services, and to ensure resident rights are communicated appropriately and acted upon. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21800	results being reported to the facility Quality Assurance Committee to determine ongoing compliance. The Director of Resident Services will be responsible for ongoing compliance. Date of compliance is 10-8-16.	

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On August 22, 2016 through August 25, 2016, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

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2 000	Continued From page 1 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on record review and interview, the facility failed to develop a care plan that included non pharmalogical interventions for 1 of 5 residents (R192) who was reviewed for unnecessary medication. Findings include: During random observations during stage one, R192 was observed visiting with his wife in his room. When approached R192 appeared very calm and agreeable but unable to participate in an interview. On 8/24/16 at 2:15 p.m. R192 was sitting in a wheelchair at his doorway to his room. Several staff persons stopped by and spoke to the resident R192 would ask about his wife and	2 560	The policy for Care plan Development has been reviewed and remains in effect. Resident R192 has had his plan of care reviewed and updated. In addition Resident R192 will have a My Best Day completed and available for facility staff to view. This My Best day includes the non pharmacologic interventions for when R192 displays behaviors. In addition all residents during their OBRA RAI process (quarterly, annual and significant change assessments) will have a My best day and/or Care strip updated to ensure non pharmacologic interventions are available to staff. These will be updated following the RAI calendar and with significant	10/8/16

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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. 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 to take me home, directions to parking lot..." Interventions included allow resident to sleep	2 560	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	

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during the night, however it lacked other non pharmacological interventions identified on the PDA.

During an interview with nursing assistant (NA)-B on 8/24/16 at 2:30 p.m. indicated R192's behavior would be yelling out most of the time and when his wife did not visit, R192 would be yelling for her and refusing cares. R192 would refuse to go to meals as well, and staff would encourage him to attend by telling him what special foods were being served.

On 8/24/16 at 1:45 p.m. the unit clinical nurse coordinator (RN)-B verified the care plan lacked non pharmacological interventions that would direct staff techniques to address R192.

Based on observation, interview and document review, the facility failed to assure the comprehensive care plan included interventions for skin breakdown and reflect the refusal of care for 1 of 1 resident (R98) reviewed for non pressure related skin concerns and did not identify risks and benefits explained to the guardian/resident.

Findings included:

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2 560	Continued From page 4	2 560		

Continued From page 4

On 8/24/16 at 8:24 a.m. the nursing assistant (NA)-C provided morning cares for R98. After changing an incontinence pad the registered nurse (RN)-D brought in treatment creams for R98. RN-D indicated the excoriated open area on the buttocks was less than 1 inch and had two small open areas above it. The open area was bright red and there was no drainage. Calmoseptine was applied to the area. R98 was assisted with dressing, transferred to wheelchair and was taken to the dining room for breakfast. RN-D indicated the unit clinical coordinator took the wound measurements and charted on the wound. RN-D added R98 refuses to lay down during the day or be checked and changed.

R98 had diagnoses that included Alzheimer's disease, dementia without behavioral disturbance, insomnia, anorexia, anemia, moderate protein calorie malnutrition and adult failure to thrive. The annual minimum data set (MDS) dated 5/4/16 indicated R98 was at risk for skin break down, did not have a pressure ulcer but was at risk and did have a moisture associated skin damage (MASD). The MDS identified R98 had severe impaired cognition, needed extensive assist of one for all transfers, bed mobility and toileting, and was always incontinent and not on a toileting program. The annual MDS did not identify any behaviors.

Review of the July 1, 2016 Wound Assessment Flow Sheet (WAFS) progress note indicated R98 had three open areas on the buttocks, the areas appeared as slit like openings. The areas were intact and resolved on 7/22/16. On 8/23/16 an area identified as moisture acquired skin damage(MASD) on the left buttocks that was .6 x .6 and 100% granulated tissue. The wound had

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2 560	Continued From page 5	2 560		

scant serosanguineous drainage. Pass treatment of calmoseptine and covered with mepiplex was used. On 8/25/16 the 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 indicated 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 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 her 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 repositioned R98 after breakfast and checked the brief, but R98 refused and would not lay down. NA-C attempted to reposition R98 in the wheelchair. NA-C indicated she also offered to lay R98 down in the afternoon and again R98 refused. NA-C verified R98 had been in the wheelchair since 8:30 a.m. and was still in the same incontinence brief.

On 8/24/16 at approximately 2:45 p.m. RN-D reported R98 had refused to be repositioned or to lay down in bed this shift.

