#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: GK88

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

		PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY		Facility ID: 00260		
1. MEDICARE/MEDIC (L1) 245387 2.STATE VENDOR OR (L2) 492242500	MEDICAID NO.		3. NAME AND AI (L3) <b>ST OLAF R</b> (L4) <b>2912 FREM</b> (L5) <b>MINNEAPO</b>	ESIDENCE ONT AVENUI		(L6) <b>55411</b>	4. TYPE OF ACTIO  1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint 9. Other		
5. EFFECTIVE DATE (L9)	CHANGE OF OW	VNERSHIP	7. PROVIDER/SU 01 Hospital	OF HHA	ORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit  8. Full Survey Afte			
6. DATE OF SURVEY 8. ACCREDITATION S 0 Unaccredited 2 AOA		<b>2015</b> (L34) (L10)	03 SNF/NF/Distinct 07 X-Ray 11 IC		10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30			
11LTC PERIOD OF C	ERTIFICATION		10.THE FACILITY	' IS CERTIFIED	AS:					
From (a):			X A. In Complia	nce With		And/Or Approved Waivers Of		ents:		
To (b):				equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Se 7. Medical Di			
12.Total Facility Beds		<b>80</b> (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code		m Size		
13.Total Certified Beds		<b>80</b> (L17)		npliance with Progents and/or Appli		* Code: A	(L12)			
14. LTC CERTIFIED BI	ED BREAKDOW!	N				15. FACILITY MEETS				
18 SNF	18/19 SNF 80	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)			
(L37)	(L38)	(L39)	(L42)	(L43)						
17. SURVEYOR SIGN	ATURE		Date :			18. STATE SURVEY AGENCY	'APPROVAL	Date:		
Magdalene J	ares, HFE NI	E II	1	0/30/2015	(L19) K	a <u>mala Fiske-Downing, E</u>	nforcement Specia	<u>list</u> 11/04/2015 (L20		
	PART	II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S	TATE AGENCY	· · · · · · · · · · · · · · · · · · ·		
-	OF ELIGIBILIT is Eligible to Part y is not Eligible			IPLIANCE WITH	H CIVIL	<ul><li>21. 1. Statement of Fina</li><li>2. Ownership/Control</li><li>3. Both of the Above</li></ul>	ol Interest Disclosure Stmt			
22. ORIGINAL DATE								σ. a.o.		
OF PARTICIPATION		23. LTC AGREEN BEGINNING		<ol> <li>LTC AGREEN ENDING DA</li> </ol>		26. TERMINATION ACTION: VOLUNTARY 00		(L30) NTARY		
12/01/1986	)IN	BEOINNING	DATE	ENDING DA	IL.	01-Merger, Closure	05-Fail to	Meet Health/Safety		
(L24)		(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement		
25. LTC EXTENSION	DATE: 2		VE SANCTIONS			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	G GI		
		A. Suspension	n of Admissions:	(L44)		or other reason for wandawar	00-Active	er Status Change		
	(L27)	B. Rescind Su	uspension Date:	(211)						
				(L45)						
28. TERMINATION D.	ATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS				
		(I 29)	03001		(1.21)					
		(L28)			(L31)					
31. RO RECEIPT OF C	MS-1539	32	. DETERMINATION	OF APPROVAL	DATE					
		(L32)			(L33)	DETERMINATION APP	ROVAL			



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245387

November 4, 2015

Ms. Mary Hamer, Administrator St Olaf Residence 2912 Fremont Avenue North Minneapolis, MN 55411

Dear Ms. Hamer:

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 10, 2015 the above facility is certified for:

80 Skilled Nursing Facility/Nursing Facility Beds

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

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

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,

Kamala Fiske. Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

October 30, 2015

Ms. Mary Hamer, Administrator St Olaf Residence 2912 Fremont Avenue North Minneapolis, Minnesota 55411

RE: Project Number S5387025

Dear Ms. Hamer:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On September 15, 2015, This Department recommended to the Centers for Medicare and Medicaid Services (CMS), CMS concurred with our recommendation and authorized this Department to notify you of the following:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective October 10, 2015. (42 CFR 488.417 (b))

Also, in our letter of September 15, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 10, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on July 10, 2015, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on September 9, 2015. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On October 12, 2015, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on September 9, 2015. We presumed, based on your plan of correction, that your

St Olaf Residence October 30, 2015 Page 2

facility had corrected these deficiencies as of October 10, 2015. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on September 9, 2015, as of October 10, 2015. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective October 10, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of October 15, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 10, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective October 10, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective October 10, 2015, is to be rescinded.

In our letter of October 15, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 10, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 10, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

### Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

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

(Y1) Provider / Supplier / CLIA / Identification Number 245387	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/12/2015
Name of Facility		Street Address, City, State, Zip Code	
ST OLAF RESIDENCE		2912 FREMONT AVENUE NOR	TH

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

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y	5)	Date
ID Prefix	F0333	Correction Completed 10/10/2015	ID Prefix		Correction Completed		ID Prefix			Correction Completed
	483.25(m)(2)						- "			<del>-</del>
		Correction Completed			Correction Completed					Correction Completed
ID Prefix			ID Prefix		, , , , , , , , , , , , , , , , , , ,		ID Prefix			_
Reg. # LSC			Reg. # LSC				Reg. # LSC			_ 
		Correction			Correction					Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix			Completed
Reg. #			Dog #				D "			_
LSC			LSC				LSC			 
ID Prefix		Correction Completed	ID Profix		Correction Completed		ID Profiv			Correction Completed
Reg. #										_
LSC							LSC			_ _
		Correction Completed			Correction Completed					Correction Completed
ID Prefix		·	ID Prefix		·		ID Prefix			_
Reg. # LSC			Reg. #				Reg. # LSC			<u> </u>
Reviewed I	By Re	viewed By	Date:	Signature of Sur	veyor:	,		D	ate:	
State Agen	cy GI	D/kfd	10/30/2015		329	982			1	0/12/2015
Reviewed I	Ву	viewed By	Date:	Signature of Sur	veyor:			D	ate:	
Followup t	to Survey Compl 7/10/20			Check for any Uncor Uncorrected Defic				ha Fasiliu.O	YES	NO

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: GK88

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I -	TO BE COMPI	LETED BY T	HE STAT	TE SURVEY AGENCY		Facility ID: 00260		
1. MEDICARE/MEDICAID PRO (L1) <b>245387</b> 2.STATE VENDOR OR MEDIC (L2) <b>492242500</b>		3. NAME AND AI (L3) <b>ST OLAF R</b> (L4) <b>2912 FREM</b> (L5) <b>MINNEAPO</b>	ESIDENCE ONT AVENUE		(L6) <b>55411</b>	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	<ol> <li>Recertification</li> <li>CHOW</li> <li>Complaint</li> </ol>		
5. EFFECTIVE DATE CHANGE (L9)	E OF OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEG	ORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other  8. Full Survey After Complaint			
8. ACCREDITATION STATUS: 0 Unaccredited 1 T	_ ` '	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDI	ING DATE: (L35)		
11LTC PERIOD OF CERTIFICATION (a): To (b):  12. Total Facility Beds  13. Total Certified Beds  14. LTC CERTIFIED BED BREA  18 SNF 18/19  80  (L37) (L37)	80 (L18) 80 (L17) AKDOWN SNF 19 SNF	Complianc1. A B. Not in Con		ram ed Waivers:	And/Or Approved Waivers Of	6. Scope of So 7. Medical Di	ervices Limit rector m Size		
16. STATE SURVEY AGENCY	REMARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):					
17. SURVEYOR SIGNATURE  Kathy Sass, HFE N	E II	Date :	09/24/2015	(L19) <b>K</b> :	18. STATE SURVEY AGENCY amala Fiske-Downing, E		Date:		
	PART II - TO BE	COMPLETED I	BY HCFA RE	( - /	L OFFICE OR SINGLE S	TATE AGENCY	(L20)		
DETERMINATION OF ELIC     1. Facility is Eligib     2. Facility is not E	GIBILITY le to Participate	20. COM	MPLIANCE WITH HTS ACT:		21. 1. Statement of Fina	ncial Solvency (HCFA-25' ol Interest Disclosure Stm			
22. ORIGINAL DATE  OF PARTICIPATION 12/01/1986  (L24)  25. LTC EXTENSION DATE:	23. LTC AGREED BEGINNING (L41) 27. ALTERNATI A. Suspension	G DATE	4. LTC AGREEM ENDING DAT (L25)		26. TERMINATION ACTION  VOLUNTARY 00  01-Merger, Closure  02-Dissatisfaction W/ Reimburs  03-Risk of Involuntary Termination  04-Other Reason for Withdrawal	D         INVOLU           05-Fail to         06-Fail to           on         OTHER	(L30)  NTARY  Meet Health/Safety  Meet Agreement  der Status Change		
(L27	B. Rescind St	uspension Date:	(L44) (L45)			00-Active			
28. TERMINATION DATE:	29	). INTERMEDIARY	/CARRIER NO.		30. REMARKS				
	(L28)	03001		(L31)					
31. RO RECEIPT OF CMS-1539	(L32)	2. DETERMINATION	N OF APPROVAL	DATE (L33)	DETERMINATION APP	ROVAL			



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

September 15, 2015

Ms. Mary Hamer, Administrator St Olaf Residence 2912 Fremont Avenue North Minneapolis, Minnesota 55411

RE: Project Number S5387025

Dear Ms. Hamer:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On July 31, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 10, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On September 9, 2015, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 10, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 19, 2015. Based on our visit we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on July 10, 2015. The deficiency not corrected is as follows:

F0333 -- S/S: D -- 483.25(m)(2) -- Residents Free Of Significant Med Errors

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

• State Monitoring effective September 20, 2015. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective October 10, 2015. (42 CFR 488.417 (b))

St Olaf Residence September 15, 2015 Page 2

The CMS Region V Office will notify you of their determination regarding our recommendations and appeal rights.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, St Olaf Residence is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 10, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

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

#### DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900 gloria.derfus@state.mn.us Telephone: (651) 201-3792 Fax: (651) 215-9697

#### 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,
- Include electronic acknowledgement signature of provider and date.

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 remedy be imposed:

• 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. 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 their respective deficiencies (if any) is acceptable.

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 10, 2016 (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.

St Olaf Residence September 15, 2015 Page 4

#### 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fishe Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 09/25/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		``	(X3) DATE SURVEY COMPLETED	
	045007					R
	245387				09/	09/2015
F RESIDENCE						
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SH			BE	(X5) COMPLETION DATE
INITIAL COMMENT	rs .	{F 00	00}			
(SFF) and a post vi	sit certification survey was					
as your allegation of Department's acceler enrolled in ePOC, yat the bottom of the form. Your electron	of compliance upon the otance. Because you are your signature is not required first page of the CMS-2567 ic submission of the POC will					
on-site revisit of you validate that substa regulations has bee your verification. 483.25(m)(2) RESI	ur facility may be conducted to ntial compliance with the en attained in accordance with DENTS FREE OF	{F 33	33}			10/10/15
by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R20) was free of insulin medication errors.  Findings include: R20's annual Minimum Data Set (MDS) dated 8/22/15, indicated R20 was cognitively intact, and required assistance in all activities of daily living (ADLs) except eating. Diagnosis identified on				Plan of Correction is a written credib assertion of substantial compliance of the Federal and State requirements nursing facilities and/or skilled nursing facilities participating in the Federal Medicare or State Medicaid program Please note that nothing set forth in document is to be or should be cons	with for ng	(X6) DATE
	PROVIDER OR SUPPLIER  FRESIDENCE  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  INITIAL COMMENT  St. Olaf Residence (SFF) and a post vi conducted on Septe 2015.  The facility's plan or as your allegation of Department's accepenrolled in ePOC, y at the bottom of the form. Your electronic be used as verificate  Upon receipt of an on-site revisit of you validate that substate regulations has been your verification. 483.25(m)(2) RESII SIGNIFICANT MED  The facility must en any significant med  This REQUIREMEN by: Based on observate review, the facility for the faci	PROVIDER OR SUPPLIER  F RESIDENCE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  St. Olaf Residence is a Special Focus Facility (SFF) and a post visit certification survey was conducted on September 8 through September 9, 2015.  The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.  Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.  483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R20) was free of insulin medication errors.  Findings include:  R20's annual Minimum Data Set (MDS) dated 8/22/15, indicated R20 was cognitively intact, and required assistance in all activities of daily living (ADLs) except eating. Diagnosis identified on	PROVIDER OR SUPPLIER  FRESIDENCE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  St. Olaf Residence is a Special Focus Facility (SFF) and a post visit certification survey was conducted on September 8 through September 9, 2015.  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.  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Diagnosis identified on	PROVIDER OR SUPPLIER  PRESIDENCE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY)  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY)  REQULATORY OR LSC IDENTIFYING INFORMATION)  St. Olaf Residence is a Special Focus Facility (SFF) and a post visit certification survey was conducted on September 8 through September 9, 2015.  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 with the regulations has been attained in accordance with your verification.  48.325(m/Q;2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R20) was free of insulin medication errors.  Findings include:  FINDING  STREET ADDRESS, CITY, STATE, ZIP CODE  2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411  PROVIDER'S PROVIDER'S LAID CORRECTION  FROM INNEAPOLIS, MN 55411  PROVIDER'S PROVIDER'S LAID CEARCORRECTIVE ATOR CORRECTION  FROM INNEAPOLIS, MN 55411  PROVIDER'S PROVIDER'S LAID CEARCORRECTIVE ATOR CORRECTION  FROM INNEAPOLIS, MN 55411  PROVIDER'S PROVIDER'S LAID CEARCORRECTIVE ATOR CORRECTION  FROM INNEAPOLIS, MN 55411  PROVIDER'S LAID CEARCORRECTION  FROM INNEAPOLIS, MN 55411  PROVIDER'S LAID CEARCORRECTION CEARCORRECTION  FROM INNEAPOLIS, MN 55411  PROVIDER'S LAID CEARCORRECTION CEARCORRECTION  FROM INNEAPOLIS, MN 55411  PROVIDER'S LAID CEARCORRECTION CEAR	A BUILDING  245387  245387  B. WING  PROVIDER OR SUPPLIER  F RESIDENCE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  St. Olaf Residence is a Special Focus Facility (SFF) and a post visit certification survey was conducted on September 8 through September 9, 2015.  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 with the regulations has been attained in accordance with your verification.  483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R20) was free of insulin medication errors.  Findings include:  12912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411  MINNEAPOLIS, MINN

Electronically Signed 9/23/2015

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245387	B. WING			R 09/ <b>2015</b>
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 337	30,2010
CT OL AF	PECIDENCE			2912 FREMONT AVENUE NORTH		
STOLAR	RESIDENCE			MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 333}	Continued From pa	_	{F 333			
	The Physician's Ord staff to administer L (medication used to unit(U)/ml (3 ml) 60 order for Novolog F 20 units every am. insulin order dated "Novolog Flexpen in BG [blood glucose] 301-350=6U, 351-4 >450=CALL NP NC	der dated 8/14/15, directed antus Solostar insulin control blood sugar) pen 100 units twice daily. R20 had an flexpen insulin 100 U/ml give R20 also had a sliding scale 8/14/15. The order read: nsulin 100 units/ml 4 TIMES 200-250=2U, 251-300=4U, 00=8U, 401-450=10U, DAT BEDTIME INSULIN IF BS ATER THAN 400 Blood sugar		to be an admission by the Facility employee of Facility, of the validit accuracy of any of the deficiencie by DHHS Centers for Medicare at Medicaid Services relative to the certification and enforcement effortissue.  Further, please note that any and documents transmitted or otherwiprovided by Facility in relation to the of Correction, as well as any and communications in writing or other or on behalf of Facility are and shoonstrued to be WITHOUT PREJ	y or s cited nd survey, rt at all se his Plan all other rwise by all be	
	insulin administration (LPN)-B was obsert LPN-B did not wipe Novolog FlexPen with needle. LPN-B did in Novolog FlexPen purphy-B dialed up 60 of Novolog. At 8:16 injections in the backinterview immediate LPN-B stated she in the s	on 9/9/15, at 8:12 a.m. of on, licensed practical nurse ved to prepare R20's insulin. top of Lantus Solostar or with alcohol prior to attaching not prime Lantus Solostar or rior to insulin administration. O units of Lantus and 22 units a.m. LPN-B gave both ck of R20's right arm. During ely after administering insuling and been observed doing th since last survey. LPN-B stakes made.		to the rights, remedies, claims, do of Facility, at law and/or in equity, which are not waived and all of where the reserved and retained by, for and behalf of Facility.  F333:  Resident #20 is receiving insulined as ordered by the physician. Other residents who have physician ord insulin are receiving the insulin coas ordered.	all of hich are on correctly er ers for orrectly	
	September 2015 in results that were in During interview on director of nurses (clean the top of the	tment Medication Record for dicated R20 had blood sugar the 180 to 250 range.  9/9/15, at 12:05 p.m. the DON) stated, "You have to e [insulin] pens before putting on them, same as you have to		Licensed nurses have been educ regarding facility expectation for t accurate administration of insulin the proper technique to include w top (rubber seal) of the insulin per inserting the sterile needle; and repriming the insulin pen with 2 unit insulin prior to each administration directed by the manufacturer.	he using iping the n prior to egarding s of	

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245387	B. WING				R <b>09/2015</b>	
	PROVIDER OR SUPPLIER FRESIDENCE			29	TREET ADDRESS, CITY, STATE, ZIP CODE 912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
{F 333}	wipe off a vial of insthe pens before the resident loses two users death of pens before the resident loses two users death of pens before the	sulin. I expect them to prime by give insulin; otherwise the units." R20 did not receive the dered insulin as the nurse did efore administration.  9/9/15, at 1:25 p.m. DON competency for LPN-B in  ency Inc. Survey 2015 three dewed on 9/8/15, for copies of Il licensed nurses related to on as stated in facility POC. No d. Facility was asked to dies for review. On 9/9/15, impetencies for insulin three ring binder. de all dated 9/8/15. There was est for LPN-B in three ring on Administration Observation address insulin administered distar pen. It only addressed the or administration of insulin by for Lantus SoloStar insulin by for Lantus SoloStar insulin by drawn on November derections of the survey of the surve		33}	Process of using insulin pen has be added as an addendum to the insuladministration policy.  Licensed nurses have had observational administration composervational audits to monitor compliance.	ational npleted.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245387	B. WING				30/0015
NAME OF	PROVIDER OR SUPPLIER	243301	B. 11.11G		TREET ADDRESS, CITY, STATE, ZIP CODE	09/0	09/2015
					912 FREMONT AVENUE NORTH		
ST OLAF	RESIDENCE				MINNEAPOLIS, MN 55411		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N .	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLÉTION DATE
{F 333}	injection. Performing the safe accurate dose by: *ensuring the pen a * removing air bubb A. Select a dose of selector. B. Take off the oute remove the used not the inner needle ca C. Hold the pen with D. Tap the insulin rebubbles rise up tow	Safety test safety test before each ety test ensures you get an and needle work properly eles 2 units by turning the dosage er needle cap and keep it to eedle after injection. Take off p and discard it. h the needle pointing upwards. eservoir so that any air eards the needle. on button all the way in. Check	{F 3:	33}			

### Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245387	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/9/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
ST	OLAF RESIDENCE		2912 FREMONT AVENUE NOR	TH
٠.	32		MININEAPOLIS MN 55411	

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

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix	F0157	(	Correction Completed 08/19/2015	ID Prefix	F0246	C	Correction Completed 8/19/2015		ID Prefix	F0274		Correction Completed 08/19/2015
Reg. # LSC	483.10(b)(11	)		Reg. # LSC	483.15(e)(1)				Reg. # LSC	483.20(b)(2)	)(ii)	
ID Prefix Reg. # LSC	F0278 483.20(q) - (	(	Correction Completed 08/19/2015	ID Prefix Reg. # LSC	F0280 483.20(d)(3), 483.	0	Correction Completed 18/19/2015		ID Prefix Reg. # LSC	F0282 483.20(k)(3)	)(ii)	Correction Completed 08/19/2015
ID Prefix Reg. # LSC	F0309 483.25	(	Correction Completed 08/19/2015	ID Prefix Reg. # LSC	F0312 483.25(a)(3)	C	Correction Completed 8/19/2015		ID Prefix Reg. # LSC	F0314 483.25(c)		Correction Completed 08/19/2015
ID Prefix Reg. # LSC	F0323 483.25(h)	(	Correction Completed 08/19/2015	ID Prefix Reg. # LSC	F0329 483.25(I)	C	Correction Completed 8/19/2015		ID Prefix Reg. # LSC	F0332 483.25(m)(1	1)	Correction Completed 08/19/2015
ID Prefix Reg. # LSC	F0371 483.35(i)	(	Correction Completed 08/19/2015	ID Prefix Reg. # LSC	F0425 483.60(a).(b)	C	Correction Completed 8/19/2015		ID Prefix Reg. # LSC	483.60(c)		Correction Completed 08/19/2015
Reviewed		Reviewed GD/kfd	Ву	Date:	Signature	of Surv	-	223			Date:	00/00/2015
Reviewed CMS RO	-	Reviewed	Ву	09/15/202 Date:	Signature	of Surv		<i>443</i>			Date:	09/09/2015

Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

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

(Y1) Provider / Su Identification 245387	pplier / CLIA / n Number	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/9/2015
Name of Facility			Street Address, City, State, Zip Code	
ST OLAF RESIDENCE			2912 FREMONT AVENUE NOR MINNEAPOLIS, MN 55411	TH

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

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
			rection				Correction					Correction
ID Prefix	F0431	Coi <b>08</b> /	mpleted 19/2015	ID Prefix	F0441		Completed <b>08/19/2015</b>		ID Prefix	F0465		Completed <b>08/19/2015</b>
	483.60(b), (d), (e)	<del></del>			483.65		•			483.70(h)		
LSC				LSC					LSC			
		Con										
			rection mpleted									
ID Prefix	F0492	08/	19/2015									
Reg. # LSC	483.75(b)											
				<u> </u>								
Reviewed	By Rev	viewed By		Date:	Signatu	ire of Sur	veyor:				Date	:
State Agen												
Reviewed	By Rev	viewed By		Date:	Signatu	ire of Sur	veyor:				Date	1
CMS RO												
Followup	to Survey Comple				Check for a	any Uncoi	rected Deficiencies (CM	cienci IS-256	es. Was a	Summary of the Facility	^	NO
	7/10/201	ıo			31100116	ou Done		. 5 250	, 55 10	o . donity	YES	NO

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

						AND TRANSMITTAL FE SURVEY AGENCY		ID: GK88 Facility ID: 00260
1. MEDICARE/MEDIC (L1) 245387 2.STATE VENDOR OR (L2) 492242500	R MEDICAID NO		3. NAME AND AI (L3) <b>ST OLAF R</b> (L4) <b>2912 FREM</b> (L5) <b>MINNEAPO</b>	ESIDENCE ONT AVENUI		(L6) <b>55411</b>	4. TYPE OF AC  1. Initial 3. Termination 5. Validation 7. On-Site Visit	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE (L9)			7. PROVIDER/SU  01 Hospital	05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey	
6. DATE OF SURVEY 8. ACCREDITATION ( 0 Unaccredited 2 AOA		/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR EN	NDING DATE: (L35)
11. LTC PERIOD OF C From (a): To (b):  12.Total Facility Beds  13.Total Certified Beds		80 (L18) 80 (L17)	Complianc1. A  X B. Not in Con	nce With equirements e Based On: cceptable POC	gram	And/Or Approved Waivers Of 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SN5. Life Safety Code  * Code: B	6. Scope o 7. Medical	f Services Limit Director Room Size
14. LTC CERTIFIED B	ED BREAKDOW	N				15. FACILITY MEETS		
18 SNF	18/19 SNF 80	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37)	(L38)	(L39)	(L42)	(L43)				
17. SURVEYOR SIGN  Kathy Sass, 1			Date : 0	08/13/2015	(L19) <b>K</b> a	18. STATE SURVEY AGENCY amala Fiske-Downing, E		Date: cialist 08/21/2015
	PAR	Г II - ТО ВЕ	COMPLETED I	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S	TATE AGENCY	`
	N OF ELIGIBILIT y is Eligible to Par ty is not Eligible			IPLIANCE WITH	H CIVIL	<ul><li>21. 1. Statement of Final</li><li>2. Ownership/Control</li><li>3. Both of the Above</li></ul>	ol Interest Disclosure S	
22. ORIGINAL DATE		23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	:	(L30)
OF PARTICIPATION 12/01/1986	ON	BEGINNING	DATE	ENDING DA	ГЕ	VOLUNTARY 00 01-Merger, Closure		LUNTARY I to Meet Health/Safety
(L24)		(L41)		(L25)		02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Termination		l to Meet Agreement
25. LTC EXTENSION	DATE:	27. ALTERNATI	VE SANCTIONS  of Admissions:			04-Other Reason for Withdrawal	OTHE	<u>ER</u> ovider Status Change
	(L27)	-	spension Date:	(L44)			00-Ac	_
				(L45)				
28. TERMINATION D	ATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
			03001					
		(L28)			(L31)			
31. RO RECEIPT OF C	MS-1539	32	. DETERMINATION	OF APPROVAL	DATE			
		(L32)			(L33)	DETERMINATION APPL	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered July 31, 2015