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2 560	Continued From page 6 On 8/24/16 at 1:45 p.m. the registered nurse clinical coordinator (RN)-C verified the open areas on the buttocks were reoccurring and they had just healed in July. The area had been reoccurring since February 2016. RN-C reported the wounds kept returning due to resident's incontinence of bowel and bladder and ongoing refusals to lay down and to be repositioned. RN-C verified the care plan did not address the behavior of continued refusals of identified cares and repositioning. RN-C also indicated there was no documentation that indicated risks and benefits had been discussed with the resident or family. A copy of a policy for care plans and skin breakdown were requested however, not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to comprehensive care plans. The DON or designee, could provide training for all nursing staff related to information documented on the of care plan. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION; Thwenty-one (21) days	2 560		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of	2 570		10/8/16

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2 570	Continued From page 7 care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the 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 assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the comprehensive care plan to include interventions for skin breakdown and reflect the refusal of care for 1 of 1 resident (R98) reviewed for non pressure related skin concerns. The care plan did not identify risks and benefits explained to the guardian/resident. Findings included: On 8/24/16 at 8:24 a.m. the nursing assistant (NA)-C provided morning cares for R98. After changing an incontinence pad the registered nurse (RN)-D brought in treatment creams for R98. RN-D indicated the excoriated open area on the buttocks was less than 1 inch and had two small open areas above it. The open area was bright red and there was no drainage. Calmoseptine was applied to the area. R98 was assisted with dressing, transferred to wheelchair and was taken to the dining room for breakfast. RN-D indicated the unit clinical coordinator took the wound measurements and charted on the wound. RN-D added R98 refuses to lay down	2 570	The facility has reviewed the policy on the Resident I Care Plan and it remains in effect. Resident R98 has had their plan of care updated to reflect their choice to refuse cares including repositioning and incontinence management. The plan of care also reflects interventions for the staff to attempt when R98 refuses cares. Resident R98, and her family has received the risks for refusal of cares, and this has been documented. The physician has also documented this refusal of care. The facility has educated the nursing staff to report to the nurse when a resident is refusing cares to ensure that the facility discusses with the resident and/or family responsible party the risks of refusing that care, and to ensure the plan of care is developed to address this risk and identify interventions to mitigate the risk. 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	

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2 570	Continued From page 8 during the day or be checked and changed. R98 had diagnoses that included Alzheimer's disease, dementia without behavioral disturbance, insomnia, anorexia, anemia, moderate protein calorie malnutrition and adult failure to thrive. The annual minimum data set (MDS) dated 5/4/16 indicated R98 was at risk for skin break down, did not have a pressure ulcer but was at risk and did have a moisture associated skin damage (MASD). The MDS identified R98 had severe impaired cognition, needed extensive assist of one for all transfers, bed mobility and toileting, and was always incontinent and not on a toileting program. The annual MDS did not identify any behaviors. Review of the July 1, 2016 Wound Assessment Flow Sheet (WAFS) progress note indicated R98 had three open areas on the buttocks, the areas appeared as slit like openings. The areas were intact and resolved on 7/22/16. On 8/23/16 an area identified as moisture acquired skin damage(MASD) on the left buttocks that was .6 x .6 and 100% granulated tissue. The wound had scant serosanguineous drainage. Pass treatment of calmoseptine and covered with mepiplex was used. On 8/25/16 the 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 indicated 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 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	2 570	to determine ongoing compliance. The Clinical Administrator will be responsible for ongoing compliance. Date of Compliance is 10-8-16	

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2 570	Continued From page 9	2 570		

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 her 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 repositioned R98 after breakfast and checked the brief, but R98 refused and would not lay down. NA-C attempted to reposition R98 in the wheelchair. NA-C indicated she also offered to lay R98 down in the afternoon and again R98 refused. NA-C verified R98 had been in the wheelchair since 8:30 a.m. and was still in the same incontinence brief.

On 8/24/16 at approximately 2:45 p.m. RN-D reported R98 had refused to be repositioned or to lay down in bed this shift.

On 8/24/16 at 1:45 p.m. the registered nurse clinical coordinator (RN)-C verified the open areas on the buttocks were reoccurring and they had just healed in July. The area had been reoccurring since February 2016. RN-C reported the wounds kept returning due to resident's incontinence of bowel and bladder and ongoing refusals to lay down and to be repositioned. RN-C verified the care plan did not address the behavior of continued refusals of identified cares and repositioning. RN-C also indicated there was no documentation that indicated risks and benefits had been discussed with the resident or family.