Ms. Mary Hamer, Administrator St Olaf Residence 2912 Fremont Avenue North Minneapolis, Minnesota 55411

RE: Project Number S5387025

Dear Ms. Hamer:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On July 10, 2015, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

#### DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900 gloria.derfus@state.mn.us

Telephone: (651) 201-3792 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 August 19, 2015, 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 October 10, 2015 (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

St Olaf Residence July 31, 2015 Page 5

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 January 10, 2016 (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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 08/04/2015 FORM APPROVED OMB\_NQ. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	(X3) DAT	E SURVEY MPLETED
		245387	B. WING		07	/10/2015
	PROVIDER OR SUPPLIER FRESIDENCE			STREET ADDRESS, CITY, STATE, Z 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	IP CODE	10/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	TS .	F0	00		
	(SFF) and a certific on July 6 through July 7 the facility's plan of as your allegation of the form. Your electronic be used as verificated Upon receipt of an a on-site revisit of you validate that substate regulations has bee your verification.  483.10(b)(11) NOTI (INJURY/DECLINE/A facility must immed consult with the resist known, notify the resort an interested farmaccident involving the injury and has the pointervention; a significantly (i.e., a mexisting form of treat consequences, or to treatment); or a decithe resident from the §483.12(a).	f correction (POC) will serve f compliance upon the otance. Because you are our signature is not required first page of the CMS-2567 c submission of the POC will ion of compliance.  acceptable electronic POC, an ir facility may be conducted to intial compliance with the in attained in accordance with FY OF CHANGES (ROOM, ETC)  Idiately inform the resident; dent's physician; and if sident's legal representative illy member when there is an increated to incompliance in the resident's psychosocial status (i.e., a th, mental, or psychosocial increatening conditions or is); a need to alter treatment increase to discontinue an itement due to adverse to commence a new form of sion to transfer or discharge of facility as specified in	F 1	notified and has been u related to h two pressu • Any resider experience: change in c without phy notification potential to affected by practice. • All resident skin impairs issues have plans reviewintervention place.	s Plan of stitute an ment with the set forth on r Plan of d and executed ously improve it to comply te and federal ots.  20 mas been d care plan pdated per stage re ulcer. Ints who is a condition y sician has the beat this is with ment e had care wed and its are in	
ABOBATORY	DIRECTOR'S OR PROVIDE	RISUPPLIER REPRESENTATIVE'S SIGN	ATURE	Derector 8	2-13-15	(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 program participation.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	(X3) DAT	E SURVEY PLETED
		245387	B. WING	i	07/	10/2015
	PROVIDER OR SUPPLIER  FRESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		10/2013
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F 157	The facility must als and, if known, the report or interested family change in room or repecified in §483.1 resident rights under regulations as specified this section.  The facility must receive address and phologal representative.  This REQUIREMENT by:  Based on observative was notified of a Stathickness skin loss or both. The ulcer is	so promptly notify the resident resident's legal representative member when there is a roommate assignment as 5(e)(2); or a change in refederal or State law or ified in paragraph (b)(1) of cord and periodically update one number of the resident's or interested family member.  IT is not met as evidenced ion, interview and document ailed to ensure the physician age 2 pressure ulcer (partial involving epidermis, dermis, a superficial and presents sion, blister, or shallow crater)	F	<ul> <li>LN educated on notification of Physician/NP for changes in condiand proper documentation of their notification.</li> <li>DON/ Designee waudit to monitor compliance 2x a week for one more then once weekly two months, or as directed by QAA.</li> <li>Findings of audits will be reviewed a QAA Q month x 3</li> <li>Completion date to August 19, 2015</li> </ul>	th, for	
	of R20's self-impose identify and assess and failed to add into to reduce the risk of R20 was obese and mattress, but not a part the bed.  On 7/8/15, at 9:57 a was observed providentifications.	notify the physician/provider ed 44 day bed rest, failed to a new pressure ulcer risk, erventions to the plan of care pressure ulcer development. had a pressure reduction pressure relief mattress on .m. nursing assistant (NA)-A ding bathing cares to R20. easy as the terry cloth tears		PER 1 3 2015		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		SURVEY PLETED
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	PROVIDER OR SUPPLIER RESIDENCE			29	TREET ADDRESS, CITY, STATE, ZIP CODE 12 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
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F 157	her skin. On 7/8/15, at 10:' left, her back was relothing/sheets, and rash that extended low lumbar area, the left then on right. In the peri area; and shard continued wire discoloration (in variables) (above glute buttocks. NA-A cleatwice with a washod cloth to pat an area upper buttocks approper buttocks approper buttocks. The blanchable during ointment to the area history of open area them. The resident checked and chander on 7/8/15, at 12: upright position with to 45 degrees (uproper con 7/8/15, at 2:5 with HOB 35 to 45 on 7/8/15, at 2:0 reported the open nurse (LPN)-C assistant as a trained median put the cream on the shed not report that she was not con 3/7/15, at 8:14 stated she had put the cream of the stated she	17 a.m. R20 was rolled to the red with creases from d appeared to have a macular from the high thoracic area to footnot have a considered and the first and then used that wash a of denuded skin on the left foroximately 3.5 to 4.0 to footnot have and the cream had healed to stated that she should be ged every two hours.  18		157			

St Olaf R 6125222921

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

PRINTED: 08/04/2015 FORM APPROVED OMB NO. 0938-0391

08-13-2015

NAME OF PROVIDER OR SUPPLIER  ST OLAF RESIDENCE  STREET ADDRESS, CITY, STATE, 2IP CODE 2312 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411  MINNEAPOLIS, MN 55411  PREPEX TAG  FEGUATORY OR LISC IDENTIFYING INFORMATION)  FREE STATE TO Continued From page 3  weeks. When asked who told her to be on bed rest, she stated that was how long it would take to heat. R2O stated she would be getting out of bed that coming Friday, when the six weeks was over.  R2O was admitted to the facility 5/1/13, with diagnoses of congestive heart failure, malunion fracture of the right ankle, abscess and cellulitis of the right leg and diabetes mellitus type II, had a history of pressure ulcers, and stroke with nemiparests (mability to move haif the body).  The annual Care Area Assessment (CAA) dated 8/20/14, indicated R2O had a cognitive loss, had a recent decline in activities of daily living (ADL) and required assistance in all ADL. R2O refused care one to three times in the look back period and had a history of noncompliance with treatments. R2O was identified at risk for pressure ulcers related to limited mobility, incontinence, and nutritional status. Staff should assist with repositioning, incontinence cares, monitor for decline, and notify MD with changes.  The care plan dated 8/26/14, indicated R2O, had a history of pressure ulcers, had a pressure reduction mattress, and should be monitored for signs and symptoms of skin break down related to incontinence and immobility. R2O was to be assisted with repositioning, and staff should notify the doctor and the wound cleam to follow as needed. The care plan lacked here with the reposition revery two hours, related to residents wish to stay in bed for six weeks due to a self-diagnosed "pulled muscle" in her neck.  A review of the Wound Clinic Notes as follows:		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l , .		E CONSTRUCTION		PLETED
TO LAF RESIDENCE    2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411   SUMMARY STATEMENT OF DEFICIENCIES   IEACH DEFICIENCY MUST are PRECEDED BY FULL   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   TAG   PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   TAG   PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION)   FREE   REGULATORY APPROPRIATE   CANASS REFERÊNCED TO HAVE APPROPRIAT			245387	B. WING			07/1	0/2015
PREFIX TAG  FIRST DEFICENCY MOST DEPRECEDED BY FULL PREFIX TAG  FORSS-REFERENCED TO THE APPROPRIATE DEFICENCY)  FIST  Continued From page 3 weeks. When asked who told her to be on bed rest, she stated that was how long it would take to heal. R20 stated she would be getting out of bed that coming Friday, when the six weeks was over.  R20 was admitted to the facility 5/1/13, with diagnoses of congestive heart failure, malunion fracture of the right lankle, abscess and cellulitis of the right legan diabetes mellifus type II, had a history of pressure ulcers, and stroke with hemiparesis (inability to move half the body).  The annual Care Area Assessment (CAA) dated 8/20/14, indicated R20 had a cognitive loss, had a recent decline in activities of dally living (ADL) and required assistance in all ADL. R20 refused care one to three times in the look back period and had a history of noncompliance with treatments. R20 was identified at risk for pressure ulcers related to limited mobility, incontinence, and nutritional status. Staff should assist with repositioning, incontinence cares, monitor for decline, and notify MD with changes.  The care plan dated 8/26/14, indicated R20, had a history of pressure lucers, had a pressure reduction mattress, and should be monitored for signs and symptoms of skin break down related to incontinence and immobility. R20 was to be assisted with repositioning, and staff should notify the doctor and the wound team to follow as needed. The care plan lacked new directions to check and change or reposition every two hours, related to residents wish to stay in bed for six weeks due to a self-diagnosed "pulled muscle" in her neck.  A review of the Wound Clinic Notes as follows:			7		29	312 FREMONT AVENUE NORTH		
weeks. When asked who told her to be on bed rest, she stated that was how long it would take to heal. R20 stated she would be getting out of bed that coming Friday, when the six weeks was over.  R20 was admitted to the facility 5/1/13, with diagnoses of congestive heart failure, malunion fracture of the right ankle, abscess and cellulitis of the right leg and diabetes mellitus type II, had a history of pressure ulcers, and stroke with hemiparesis (inability to move half the body).  The annual Care Area Assessment (CAA) dated 8/20/14, indicated R20 had a cognitive loss, had a recent decline in activities of daily living (ADL) and required assistance in all ADL. R20 refused care one to three times in the look back period and had a history of noncompliance with treatments. R20 was identified at risk for pressure ulcers related to limited mobility, incontinence, and nutritional status. Staff should assist with repositioning, incontinence cares, monitor for decline, and notify MD with changes.  The care plan dated 8/26/14, indicated R20, had a history of pressure ulcers, had a pressure reduction mattress, and should be monitored for signs and symptoms of skin break down related to incontinence and immobility. R20 was to be assisted with repositioning, and staff should notify the doctor and the wound team to follow as needed. The care plan lacked new directions to check and change or reposition every two hours, related to residents wish to stay in bed for six weeks due to a self-diagnosed "pulled muscle" in her neck.  A review of the Wound Clinic Notes as follows:	PRÉFIX	(FACH DEFICIENT	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION
- On 4/1/15 through 4/29/15, all documentation	F 157	weeks. When ask rest, she stated the heal. R20 stated that coming Fridated and that coming Fridated and state of the right leg are history of pressurption of the care one to three and had a history treatments. R20 ulcers related to and nutritional strepositioning, included and nutritional strepositioning, included and symption of the care plan data history of pressureduction mattresigns and symption incontinence assisted with reptite doctor and the doctor and the needed. The care check and change related to reside weeks due to a sher neck.  A review of the National Radiana related to reside weeks due to a sher neck.	ted who told her to be on bed hat was how long it would take to she would be getting out of bed by, when the six weeks was over. It to the facility 5/1/13, with gestive heart failure, malunion ht ankle, abscess and cellulitis and diabetes mellitus type II, had a re ulcers, and stroke with boility to move half the body).  Area Assessment (CAA) dated do R20 had a cognitive loss, had a activities of daily living (ADL) istance in all ADL. R20 refused a times in the look back period of noncompliance with was identified at risk for pressure limited mobility, incontinence, atus. Staff should assist with continence cares, monitor for fry MD with changes.  Ated 8/26/14, indicated R20, had sure ulcers, had a pressure ss, and should be monitored for oms of skin break down related and immobility. R20 was to be cositioning, and staff should notificate wound team to follow as re plan lacked new directions to ge or reposition every two hours, nts wish to stay in bed for six self-diagnosed "pulled muscle" in Mound Clinic Notes as follows:	y	157			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 08/04/2015 FORM APPROVED OMB NO. 0938-0391

TATEMENT ND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY MPLETED
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F 157	refers to a right be documentation of - On 5/13/15, she deteriorated due "Optimize nutrition ochange." - On 5/27/15, she deteriorated due "Optimize nutrition ochange." - On 6/10/15, she improved. Sheer on 6/10/15) On 6/24/15, she at least 197 days improved (did not The Nursing Produced (did not the Nur	uttock wound; there was no a left buttock wound. Her wound of right shin to generalized decline of patient. In. Sheer wound of right buttock her wound of right shin to nutritional compromise. In. Sheer wound of right buttock her wound of right inferior shin wound of right buttock her wound of right inferior shin wound of right buttock (resolved her wound of right inferior shin of a duration, venous insufficiency of address right buttock).  In that date by the wound rounds her in that date by the wound team ght shin and left buttock area her worders were written. However to notes dated 4/29/15, indicated on the right buttock. In that indicated a call placed to the right buttock. In the right buttock area her indicated a call placed to the right buttock. In the right buttock. In the right buttock area had indicated a call placed to the right buttock. In the right buttock. In the right buttock. In the right buttock area had not on the right buttock. In the right buttock area had not on the right buttock. In the right buttock area had not on the right buttock. In the right buttock area had not on the right buttock. In the right buttock area had not on the right buttock. In the right buttock area had not on the right buttock. In the right buttock area had not on the right buttock. In the right buttock area had not on the right buttock area had not o	d, a	157		
	Pillow to profito	3.77		Facility ID: 00260	If continuation	sheet Page 5 of

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DATE COMF	SURVEY
		245387	B. WING		07/1	0/2015
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F.157	said 'No honey.' A re-approached ar to prevent further repositioning." The intervened. A rev medical record dibed rest. There we physician/provide to get out of bed.  A review of the Windicated:  On 4/29/15, a we R20 had wounds area.  On 6/14/15, become of the Windicated:  On 6/20/15, dicextremity (RLE) addressed.  On 6/27/15, become of the wear termity in the composition on the incontinent and the compositioned side of the wear terminal or the indicated:  A review of the wear terminal or the compositioned side on 7/9 new documental nursing progressions.	Jound Care Documentation book Jound progress note indicated Jound Indi		157		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		ONSTRUCTION	(X3) DATE COMF	SURVEY
		245387	B. WING			07/1	0/2015
	PROVIDER OR SUPPLIER			2912	ET ADDRESS, CITY, STATE, Z FREMONT AVENUE NORT NEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 157	cares on 7/8/15. Hintervention, the fa 7/9/15, (untimed) a indicated an obser buttock, area mea cm, no drainage o "Area surrounding does blanch. Dark 10 cm x 5 cm. Cal inform of open are call placed to NP [left informing of opbook. Area cleans awaiting call back need for [R20] to pressure-avoid this stated that should be entrefused getting we and lift. [R20] does decision. Benefits getting up were diprogress note was which ok'd the Stacream to open are cares.  On 7/9/15, at 1:37 told about the open report, "let me go less than one min write anything down and I looked at he think it's from preserves it is a doc but she refused."	open area observed during owever after surveyor cility did notify the NP on as the Nursing Progress Note ved open area on the left sures approximately 4 cm x 2 r swelling, and denied pain. the open area is dark in color, area measures approximately led placed to 3 contacts to a, unable to connect with any. nurse practitioner], message pen area. Also placed in wound ed and left open at this time, from NP. Have discussed the		157			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245387	B. WING			07/1	0/2015
	PROVIDER OR SUPPLIER RESIDENCE			29	TREET ADDRESS, CITY, STATE, ZIP CODE 12 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	red area with macu dermatomes, a dist that might be. LPN-"perhaps it was her but then I didn't loo - At 2:16 p.m. the distated "I will need t documentation/lack are seeing (MDS a On 7/10/15, at 9:25 document on the sit was not her offici nurse. "That is not much worse than that it had been he book.  The physician for F policy for notification but not provided. 483.15(e)(1) REAS OF NEEDS/PREFI	lirector of nursing (DON) o review the of of documentation that you and wounds)." of a.m. NA-A stated she did not kin assessment sheet because al bath day. But she did tell the a new wound, it has looked hat." The NA-A was not aware aled according to the wound of change was requested, son of change was requested,		246			
	by: Based on observa review, the facility	NT is not met as evidenced ation, interview and document did not ensure call light was of 1 resident (R73) reviewed for					

PRINTED: 08/04/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER  RESIDENCE			29	REET ADDRESS, CITY, STATE, ZIP CODE 112 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411		
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F 246	Findings include:  R73 was observed awake sitting up in located underneath was not within R73 assistance from st came in the room alight cord should newithin resident's repull call light from and place it within further stated resident also of the Admission Readmitted on 3/10/10 Diabetes type II, a giddiness.  The admission Mil 3/16/15, noted R73 Care Area Assess dated 3/18/15, indicated resident history of falls and transfers. The quanticated resident history of falls and transfers. The quanticated R73 to have and R73 also was himself.  R73's care plan dability to perform a independently was indepe	age 8 cerns.  I on 7/6/15, at 5:52 p.m. to be bed with the call light cord head of the bed. The call light is reach if he needed aff. Nursing assistant (NA)-E and when asked, stated call ot be on floor, it should be each. NA-E was observed to underneath head of the bed reach of R73's right side. NA-E dent was able to use call light confirmed he used the call light. It confirmed he used to include a to have intact cognition. R73's ment (CAA) analysis of findings icated resident required. It to weakness, dizziness and if to assist as needed. CAA was at risk for falls related to a weakness, staff to assist with arterly MDS dated 6/15/15, and fallen twice in the last 90 days noted not to have injured atted 3/25/15, indicated R73's activities of daily living (ADL's) impaired, required assist with the with assist and use of		246	P246  Resident # 73 ha had no adverse effects from not having his call light reach. Call light device checked maintenance so can be clamped bed or area where resident can reach maintenance had one 100% room sweep to assure call light device attachable and available for all residents.  ED/designee with audit to monitor compliance 2x week for one muthen once week two months, or directed by QAA.  Educate staff or light policy and document if resident resident if resident attached.  Findings of audit to month attached.  Findings of audit attached.  Completion data August 19, 2015	ight pht by it onto ere ech it. s n e all s are  II r a onth, dy for as A. n call sident e call dit will QAA	

F 246  Continued From page 9 walker. The care plan also indicated R73 was at risk for falls and the staff was to place the call light within reach.  On 7/7/15, at 8:51 a.m. licensed practical nurse (LPN)-A stated he expected resident's call light to be put in bed with resident or around the bed table and if resident was in bed it should be with him. LPN-A further stated resident was independent and ambulated with rolling walker.  On 7/10/15, at 8:26 a.m. director of nursing (DON) was interviewed regarding call light placement. DON stated she expected staff should follow facility policy with placement of call light.  The resident call system policy dated 4/1/08, indicated "all residents have call system access while in bed or while sitting at their bedside or in the bathroom."  F 274 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCT			MPLETED
ST OLAF RESIDENCE  (X4) ID PREFIX TAG  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 246  Continued From page 9 walker. The care plan also indicated R73 was at risk for falls and the staff was to place the call light within reach.  On 7/7/15, at 8:51 a.m. licensed practical nurse (LPN)-A stated he expected resident's call light to be put in bed with resident or around the bed table and if resident was in dependent and ambulated with rolling walker.  On 7/10/15, at 8:26 a.m. director of nursing (DON) was interviewed regarding call light.  The resident call system policy dated 4/1/08, indicated "all residents have call system access while in bed or while sitting at their bedside or in the bathroom."  F 274  483.20(b)(2)(iii) COMPREHENSIVE ASSESS  F 274  SS=D  AFTER SIGNIFICANT CHANGE			245387	B. WING_			07	/10/2015
F 246  Continued From page 9 walker. The care plan also indicated R73 was at risk for falls and the staff was to place the call light within reach.  On 7/7/15, at 8:51 a.m. licensed practical nurse (LPN)-A stated he expected resident's call light to be put in bed with resident or around the bed table and if resident was in bed it should be with him. LPN-A further stated resident was independent and ambulated with rolling walker.  On 7/10/15, at 8:26 a.m. director of nursing (DON) was interviewed regarding call light placement. DON stated she expected staff should follow facility policy with placement of call light.  The resident call system policy dated 4/1/08, indicated "all residents have call system access while in bed or while sitting at their bedside or in the bathroom."  F 274  483.20(b)(2)(ii) COMPREHENSIVE ASSESS  AFTER SIGNIFICANT CHANGE	,				2912 FREMON	NT AVENUE NORTH	CODE	
walker. The care plan also indicated R73 was at risk for falls and the staff was to place the call light within reach.  On 7/7/15, at 8:51 a.m. licensed practical nurse (LPN)-A stated he expected resident's call light to be put in bed with resident or around the bed table and if resident was in bed it should be with him. LPN-A further stated resident was independent and ambulated with rolling walker.  On 7/10/15, at 8:26 a.m. director of nursing (DON) was interviewed regarding call light placement. DON stated she expected staff should follow facility policy with placement of call light.  The resident call system policy dated 4/1/08, indicated "all residents have call system access while in bed or while sitting at their bedside or in the bathroom."  F 274 SS=D AFTER SIGNIFICANT CHANGE  F 274 SS=D AFTER SIGNIFICANT CHANGE	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI)	(EAC	H CORRECTIVE ACTIC S-REFERENCED TO TH	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	F 274	walker. The care plants for falls and the light within reach.  On 7/7/15, at 8:51 (LPN)-A stated here be put in bed with reable and if resider him. LPN-A further independent and a On 7/10/15, at 8:26 (DON) was intervied placement. DON service follow facility policy.  The resident call service indicated "all resident while in bed or whith the bathroom."  483.20(b)(2)(ii) CC AFTER SIGNIFICA A facility must concassessment of a refacility determines that there has bee resident's physical purpose of this service means a major deresident's status the insplementing star interventions, that one area of the rerequires interdisciplination.	lan also indicated R73 was at e staff was to place the call  a.m. licensed practical nurse expected resident's call light to resident or around the bed at was in bed it should be with stated resident was inbulated with rolling walker.  5 a.m. director of nursing ewed regarding call light tated she expected staff should with placement of call light.  ystem policy dated 4/1/08, ents have call system access lie sitting at their bedside or in DMPREHENSIVE ASSESS ANT CHANGE  duct a comprehensive esident within 14 days after the or should have determined, in a significant change in the lor mental condition. (For ection, a significant change in the lor mental condition. (For ection, a significant change in the lat will not normally resolve er intervention by staff or by indard disease-related clinical has an impact on more than sident's health status, and plinary review or revision of the	F		Resident # 5 a new comprehens assessment completed r her decline transfers an mobility and significant of MDS has be completed. All resident Olaf Reside	sive t related to in nd d change een ts at St.	