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2 570	Continued From page 10 A copy of a policy for care plans and skin breakdown were requested however, not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. 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 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		10/8/16

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2 830	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, document review and interview the facility failed to ensure a resident identified at risk for skin breakdown consistently received services and treatments identified in the plan of care and modified the interventions to prevent further breakdown in skin for 1 of 1 (R98) resident reviewed for skin break down. The facility also failed to explain risks and benefits to resident/family regarding refusal of care. Findings include: On 8/24/16 at 8:24 a.m. the nursing assistant (NA)-C provided morning cares for R98. After changing an incontinence pad the registered nurse (RN)-D brought in treatment creams for R98. RN-D indicated the excoriated open area on the buttocks was less than 1 inch and had two small open areas above it. The open area was bright red and there was no drainage. Calmoseptine (moisture barrier) was applied to the area. R98 was assisted with dressing, transferred to wheelchair and was taken to the dining room for breakfast. RN-D indicated the unit clinical coordinator took the wound measurements and charted on the wound. RN-D added R98 refuses to lay down during the day or be checked and changed. R98 had diagnoses that included Alzheimer's disease, dementia without behavioral disturbance, insomnia, anorexia, anemia, moderate protein calorie malnutrition and adult failure to thrive. The annual minimum data set (MDS) dated 5/4/16 indicated R98 did not have a pressure ulcer but was at risk and did have a moisture associated skin damage (MASD). The MDS identified R98 had severe impaired	2 830	The facility has reviewed the policy on the Resident I Care Plan and it remains in effect. Resident R98 has had their plan of care updated to reflect their choice to refuse cares including repositioning and incontinence management. The plan of care also reflects interventions for the staff to attempt when R98 refuses cares. Resident R98, and her family has received the risks for refusal of cares, and this has been documented. The physician has also documented this refusal of care. The facility has educated the nursing staff to report to the nurse when a resident is refusing cares to ensure that the facility discusses with the resident and/or family responsible party the risks of refusing that care, and to ensure the plan of care is developed to address this risk and identify interventions to mitigate the risk. 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	

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2 830	Continued From page 12	2 830		

cognition, needed extensive assist of one for all transfers, bed mobility and toileting, and was always incontinent and not on a toileting program. The annual MDS did not identify any behaviors. The quarterly MDS, dated 8/1/16 identified R98 with severe impaired cognition, at risk for pressure ulcers, did have MASD, and needed extensive assist for all turning repositioning and toileting. No behaviors were noted.

A review of the most current medical doctor's notes dated 6/16/16 indicated R98 had a coccyx wound and was getting Calmoseptine to the area.

A review of body audit forms for 8/21/16 indicated the resident's buttock was red and excoriated. A progress note by the dietician dated 8/22/16 referred to body audit and excoriated buttocks and groin.

Review of the July 1, 2016 Wound Assessment Flow Sheet (WAFS) progress note indicated R98 had three open areas on the buttocks, the areas appeared as slit like openings. The areas were intact and resolved on 7/22/16. On 8/23/16 an area identified as moisture acquired skin damage(MASD) on the left buttocks that was .6 x .6 and 100% granulated tissue. The wound had scant serosanguineous drainage. Pass treatment of calmoseptine and covered with mepiplex was used. On 8/25/16 the 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 indicated the nurse practitioner had been requested to assess the area.

The most current skin risk and braden assessment completed on 8/23/16 identified R98 as a moderate risk for skin breakdown, The

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2 830	Continued From page 13	2 830		

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assessment indicated the resident had an air mattress and cushion in wheelchair, had a turn and reposition schedule of 2 -21/2 hours and had a check and change schedule for urinary incontinence. The assessment indicated the resident did not have any preferences or resistance to a particular position. The summary indicated interventions as specific turning and repositioning and pressure reducing devices, a scheduled turning and repositioning check and change, pressure reliving air mattress calmoseptine cream and dressing to prevent further breakdown. The evaluation of interventions indicated resident had a history of excoriation to coccyx/buttocks. Excoriation noted on left buttock with minimal bleeding. There was no indication of refusal of turning/repositioning schedule or of checking and changing of incontinent products,

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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2 830	Continued From page 14 repositioned R98 after breakfast and to check her, but R98 refused and would not lay down. NA-C attempted to reposition R98 in her wheelchair. NA-C indicated she also offered to lay R98 down in the afternoon and again R98 refused. NA-C verified R98 had been in the wheelchair since 8:30 a.m. and was still in the same incontinence brief. On 8/24/16 at approximately 2:45 p.m. RN-C reported R98 had refused to be repositioned or to lay down in bed this shift. On 8/24/16 at 1:45 p.m. the registered nurse clinical coordinator (RN)-C verified the open areas on the buttocks were reoccurring and they had just healed in July. The area had been reoccurring since February 2016. RN-C reported the wounds kept returning due to resident's incontinence of bowel and bladder and ongoing refusals to lay down and to be repositioned. RN-C verified the care plan did not address the behavior of continued refusals of identified cares and repositioning. RN-C also indicated there was no documentation that indicated risks and benefits had been discussed with the resident or family. On 8/25/16 from approximately 9:00 a.m. R98 was eating breakfast in main dining room and was taken to her room at 9:42 a.m. R98 sat in her room in the wheelchair with window shade opened. The nursing assistant asked if she wanted to lay down and R98 declined. The nursing assistant told R98 she would return later. At 10:13 a.m. the clinical coordinator, the nursing assistant and the nurse practitioner entered the room and spoke to R98. The nursing assistant asked R98 if she could lay her down, and R98 refused. The RN-C explained because the	2 830		