11:09:19

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	FIPLE CONSTRUCTION  NG		E SURVEY IPLETED
		245387	B. WING		07/	10/2015
	PROVIDER OR SUPPLIER  RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP COD 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 274	This REQUIREMEI by: Based on observat review, the facility f assess a significan resident (R5) who hed mobility, and a Findings include: On 7/8/15, at 7:50 a morning cares. R5 assistant (NA)-G w R5's upper body. B upper arms and on then washed hands gloves and with new body and peri area. gloves again, applied hands, applied glove R5's breasts, put or assist of NA-D and up to side of bed. F get me in the chair; was yelling out duri EZ stand (mechani front of resident and hand on the hand he straps around wrist appeared very upself in scared." NA-G at to calm R5; raised R5 had a bowel mo "I don't like the star started to slip out o slowly lowering. NA incontinent product	ge 10  NT is not met as evidenced ion, interview and document ailed to comprehensively the change in status for 1 of 1 and a decline in transfer ability, inbulation.  A.m. R5 was observed for was lying down in bed, nursing ashed hand, gloved, washed ruises were noted on both her right upper thigh. NA-G washeld another pair of washcloth cleaned lower NA-G washed hands, applied another and with much encouragement sat R5 was continually stating "just just get me in the chair." R5 and all morning cares. With the call standing lift) positioned in diffect on stand, R5 put her olders, NA-D secured the chands and back, R5 and repeating "I'm scared, and NA-D continued to attempt R5 with EZ stand to wipe after vement. R5 continued to yell d" and arms at that time of EZ stand with her body G was able to get a clean on, pulled up her pants and ariatric wheelchair at which		significant chang mobility or ambulation may be affected by this practice.  Nursing staff will educated on alert the DON on any changes in a patient's mobility a new comprehensive assessment can be completed if indicated.  DON/Designee to check 24 hour bo and review for an changes in reside transfers and mobility changes  DON/ Designee we audit to monitor compliance 2x a week for one more then once weekly two months, or as directed by QAA.  Findings of audit be reviewed at QAQ month x 3.  Completion date August 19, 2015	be ing so be ard y ent ill ath, for s	

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMP	LETED
		245387	B. WING			07/1	0/2015
NAME OF PROVIDER OR SUPPLIER  ST OLAF RESIDENCE				2	TREET ADDRESS, CITY, STATE, ZIP CODE 912 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE	(X5) COMPLETION DATE
F 274	time R5 immediate purposefully swunbed to transfer and On the morning of 7/9/15, at 7:09 a.m as she wheeled he observed to be se was not observed ambulate at anytin On 7/9/15, at 11:4 the bed with staff R5's diagnoses in bipolar disorder, ipain) and obesity Resident Admissi The Care Area As indicated R5 used limitations, and wunsteady gait, trastaff to assist as R5's current care was independent w/c (wheelchair) short distance (a and required occ locomotion. The ambulation, transcontraindicated to 7/9/15.  The quarterly Mind 4/7/15, indicated	0 a.m. R5 was transferred into assist utilizing a Hoyer lift. cluded paranoid schizophrenia, acontinence, lumbago (low backas listed on the undated on Record. seessment (CAA) dated 1/6/15, d a wheelchair, had physical as at risk for falls due to insferred independently and for needed.  plan dated 1/9/15, indicated R5 with bed mobility, transferring, locomotion, ambulated very few steps) with unsteady gait asional assist with wheelchair care plan information for sfers and bed mobility he observations on 7/8 and inimum Data Set (MDS) dated R5 had moderate cognitive independent with bed mobility,		274			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING			X3) DATE SURVEY COMPLETED	
		245387	B. WING	3	07/	10/2015	
NAME OF PROVIDER OR SUPPLIER  ST OLAF RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE  2912 FREMONT AVENUE NORTH  MINNEAPOLIS, MN 55411				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		I SHOULD BE	(X5) COMPLETION DATE	
F 274	During an interview stated the Hoyer (m time. R5 was over the was lowered down use it. NA-G stated help R5, she will figher to the front so the bottom when she well bottom when she well as stand. NA-G verthe EZ stand. NA-G verthe EZ stand, stating of it, maybe they nell don't know." NA-G nursing assistant for R5 was assist of two one for wheelchair.  During an interview stated they have us two to three weeks "we told the nurses.  During an interview director of nursing (when there was a cability. The administ about doing a significant pour ing an interview MDS coordinator st was identified, there her up due to a decof the time, that mother on for a significant puring an interview During an interview puring an interview mas identified, there her up due to a decof the time, that mother on for a significant puring an interview puring an	con 7/8/15, at 8:08 a.m. NA-G nechanical lift) tipped over one the bed at the time, so she and that was why they do not it took two or more staff to the them, will not let them roll hey could wash her back and was in the bed, so they use the rified R5 was slipping out of any "we report it, they are aware sed to get a different EZ stand, at then showed surveyor the eatment sheet which indicated to for transfers and assist of any of the EZ stand for the past and that R5 was complaining, "  on 7/9/15, at 11:23 a.m. NA-H and the EZ stand for the past and that R5 was complaining, "  on 7/9/15, at 12:41 p.m. (DON) stated she was not sure thange in R5's transferring trator stated "we have talked ficant change."  on 7/9/15, at 12:49 p.m. the ated "I do not know when it apy told him they were picking the last week, I'm not here all training it was discussed to put	F:	274			
	nursing assistant ca	are sheet for 7/6/15 and use the EZ stand with assist	Andrews and the state of the st				

CENTERS FOR MEDICARE & MEDICAID SERVICES  TATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER:  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245387		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY	
		B. WING			07/10/2015		
	ROVIDER OR SUPPLIER			2912	EET ADDRESS, CITY, STATE, ZIP COI 2 FREMONT AVENUE NORTH INEAPOLIS, MN 55411	DE	
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 278 SS=D	According to the L Resident Assessm version 3.0 dated "A 'significant cha improvement in a not normally resol staff or by implem clinical intervention declines only); 2. the resident's hea interdisciplinary re care." 483.20(g) - (j) AS ACCURACY/COM The assessment resident's status. A registered nurs each assessment participation of h A registered nurs each assessment is compared to a civil assessment must that portion of the Under Medicare willfully and know false statement subject to a civil \$1,000 for each willfully and know willfully and know false statement	must accurately reflect the must conduct or coordinate at with the appropriate ealth professionals.  See must sign and certify that the completed.  Who completes a portion of the set sign and certify the accuracy of the set sign and certification and the set sign and certification accuracy of the set sign and certification accuracy of the set sign and certification accuracy of the set sign accuracy	of n	274	F278  Corrections assessment resident # 20 have been completed. Other residerisk for inact assessment been review updated as DON/ Desig audit to mo compliance week for on then once with the thickness of the reviewed Q month x Completion August 19,	s on 0, and 19 ents at curate is have yed and needed. nee will nitor 2x a ne month, yeekly for 3, or as QAA. Faudit will d at QAA 3.	

**FORM APPROVED** 

#### PRINTED: 08/04/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING \_

(X3) DATE SURVEY COMPLETED B. WING 07/10/2015 245387 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2912 FREMONT AVENUE NORTH ST OLAF RESIDENCE MINNEAPOLIS, MN 55411 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 278 F 278 Continued From page 14 resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was coded accurately for 2 of 3 residents (R19, R20) reviewed for dental concerns, pressure and venous stasis ulcers. Findings include: R19 was observed on 7/7/15, at 8:53 a.m. and was noted to have several missing teeth to the front, back and sides of both her upper and lower On 7/8/15, at 7:22 a.m. R19 was asked if she had any problems with chewing or eating R19 stated "no." R19 stated she had been to the dentist and had been told was getting her partials soon but was not sure how soon. R19 indicated she was able to brush her own teeth after set and she had completed it this morning when she had gotten up. On 7/8/15, at 11:55 to 12:15 p.m. during continuous meal observation R19 was approached and asked how the food was she

stated "never good am a southern girl and lived in the farm and we had good food." When asked if she was having any problems with chewing the food due to the several missing teeth R19 stated

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		245387	B. WING _		07/10/2015	
•	PROVIDER OR SUPPLIER RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CO 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 278	"no." During obsernher sandwich with lower front jaw and discomfort noted.  R19 was admitted diagnoses includin impaired, peripher presbyopia obtaine 5/25/15.  R19's quarterly MI R19 required externion status was left bla which included rejumoderately impaired status was left bla which included but fitting full or partial tooth fragments, a cavity or loose nat gums, mouth or fawith chewing.  Review of documed Jumes and Jumes are present of the state of the	vation R19 was noted to bite her gums and one tooth on the I chewed it no difficultly or to the facility on 7/8/04, with g hemiplegia, mild cognitive al vascular disease (PVD) and ed from annual MDS dated DS dated 2/24/15, identified asive physical assist of one hygiene, had no behaviors ection of cares and had ed cognition. The Oral/Dental nk of any dental concerns to not limited to broken or loosely denture, no natural teeth or bnormal mouth tissue, obvious ural teeth, inflamed or bleeding cial pain, discomfort or difficulty ents revealed the following: are Services progress note icated R19 had an initial exambrace services progress note icated care completed essions for (teeth #18, #21, #27 ull upper and partial lower resine taken with genie material" sment dated 5/27/15, indicated chewing or swallowing r the assessment did not		78		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/04/2015 FORM APPROVED OMB NO. 0938-0391

08-13-2015

OUNTERS FOR MEDICARE	& MEDICAID SERVICES					0330-0391
CENTERS FOR MEDICARE TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l <b>`</b> '		CONSTRUCTION		E SURVEY IPLETED
	245387	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE		10/2015
NAME OF PROVIDER OR SUPPLIER  ST OLAF RESIDENCE			29	REET ADDRESS, CITY, STATE, ZIP CODE 112 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411		
(X4) ID SUMMARY ST.	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	-IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ひいしひ BE	(X5) COMPLETION DATE
concerns which in or loosely fitting futeeth or tooth frag obvious cavity or I bleeding gums, mor difficulty with chemical section of the above the cerebrovascular adental section Canot trigger.  R19's ADL care prequired assistant dressing, bathing care plan directe encourage particulated for the ne R19's CAA nor of decline. R19's nughts, indicated Frelated to the ne R19's CAA nor of dental/oral health.  On 7/8/15, at 10 stated usually in would usually in would usually not for residents in the it only for the initionly for the initionly go off the of the time the resident datase.	was left blank of any dental cluded but not limited to broken all or partial denture, no natural ments, abnormal mouth tissue, oose natural teeth, inflamed or outh or facial pain, discomfort newing and was marked as	A D) s did	278			

PRINTED: 08/04/2015 FORM APPROVED OMB NO. 0938-0391

245387 B. WING	07/10/2015
CTREET ADDRESS CITY STATE ZIP CODE	
ST OLAF RESIDENCE  2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATION)  DEFICIENCY)	COMPLETION DATE
F 278 Continued From page 17 had any chewing or swallowing problems and for R19 she had indicated the missing teeth did not cause any problems. CD acknowledged she should have still indicated on the side of R19's nutritional assessment that "she was missing teeth or was denture less."  - At 2:27 pm. the consultant MDS coordinator verified no dental comprehensive assessment had been completed despite R19's dental concerns. In addition he verified the comprehensive MDS was inaccurate and stated the comprehensive annual MDS should have captured the missing teeth and all the dental status concerns.  - At 2:36 pm. after the consultant MDS coordinator reviewed the entire care plan he verified a care plan had not been developed to identify R19's dental concerns. MDS coordinator indicated although an ADL care plan had been developed it had not address the dental concerns R19 had and care.  On 7/9/15, at 10:15 a.m. when asked what cares R19 required nursing assistant (NA)-B stated night shift got her up and was not sure after looking through the 1st Floor Team 1 Assignment NA-B stated R19 required assistance of one with ADLs which included dental care and because R19 was gotten up by the night shift the staff assisted her with dental cares also.  - At 3:17 p.m. the director of nursing (DON) approached and stated the facility did not have an assessment policy and rather followed the Resident Assessment Instrument (RAI) manual for assessments.  On 7/10/15, at 9-46 a.m. when asked what her expectation was of the MDS nurse when completing MDSs DON stated she expected the	

TATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CON	ISTRUCTION	(X3) DATE SURVEY COMPLETED		
		245387	B. WING			The second secon	10/2015	
	PROVIDER OR SUPPLIER			2912 F	T ADDRESS, CITY, STATE, ZIP COD REMONT AVENUE NORTH EAPOLIS, MN 55411			
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F 278	MDS nurse to follo regulations. When supposed to compasses ment for R	ow State and Federal asked if the MDS nurse was blete a comprehensive 19's dental stated DON again pposed to follow State and	F	278				
	after had a self-in was obese and had mattress, but not	th a new pressure ulcer risk nposed 44 day bed rest. R20 ad a pressure reduction a pressure relief mattress on ity failed to identify and assess						
	diagnoses of confracture of the right leg an	d to the facility 5/1/13, with gestive heart failure, malunion ht ankle, abscess and cellulitis d diabetes mellitus type II, had are ulcers, and stroke with bility to move half the body).	a	ANY PERSONAL PROPERTY OF THE PERSONAL PROPERTY				
	had a cognitive lo and required ass care one to three and had a history R20 was at risk f limited mobility, i status. Staff sho incontinence car	dated 8/20/14, indicated R20 oss, had a recent decline in ADL istance in all ADL. R20 refused times in the look back period noncompliance with treatments or pressure ulcers related to ncontinence, and nutritional uld assist with repositioning, es, monitor for decline, and noti MD) with changes.	S.					
	a history of pres reduction mattre signs and sympt	ated 8/26/14, indicated R20, har sure ulcers, had a pressure less, and should be monitored for coms of skin break down related and immobility. R20 was to be positioning, and staff should noti	and the second s					

TATEMENT	IS FOR MEDICAKE OF DEFICIENCIES F CORRECTION			TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245387	B. WING			/10/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	ODE		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 278	needed.  A review of the work on 4/1/15 through revisit date), all do buttock wound, the left buttock wound. On 5/13/15, she deteriorated due of the Optimize nutrition no change.  The Nursing Programmed A/29/15, going for on 4/29/15, untindicated "wound date by the wound and left buttock awere written. How dated 4/29/15, in right buttock.	e wound team to follow as bound clinic notes as follows: gh 4/29/15, (time limited by last ocumentation refers to a right tere was no documentation of a d. For wound of right shin to generalized decline of patients as Sheer wound of right buttock gress Notes were reviewed from rward: imed nursing progress notes I rounds." R20 was seen on that are a wound and no new orders wever, the Wound Clinic notes adicated a pressure ulcer on the		278			
	indicated:	vound care documentation book wound progress note indicated s on right shin and left buttock	A. C.				
	was cognitively not reject cares two staff for bec for transfers, to one staff for loc always incontin-	DS dated 5/18/15, indicated R20 intact, had no depression and did. R20 required extensive assist of mobility, a total mechanical lift let use, and extensive assist of omotion on the unit. R20 was ent and did not have a pressure terly MDS lacked evidence of the er being identified on the MDS.	of		If continuation s		

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ND PLAN OI	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		B. WING			07/10/2015		
	ROVIDER OR SUPPLIER	243301		291	REET ADDRESS, CITY, STATE, ZIP CODE  2 FREMONT AVENUE NORTH  NNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 278	On 7/9/15, at 1:37 (LPN)-B stated shin her nursing shift sheet." LPN-B rett and stated "I did r I talked to R20 too her 'it is red, and I tweighed daily, bushe did view the bescribed to her shapes, that croswas had about wishe does get hot didn't notice it too On 7/9/15, at 2:1 need to review the documentation the wounds)."	age 20 p.m. licesned practcial nurse e was told about the open area t report, "let me go get my urned less than one minute later not write anything down I guess day and I looked at her, I told I do think it's from pressure', she ositioned, which she does old her it is a doctors order to be t she refused." LPN-B stated outtocks. The rash was as a very red area with macular sed dermatomes, a discussion hat that might be. LPN-B stated, "perhaps it was heat rash, I day, but then I didn't look."  6 p.m. the DON stated "I will be documentation/lack of nat you are seeing (MDS and eskin assessment sheet because icial bath day, but she did tell the ot a new wound, it has looked	t e	278				
	much worse tha that it had been book.	n that." The NA-A was not aware healed according to the wound	,					
	Resident Assest version 3.0 date the "DEFINITIO pressure ulcer i and/or underlyir prominence, as	E Long Term Care Facility sment Instrument User's Manua ed last revised on October 2014, N PRESSURE ULCER" was "A s localized injury to the skin ng tissue usually over a bony a result of pressure, or pressure with shear and/or friction." manual provided "Steps for	- N. V.					

PRINTED: 08/04/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTIONG	(X3) DATE : COMPI		
		245387	B. WING				0/2015
	ROVIDER OR SUPPLIER RESIDENCE			2912 FREMONT A	, MN 55411		
(X4) ID PREFIX TAG	/FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH C	IDER'S PLAN OF COI ORRECTIVE ACTION FERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 280 SS=D	"1. Review the me flow sheets or other notes, and pressure 2. Speak with the staff on all shifts to medical record revision." 3. Examine the resident. 3. Examine the resident. 3. Examine the resident or resident. 4. Examine the resident electrocyx, trochante heels). Also assessed bows and ankles or subjected to proper tubing)." 483.20(d)(3), 483 PARTICIPATE PL  The resident has incompetent or of incapacitated uncompetent or of incapacitated uncomparticipate in plan changes in care at a comprehensive within 7 days after comprehensive and interdisciplinary to physician, a regist for the resident, a disciplines as defined in the extent the resident, the legal representation and revised by a staff or the resident of the resident	directed the staff to: dical record, including skin care er skin tracking forms, nurses' re ulcer risk assessments. treatment nurse and direct care of confirm conclusions from the view and observations of the sident and determine whether or non-removable are present. Assess key areas development (e.g., sacrum, rs, ischial tuberosities, and as bony prominences (e.g., s) and skin that is under braces essure (e.g., ears from oxygen  10(k)(2) RIGHT TO  ANNING CARE-REVISE CP  the right, unless adjudged therwise found to be der the laws of the State, to nning care and treatment or and treatment.  c care plan must be developed er the completion of the essessment; prepared by an eam, that includes the attending stered nurse with responsibility and other appropriate staff in termined by the resident's needs t practicable, the participation of resident's family or the resident' tive; and periodically reviewed team of qualified persons after	E L	280			
	each assessmer	Event ID: GK		Facility ID: 00260		If continuation shee	t Page 22 of 9

PRINTED: 08/04/2015 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING \_ AND PLAN OF CORRECTION 07/10/2015 B, WING 245387 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 ST OLAF RESIDENCE (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 280 F280 Continued From page 22 F 280 Resident # 31 has had his care plan reviewed and revised for falls and toileting This REQUIREMENT is not met as evidenced care. Other residents with by: Based on observation, interview and document recent falls have had review, the facility failed to revise the plan of care their care plan to reflect the need for assistance with toileting for reviewed and revised 1 of 3 residents (R31) reviewed for accidents, if indicated. who had repeated falls. DON/designee will review and revise residents fall and Findings include: toileting care plan. On 7/10/15, at 10:20 a.m. R31 was observed Nursing staff will be walking in hallway with nursing assistant (NA)-F. educated to alert the R31 had his left arm in a sling and pulled up to DON to any changes nipple line. R31's right hand held the walker in a resident's (which was a one sided stand walker with 4-pronged walker). The left foot was extended in toileting needs and front of him and did not appear to bend at the falls so care plan can knee. While R31 ambulated, he was hunched be revised to reflect forward with his left leg extended in front of him, the needs of the and he did a hop/shuffle step to catch up to the resident. DON/ Designee will walker. audit to monitor R31 was admitted to the facility on 9/19/12, with compliance 2x a admission diagnoses of vascular dementia, week for one month, dysphagia (difficulty swallowing), muscle spasm, then once weekly for osteoarthritis, persistent mental disorder, two months, or as depression, left hemiplegia, and neurogenic directed by QAA. bladder. Findings of audit will be reviewed at QAA The Care Area Assessment (CAA) dated 9/12/14, indicated R31 was cognitively intact. R31 required Q month x 3.

limited assistance with walking, hygiene, bathing

needed, monitor for changes in status and notify MD of changes. In addition the CAA indicated

and dressing. CAA directed staff to assist as

Completion date by:

August 19, 2015

St Olaf R

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		245387	B, WING		07	/10/2015
•	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 2912 FREMONT AVENUE NO MINNEAPOLIS, MN 55411	RTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETION DATE
F 282 SS=D	increased. Falls C/for falls related to he transfers, had a fall to toilet and physic occupational thera. The Care Plan datintact cognition, resided weakness, hand that the reside independent as pormotion (ROM) and restorative nursing assistance. R31 us (communal) for toil was to offer toiletir R31 was currently and able to toilet ir assist and prefers plan lacked directitransfers related to The Minimum Datindicated R31 had behaviors and requiting bed mobility, plan of care for R3 needed assist of and toilet use.  On 7/10/15, at 12: was interviewed a not updated to revassistance with to 483.20(k)(3)(ii) SE	depression which had AA indicated R31 was at risk nemiparesis, independent I that quarter when transferring all therapy (PT) and py (OT) had been ordered.  ed 9/16/14, indicated R31 had quired assistance related to left emiparesis, limited mobility interpreters to be as ssible. R31 received range of a walking program with a R31 used a quad can with sed a large bathroom leting for easier transfers. Staffing assistance as needed as continent of bowel and bladder independently. R31 "refuses to be independent." The care on for increased assistance in a recent decline in abilities.  a Set (MDS) dated 3/13/15, intact cognition did not have uired limited assist of one staff transfers, and toilet use. The B1 was not revised for the one staff bed mobility, transfers, on one on the director of nursing ind verified the care plan was riew the need for increased ileting. ERVICES BY QUALIFIED		282		

F 282  Continued From page 24 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care as directed for 1 of 1 resident (RZ9) reviewed for activities of daily living (ADLs) and for 1 of 1 resident (RZ9) whose call light was not within reach.  Findings include:  On 7/6/15, at 5:16 p.m. R25 was observed un-removed multiple white facial hairs approximately half (1/2) inch on her chin area.  On 7/7/15, at 12:15 p.m. during a random observation R25 was observed seated on her wheelchair in the dining table still noted to have the white facial hairs in her chin.  On 7/8/15, at 7:31 a.m. to 8:06 a.m. when morning cares were observed nursing assistant (NA)-B dressed R25, provided pericare's and oral cares. During the entire observation NA-B never offered to remove the visible white facial hairs.  On 7/8/15, at 11:43 a.m. R25 was observed lying in bed awake looking around the room facial hairs special on the chip.	TATEMENT OF DEFICIENCIES (X1) PROVIDER, ND PLAN OF CORRECTION IDENTIFICA		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		ESURVEY
NAME OF PROVIDER OR SUPPLIER  ST OLAF RESIDENCE    X,4   ID   PRIEFIX   RAMPORT STATEMENT OF DESICENCIES   PROVIDERS STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH			245387	B. WING				10/2015
PREFIX TAG  F 282  Continued From page 24 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care as directed for 1 of 1 resident (R25) reviewed for activities of daily living (ADLs) and for 1 of 1 resident (R73) whose call light was not within reach.  Findings include:  On 7/6/15, at 5:16 p.m. R25 was observed un-removed multiple white facilal hairs approximately half (1/2) inch on her chin area.  On 7/7/15, at 12:15 p.m. during a random observation R25 was observed seated on her wheelchair in the dining table still noted to have the white facial hairs in her chin.  On 7/8/15, at 7:31 a.m. to 8:06 a.m. when morning cares were observed nursing assistant (NA)-B dressed R25, provided pericare's and oral cares. During the entire observation NA-B never offered to remove the visible white facial hairs.  On 7/8/15, at 11:43 a.m. R25 was observed lying in bed awake looking around the room facial hairs searched on the chine care and oral cares on the chip.					2912	FREMONT AVENUE NORTH		
The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by:  Based on observation, interview and document review, the facility failed to follow the plan of care as directed for 1 of 1 resident (R25) reviewed for activities of daily living (ADLs) and for 1 of 1 resident (R73) whose call light was not within reach.  Findings include:  On 7/6/15, at 5:16 p.m. R25 was observed un-removed multiple white facial hairs approximately half (1/2) inch on her chin area.  On 7/7/15, at 12:15 p.m. during a random observation R25 was observed seated on her wheelchair in the dining table still noted to have the white facial hairs in her chin.  On 7/8/15, at 7:31 a.m. to 8:06 a.m. when morning cares were observed nursing assistant (NA)-B dressed R25, provided pericare's and oral cares. During the entire observation NA-B never offered to remove the visible white facial hairs.  On 7/8/15, at 11:43 a.m. R25 was observed lying in bed awakke looking around the room facial hairs accordance with proper grooming from staff including removing facial hairs with facial hairs and that requires assistance with grooming could be affected by this practice.  • Educate staff on morning cares policy including proper bathing and grooming.  • ED/designee will audit to monitor compilance 2x a week for one month, then once weekly for two months, or as directed by QAA.  • Resident #25 has had no adverse effects from not having her call light in reach. Call light device checked by maintenance so it can be clamped onto bed or area where	(X4) ID PREFIX	SUMMARY ST	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETION DATE
On 7/9/15, at 7:59 a.m. R25 was seated on her wheelchair in the dining table when still had	F 282	The services prover must be provided accordance with exact accordance accordance with exact accordance accordance with exact accordance accorda	ided or arranged by the facility by qualified persons in each resident's written plan of each resident's written plan of each resident's written plan of each resident at failed to follow the plan of care of 1 resident (R25) reviewed for living (ADLs) and for 1 of 1 mose call light was not within  6 p.m. R25 was observed iple white facial hairs alf (1/2) inch on her chin area.  15 p.m. during a random was observed seated on her dining table still noted to have airs in her chin.  11 a.m. to 8:06 a.m. when here observed nursing assistant R25, provided pericare's and oracle entire observation NA-B never the visible white facial hairs.  143 a.m. R25 was observed lying oking around the room facial hairs chin.	al	282	<ul> <li>Resident #25 h received proper grooming from including remore facial hairs from the facial hairs from the facial hair and requires assist with grooming be affected by practice.</li> <li>Educate staff morning carest including proper bathing and grooming.</li> <li>ED/designee wand to monit compliance 20 week for one then once week for one then once week two months, and if the face of the form of the form</li></ul>	er staff oving m chin. vith that tance could this on spolicy oer vill or ca month, ekly for or as AA. has had fects ng her each. ice so it	