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2 830	Continued From page 15 wound had changed, the nurse practitioner was going to assess the area. Because R98 refused, the team agreed to try 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 practitioner note and a policy for care plans and skin breakdown were requested however, not provided. 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 CORRECTIONS: Twwenty-one (21) days	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing	21375		10/8/16

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21375	Continued From page 16 home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement procedures to prevent the spread of infection during blood glucose monitoring for 1 of 3 residents (R346) observed who required blood glucose monitoring and failed to ensure appropriate infection control measures were maintained for 1 of 1 residents (R209) observed for activities of daily living. Findings include: 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 completed insulin administration for R346 and walked back to the medication cart. RN-A removed the blood glucose monitor from the top of the cart and walked down the hall to the Sani-cloth bleach container located near the	21375	The facility has reviewed the Infection Control policies of Blood Glucose Machine Cleaning and Use of Gloves, and these both remain in effect. The facility removed the expired wipes from use on 8/25/16 and reviewed all remaining wipes to ensure they were not expired on 8/25/16. The facility has provided education to all staff on Infection Control, and specifically 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 audits for to ensure infection control program is in place 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.	

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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 that are shared between residents." "11. Follow manufacturer's guidelines for cleaning and 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.
*Please note, what looks visibly wet on one

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surface type may look different on another surface type. Evaporation rates are affected by room humidity, temperature and air flow. These factors must be taken into consideration when following label directions.

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.

On 8/22/16, at 12:53 p.m. NA-Z acknowledged walking in the hallway with gloves on and not washing hands or using hand sanitizer after removing the gloves, prior to opening the clean linen room and NA-Z stated, was supposed to wash hands or use hand sanitizer after removing gloves.

When interviewed on 8/25/16, at 1:27 p.m. director of nursing stated her expectation was that all staff should know when to use gloves, should remove gloves when finished exposure to bodily fluids, disinfect hands by washing hands or using hand sanitizer upon removing gloves, before entering, leaving the room and after doing cares to prevent contaminating clean surfaces. DON, added, Staff should not wear gloves in the hallway unless actively cleaning up bodily fluids.

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21375	Continued From page 19 Policy and procedure titled INFECTION CONTROL STANDARD PRECAUTIONS dated 2015, indicated, "Perform hand hygiene: 20. After performing your personal hygiene (hand washing with soap and water); 21. After removing gloves or aprons ... After removing gloves. Wash hands with non-antimicrobial soap and water or with antimicrobial soap and water." Further revealed, "Remove gloves after contact with a patient, bodily fluids/excretions, and/or the surrounding environment (including medical equipment) using proper technique to prevent hand contamination. Do not wear the same pair of gloves for the care of more than one patient. Do not wash gloves for the purpose of reuse since this practice has been associated with transmission of pathogens." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review policies and procedures related to infection control, specific to cleaning of blood glucose machines and hand washing, train staff and monitor to assure proper techiniques are being utilized. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTIONS: Twenty one (21) days	21375		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their	21800		10/8/16

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21800	Continued From page 20 stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility did not provide liability notice to a Medicare beneficiary for 1 of 3 residents (R34) reviewed for liability notice. Findings include: Record review for R34 revealed a Transfer/Discharge Report showing that R34 was	21800	The policy for Determination of Medicare Benefits on Continued Stay has been reviewed and remains in effect. The Resident Services staff and Health Information Director will receive education on this on 9/16/16. The facility will complete random audits of 25% of the residents who end Medicare coverage weekly for 6 weeks with the	

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21800	Continued From page 21 admitted on 6/17/16 and discharged on 7/9/16. A Physician Certification and Recertification form, signed by a provider on 6/23/16, described R34 as needing inpatient skilled nursing facility services after inpatient hospital services and needing daily skilled therapy for an estimated 30 day period. When a surveyor requested a denial letter or liability notice for this resident on 8/25/16, at 8:33 a.m. the director of health information management (HIM) stated that a denial letter or liability notice could not be located. This HIM director went on to explain that R34 had been covered by Medicare for therapies, a denial form was given to the social worker on this resident's unit to complete, but a completed denial letter form could not be found. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure staff are educated on the appropriate liability notices to provide residents at the end of Medicare services, and to ensure resident rights are communicated appropriately and acted upon. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21800	results being reported to the facility Quality Assurance Committee to determine ongoing compliance. The Director of Resident Services will be responsible for ongoing compliance. Date of compliance is 10-8-16.	