PRINTED: 08/04/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

1	IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245387	B. WING		07/10/2015	
NAME OF PROVIDER OR SUPPLIER  ST OLAF RESIDENCE		2	TREET ADDRESS, CITY, STATE, ZIP CODE 912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
CEACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
approached and ash her she smiled and On 7/9/15, at 10:56 practical nurse (LPN facial hairs. When a hairs NA-B stated s because she hersel think it bothered R2 lip. NA-B further state but R25 did not have -At 10:58 a.m. when was LPN-B stated s removed the facial some residents are clarified if R25 was stated "She is a who to have facial hair" not been close to FO On 7/10/15, at 8:32 seated on her when had facial hairs in her R25's ADL function Area Assessment (R25 required some to weakness.  R25's ADL function plan dated 3/10/15 for self was impair goal to "will be nead directed staff to se assist of one daily behavioral sympto	n asked what her expectation she expected NA-B to have hairs "If it's on the care plan as independent." When surveyor independent then LPN-B lite female and it is not normal LPN-B further stated she had 325 during her shift.		<ul> <li>Maintenance has done 100% room sweep to assure all call light devices ar attachable and available for all residents.</li> <li>ED/ designees will make rounds 3x weekly to monitor that residents call lights are in place. Corrective action to staff will take place time of infraction.</li> <li>Educate staff on calight policy and document if residerefused to have calight attached.</li> <li>Findings of audit to be reviewed at QAQ month x 3.</li> <li>Completion date to August 19, 2015</li> </ul>	o at all ent all	

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STATEMENT	S FOR MEDICARE OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
MAD L TWIN OL	55,11,125,136,1	245387	B. WING			07/	10/2015
	ROVIDER OR SUPPLIER			291	REET ADDRESS, CITY, STATE, ZIP CODE 12 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEEICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	during the followin 5/12/15, 5/18/15 a either a bed bath of R25 and the box "never been check and osteoporosis Minimum Data Se addition the MDS extensive physica toileting, dressing included shaving hands.  On 7/9/15, at 9:48 (DON) stated stafacility policy and provided the polich had right for choi When asked if R decision as she hwould have to se progressed.	g dates 4/7/15, 4/14/15, 5/5/15, and 6/30/15, it was revealed or shower had been given to Shaved (Men & Women)" had ed off for any of the dates.  Included Alzheimer's disease, obtained from the quarterly of (MDS) dated 6/1/15. In indicated R25 required all assist of one staff with and personal hygiene which and washing/drying face and for any of the directed surveyor she had by. DON also stated a resident ces and had the right to refuse. 25 was being to make care and dementia DON stated she he how far her dementia was		282			
	Morning Care po staff to "9. Shavi needed"	licy dated April 1, 2008, directeding as needed; assist as					
	the plan of care.  R73 was observ	ed on 7/6/15, at 5:52 p.m. to be in bed with the call light cord					
2.1	located underne	ath head of the bed. The call lig 173's reach if he needed staff. NA-E came in the room	ht				eet Page 27

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	COMPLETED		
MAD I EVILLO		245387	B. WING			07/10/2015		
NAME OF P	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE FREMONT AVENUE NORTH			
	RESIDENCE			MINI	NEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	שפע	(X5) COMPLETION DATE	
F 282	and when asked, be on floor, it sho NA-E was observunderneath head reach of R73's rig resident was able also confirmed he R73's care plan of ability to perform impaired, require ambulated with a care plan also in and the staff was reach.  On 7/7/15, at 8:5 expected resident or arou was in bed it sho stated resident with rolling walk.  On 7/10/15, at 8 regarding call lie expected staff is placement of call from the bathroom."  483.25 PROVI HIGHEST WE	stated call light cord should not uld be within resident's reach. ed to pull call light from of the bed and place it within the bed and place it within the side. NA-E further stated to use call light and resident e used the call light.  Idated 3/25/15, indicated R73's ADLs independently was ad assist with transfers, assist and use of walker. The dicated R73 was at risk for falls to place the call light within  In a.m. LPN-A stated he ent's call light to be put in bed with the bed table and if resident build be with him. LPN-A further was independent and ambulated er.  In a.m. DON was interviewed the placement. DON stated she should follow facility policy with all light.  It system policy dated 4/1/08, esidents have call system acces while sitting at their bedside or the DE CARE/SERVICES FOR LL BEING	th d	282 F 309				
	provide the ne	must receive and the facility mucessary care and services to attended highest practicable physical,	tain					
1 .	i e				11		shoot Dago 28 c	

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	, ,		CONSTRUCTION		TE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			
		245387	B. WING				/10/2015
	PROVIDER OR SUPPLIER RESIDENCE			291	REET ADDRESS, CITY, STATE, ZIP CODI 2 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411	Ē	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 309	accordance with the and plan of care.  This REQUIREME by: Based on observative, the facility the causative factoresidents (R5) and physician order for therapy (PT/OT) with residents (R5).  Findings include: Bruises: Review of nurse's skin was clean, drives was intact; on 5/4, injuries noted after fall follow-up, a let No other injuries with dia body check; fall: a bruise 13 conted on outer lat no documentation 7/8/15, after survet the director of nursing assistant (mechanical lift) to over the bed at the down and that was	ecomprehensive assessment in the comprehensive assessment ation, interview and document failed to identify and investigate ors for bruises for 1 of 3 if the facility failed to ensure a rephysical and occupational was carried forward for 1 of 3 in total body audit; on 6/13/15, after a fall, no physical results to the facility failed to ensure a rephysical and occupational was carried forward for 1 of 3 in total body audit; on 6/13/15, after a fall, no physical results to the facility for the facility of the facility and intact; on 3/26/15, skin four thigh bruise was noted. Were observed when the nurse 7/5/15 follow-up from 7/4/15, antimeters (cm) by 15 cm was eral view of right hip. There was not upper arm bruises until eyor noted them and reported to		309	F309  Resident #5 has seen by therapy screening. DON has review causative facto bruises and investigated in that occurred to cause bruises of Resident #5 DON/designee review and investigate any bruises of unknorigins and review and providents. Any resident with new therapy of will have a copport of the part of lea voice messag. Educate staff system change. DON/ Designer audit to monit compliance 2 week for one then once we two months, of directed by Q	y for yed rs for cident co on will y nown yith rders oy of ced in ON orove n rtments ving a e. on ie. ee will cor x a month, ekly for or as	

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION		SURVEY
ND PLAN C	DF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING_			
		245387	B. WING			07/	10/2015
	PROVIDER OR SUPPLIER  RESIDENCE	A		29	REET ADDRESS, CITY, STATE, ZIP CODE 012 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	stated it takes two will fight them, will so they could wash she was in the bed (mechanical stand slipping out of the they are aware of different EZ stand showed surveyor sheet which indicatransfers and assi  During an interviel licensed practical fight cares, yell ducomplete. LPN-A completed on bath her bath thus a bostated the bruises from the ill-fitting sink down in the veatch on the back and that is why we states he has obsthe belt is put on holding on proper.  During an interviel DON stated R5 woof body so she we 7/3/15. R5 was used a Hoyer to bruises could be and forth to get the stated "I would even will be stated" in would even will be stated "I would even will be safe to be stated" in would even will be safe to be saf	or more staff to help R5, she not let them roll her to the front in her back and bottom when it, so they use the EZ stand it lift). NA-G verified R5 was EZ stand, stating "we report it, it, maybe they need to get a it, I don't know." NA-G then the nursing assistant treatment ated R5 was assist of two for st of one for wheelchair.  I w on 7/8/15, at 9:42 a.m. nurse (LPN)-A stated R5 will uring any that she did let staff stated a body audit should be in days, on 7/4/15, R5 refused by audit was not done. LPN-A is on the arms are or "could be" wheelchair, her arms would a and sides of the wheelchair e got a new larger one. LPN-A served her in the EZ stand and it correctly and she cooperates by		309	<ul> <li>Any bruise noted residents will hav causative factors reviewed and IR completed for thorough investigation.</li> <li>Staff educated or reporting new bruises to DON s investigation can start ASAP.</li> <li>DON/designee wi audit to monitor compliance 2x a week for one mo then once weekly two months, or a directed by QAA</li> <li>Findings of audit will be reviewed QAA Q month x</li> <li>Completion date August 19, 2015</li> </ul>	e  o  ill  for  s  ts  at  3.	

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245387	B. WING	-		07/1	0/2015
	PROVIDER OR SUPPLIER			29	REET ADDRESS, CITY, STATE, ZIP CODE 12 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE (	(X5) COMPLETION DATE
F 309	find they document check."  During an interview stated after she as submitted a vulner started an investiguorigin. DON furthe PT yesterday and stand so staff now During an interview LPN-A stated the respective check."	and there were no bruises. I tin many different places, I will on 7/9/15, at 8:21 a.m. DON sessed R5's bruises, she able adult report and has ation for bruises of unknown r stated R5 was assessed by deemed not safe to use the EZ uses the Hoyer.  In on 7/10/15, at 8:56 a.m. hursing assistant care sheet for indicated to use the EZ stand		809			
	review the facility of device was utilized resident (R5) revie the facility failed to in good operating armrests was mai manner for 1 of 1	tion, interview and document failed to ensure a mechanical din a safe manner for 1 of 1 ewed for accidents. In addition, o ensure grab bars in toilet were condition and wheelchair ntained in a safe operating resident (R24).					
	morning cares. Riswashed hand, globody. Bruises wer and on her right ustating "just get mchair." R5 was ye cares. With the E.	a.m. R5 was observed for was lying down in bed; NA-G ved, and washed R5's upper e noted on both upper arms pper thigh. R5 was continually e in the chair; just get me in the lling out during all morning Z stand positioned in front of on stand, R5 put her hand on	e				

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			Ol		938-0391
CENTER	S FOR MEDICARE	& MEDICAID SERVICES		TIP!		(X3) DATE	- Control of the Cont
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		LETED
		245387	B. WING			07/1	0/2015
NAME OF P	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 912 FREMONT AVENUE NORTH		
ST OLAF	RESIDENCE				MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	/EACH DEEICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	the hand holders, around wrist/hands upset, repeating "I and NA-D continue continued to yell "I at that time started body slowly loweri calling out "I'm goi get a clean incontipants and transfer (W/C) at which timedown.  On 7/9/15, at 7:09 a wheelchair, war Staff stated R5 warmorning cares we at 9:08 a m. two	age 31.  NA-D secured the straps is and back, R5 appeared very im scared, I'm scared." NA-G and to attempt to calm R5. R5 don't like the stand" and arms id to slip out of EZ stand with hering. R5 appeared distresseding to fall." NA-G was able to inent product on, pulled up hering R5 immediately calmed  a.m. R5 was dressed, sitting in the to go outside to the pationas up at 6:00 a.m. at which time are completed.  a aides and one nurse attempted as screaming and yelling and		309			
	R5's diagnoses in bipolar disorder, i pain) and obesity Resident Admiss	ncluded paranoid schizophrenia ncontinence, lumbago (low bac as listed on the undated ion Record. ssessment (CAA) dated 1/6/15,					
	indicated R5 use limitations, and w unsteady gait, tra staff to assist as	d a wheelchair, had physical vas at risk for falls due to ansferred independently and for needed.					
	independent with locomotion, walk steps) with unste	ated 1/9/15, indicated R5 was bed mobility, transferring, w/c s very short distance (a few eady gait and requires occasion lchair locomotion.	al				

The quarterly Minimum Data Set (MDS) dated

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CTATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLÍA			CONSTRUCTION		E SURVEY MPLETED
AND PLAN OF	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			14 0 10 0 4 F
		245387	B. WING		REET ADDRESS, CITY, STATE, ZIP		/10/2015
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STOLAR		The Table of	ID		DROVIDER'S PLAN OF CO	ORRECTION	(X5) COMPLETION
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F 309	impairment, was i transfers, and wal	R5 had moderate cognitive ndependent with bed mobility, king.		309			
	indicated R5 was gets around in a l joint disorder (DJ	an progress notes dated 6/4/15 very limited in her ambulation, N/C due to chronic degenerativD) of the knees and knee pain.	е				
	6/12/15, indicated treat." On 6/15/15 [evaluate] and tx	sician's Telephone Orders dated d "OK for PT/OT to evaluate an 5, another order for "PT to eval [treat] for WC safety, OK for lip nedical record lacked evidence ders had been communicated t					
	LPN-A stated the	ew on 7/8/15, at 8:01 a.m., e EZ stand was the only way the hich she generally refuses but in the Hoyer lift (mechanical lift) ated they tried the Hoyer a while twork.					
	stated the Hoye over the bed at down and that we stated it takes the will fight them, we she was in the NA-G verified Festand, stating "maybe they ne don't know." No purging assistant.	riew on 7/8/15, at 8:08 a.m., NA r tipped over one time. R5 was the time, so she was lowered was why they do not use it. NAwo or more staff to help R5, shwill not let them roll her to the freash her back and bottom when bed, so they use the EZ stand. R5 was slipping out of the EZ We report it, they are aware of ed to get a different EZ stand, I A-G then showed surveyor the ant treatment sheet which indicatof two for transfers and assist of	G e cont it,				

PRINTED: 08/04/2015 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 07/10/2015 B. WING 245387 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 ST OLAF RESIDENCE PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 309 Continued From page 33 F 309 During an interview on 7/8/15, at 9:42 a.m. LPN-A stated R5 will fight cares and would yell during any that she did let staff complete. LPN-A stated he has observed her in the EZ stand and " if the belt is put on correctly and she cooperates by holding on properly, it works well. " During an interview on 7/8/15, at 10:33 a.m. LPN-A stated the Hoyer was never used to

transfer R5, just to get her up off the floor when she fell. LPN-A further stated to his knowledge the Hoyer never tipped over when staff was using it, they have always used the EZ stand "R5 can transfer herself from wheelchair to bed and does do this."

During an interview on 7/9/15, at 8:07 a.m. LPN-A stated R5 was now a Hoyer lift due to therapy abanging it vesterday LPN-A stated there are no

Stated R5 was now a Hoyer lift due to therapy changing it yesterday. LPN-A stated there are no assessments for use of the Hoyer, but residents are assessed by therapy for use of the EZ stand. The assessment for the EZ stand was requested. LPN-A stated "it was before my time, I will look for it."

- At 8:13 a.m. LPN-A stated he could not find it and was requesting medical records to look for it. - At 9:31 a.m. the physical therapy director (PTD) stated there was no assessment to use the EZ stand and that nursing or therapy can change to use of the Hoyer if transfers are unsafe, but that therapy needed orders for the EZ stand assessment. PTD stated "I didn't know about the use of the EZ stand, we never recommended it." - At 11:23 a.m. NA-H stated they have used the EZ stand for the past two to three weeks and that R5 was complaining, "We told the nurses." - At 12:41 p.m. DON stated she was not sure when there was a change in R5's transferring

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If continuation sheet Page 34 of 95

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FFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	NG			0/2015
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/IDER OR SUPPLIER			2912	FREMONT AVENUE NORTH		
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DEFIGIENC	A MUST BE BRECEDED BY LOOP			CACH CORRECTIVE ACTION SHO	DULD BE	COMPLETION DATE
bility. The admin pout doing a sign wring an intervie PN-A states that heet for 7/6/15 at Z stand with assisted 4/1/08 directions and safety according to mark the policy lacked esident prior to Review of the factorial provided therapy to attain prevent decline treatment plan a should be notific rehabilitation should be notificated and oral hygien.  This REQUIRE by:	istrator stated "we have talked nificant change."  w on 7/10/15, at 8:56 a.m. the nursing assistant care and 7/7/15 indicated to use the sist of two staff.  sility policy, Lift - Sit to Stand cted that staff must be trained in y precautions and transfer nufacture direction guidelines. It direction for assessment of use.  cility policy, Rehabilitation dated 4/1/08, indicated the physical, occupational, or speed or maintain function and/or with a physician-ordered and that the therapy department and of any physician orders and ould be noted on the resident's is unable to carry out activities of ives the necessary services to nutrition, grooming, and personale.	th the state of th		Resident #2 received pr grooming f including re facial hairs Any reside facial hair requires as with groon	oper rom staff emoving from chin nt with and that ssistance ning could	**************************************
	SUMMARY ST. (EACH DEFICIENCE SUMMARY ST. (EACH DEFICIENCE REGULATORY OR CONTINUED A STATE OF THE POLICY AS STATE OF THE POLICY IN THE POLICY I	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  ontinued From page 34 boility. The administrator stated "we have talked bout doing a significant change."  Juring an interview on 7/10/15, at 8:56 a.m. PN-A states that the nursing assistant care heet for 7/6/15 and 7/7/15 indicated to use the EZ stand with assist of two staff.  Review of the facility policy, Lift - Sit to Stand lated 4/1/08 directed that staff must be trained in the stage of the policy lacked direction guidelines. The policy lacked direction for assessment of resident prior to use.  Review of the facility policy, Rehabilitation Services Orders dated 4/1/08, indicated the facility provided physical, occupational, or speed therapy to attain or maintain function and/or prevent decline with a physician-ordered treatment plan and that the therapy department should be notified of any physician orders and rehabilitation should be noted on the resident's care plan.  483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by:	DEFICIENCIES (X1) PROVIDER SUPPLIER (X2) IDENTIFICATION NUMBER:  245387  DEFICIENCE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Ontinued From page 34  Dility. The administrator stated "we have talked bout doing a significant change."  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This REQUIREMENT is not met as evidenced by:  This REQUIREMENT is not met as evidenced by:	A BUILDING  245387  245387  A BUILDING  STREET ADDRESS, CITY, STATE, ZIP CODE  2912 FREMONT AVENUE NORTH  MINNEAPOLIS, MN 55411  PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REQUILATORY OR LSC IDENTIFYING INFORMATION)  ontinued From page 34  pointinued From page 34  priving an interview on 7/10/15, at 8:56 a.m.  pointinued From page 34  pointinued From page 34  priving an interview on 7/10/15, at 8:56 a.m.  pointinued From page 34  priving an interview on 7/10/15, at 8:56 a.m.  pointinued From page 34  priving an interview on 7/10/15, at 8:56 a.m.  pointinued From page 34  priving an interview on 7/10/15, at 8:56 a.m.  pointinued From page 34  priving an interview on 7/10/15, at 8:56 a.m.  pointinued From page 34  priving an interview on 7/10/15, at 8:56 a.m.  priving an interview on 7/10	DEPTICIONICE DENTIFICATION NUMBER:  245387  245387  245387  245387  245387  245387  245387  245387  245387  2572 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411  2572 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411  PROVIDERS LIGHT OF DEPTICIENCIES (EACH DEPTICIENCY MIST BE PRECEDED BY FULL FREGULATORY OR LSC IDENTIFYING INFORMATION)  Ontinued From page 34  Ontinued From page 34  In providers PLAN of CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPTICIENCY OF THE APPROPRIATE DEPTICATION OF THE APPROPRIATE DEPTICA

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		245387	B. WING			07/1	0/2015
	PROVIDER OR SUPPLIER			291	REET ADDRESS, CITY, STATE, ZIP CODE 12 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411		
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F 312	hair was provided are unable to carry reviewed for activity. Findings include:  On 7/6/15, at 5:16 un-removed multiple approximately half observation R25 wheelchair in the white facial half on 7/8/15, at 7:31 morning cares were (NA)-B dressed Forces. During the offered to remove on 7/8/15, at 11:4 in bed awake look remained on the offered to remove on 7/9/15, at 7:5 wheelchair in the multiple white facial hairs in the multiple white facial hairs. When hairs NA-B state because she her think it bothered	a.m. to 8:06 a.m. when are observed nursing assistant a25, provided pericare's and ora entire observation NA-B never the visible white facial hairs.  A3 a.m. R25 was observed lying king around the room facial hair chin.  B9 a.m. R25 was seated on her dining table when still had sial hairs in her chin. When asked if the facial hairs botherend was not able to respond.  S6 a.m. both the licensed LPN)-B and NA-B verified the in asked if she had noticed the dishe had and did take it out reelf had facial hair and did not R25 as she pointed to her upper stated male residents had razo	l ss	312	require assistan with removal of hairs are receivi this assistance indicated.  Educate staff or morning cares princluding proper bathing and grooming.  ED/designee where we for one may then once week two months, or directed by QA.  Findings of aux will be reviewe QAA Q month?  Completion da August 19, 201	ce facial fing if  n colicy fr a conth, kly for as A. dits d at x 3. te by:	

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION		PLETED
		245387	B. WING			07/	10/2015
	PROVIDER OR SUPPLIER			29	TREET ADDRESS, CITY, STATE, ZIP CODE 912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
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F 312	-At 10:58 a.m. who was LPN-B stated removed the facial some residents ar clarified if R25 was tated "She is a was to have facial hair not been close to On 7/10/15, at 8:3 seated on her who had facial hairs in R25's ADL function Area Assessment R25 required some to weakness.  R25's ADL function for self was impagoal to "will be nead in the directed staff to sassist of one dail behavioral symptimicated R25 did issues.  Review of R25's	en asked what her expectation is she expected NA-B to have all hairs "If it's on the care plan as re independent." When surveyor is independent then LPN-B white female and it is not normal." LPN-B further stated she had R25 during her shift.  32 a.m. R25 was observed eelchair in the dining room still in her chin.  In her chin.  In all status/rehabilitation Care it (CAA) dated 3/7/15, indicated ne assistance with cares related to mal/rehabilitation potential care in potential care in the care plan is to complete tasks. In addition to care plan dated 3/10/15, in ot have any mood/behavior.  Body Audit Form completed		312			
	during the follow 5/12/15, 5/18/15 either a bed bath R25 and the box	ing dates 4/7/15, 4/14/15, 5/5/15 and 6/30/15, it was revealed n or shower had been given to c "Shaved (Men & Women)" had cked off for any of the dates.					
	and osteoporosi Minimum Data S	s included Alzheimer's disease, s obtained from the quarterly Set (MDS) dated 6/1/15. In S indicated R25 required	of country many objectives and an extension of the country of the				

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			ONICTONICTION	(X3) DATE	
TATEMENIT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		PLETED
AND PLAN C	F CORRECTION	DERTH TOTAL CONTROL	A. DUILD				
		245387	B. WING			07/1	10/2015
NAME OF	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
					FREMONT AVENUE NORTH NEAPOLIS, MN 55411		
ST OLAF	RESIDENCE			MIIA	PROVIDER'S PLAN OF CORRECTION	ON	(X5) COMPLETION
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F 312	extensive physica	rage 37 I assist of one staff with and personal hygiene which and washing/drying face and	F	312			
	(DON) stated stated facility policy and provided the policy had right for choice When asked if Right decision as she had would have to se progressed. When was of staff filling the protection of the progressed of the protection of the protection of the provided protection of the protection of the provided provided protection of the provided pro	5 a.m. the director of nursing if was supposed to follow the directed surveyor she had by. DON also stated a resident ces and had the right to refuse. 25 was being to make care had dementia DON stated she how far her dementia was a nasked what her expectation if the Body Audit Form as it had blank in the "shaving" boxes DON was supposed to follow the facilit	y y				
F 31	staff to "9. Shavi needed" 483.25(c) TREA	olicy dated April 1, 2008, directeding as needed; assist as TMENT/SVCS TO L PRESSURE SORES	, , , , , , , , , , , , , , , , , , ,	F 314			
	resident, the fact who enters the does not develor individual's clinithey were unav- pressure sores	omprehensive assessment of a sility must ensure that a resident facility without pressure sores op pressure sores unless the cal condition demonstrates that oidable; and a resident having receives necessary treatment a mote healing, prevent infection a tres from developing.	nd				
	This REQUIRE	EMENT is not met as evidenced	(				
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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08-13-2015

CENTER	S FOR MEDICARE	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRU	CTION .	(X	3) DATE SURVEY COMPLETED
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		245387	B. WING _				07/10/2015
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F 314	Continued From p Based on observ review, the facility were in place to p 2 pressure ulcer ( involving epiderm superficial and problister, or shallow (R20) reviewed for Findings include: The facility failed of R20's self implied include to add to reduce the rist R20 was obesed mattress, but now her bed.  On 7/7/15, at 8:1 stated she had provided she had provided to the state of th	rage 38 ation, interview and document failed to ensure interventions revent development of a Stage partial thickness skin loss is, dermis, or both. The ulcer is esents clinically as an abrasion, crater) for 1 of 2 residents or pressure ulcers.	d d s e lar to	F3	• Resiskin care and impose impose impose impose to place to present on ope so assint im Ed als skint reserved to preserved to preserve to preserved to preserved to preserve to prese	dent #20 has had assessment with plan reviewed revised for skin airment.  resident with ential for skin airment will have per interventions ced on care plan brevent relopment of ssure ulcers. If will be educate reporting any newn areas to DON proper sessment and erventions can be plemented. In care terventions for all sidents. DN/designee will entit to monitor ompliance 2x a rected by QAA. Indings of audits ill be reviewed at AA Q month x 3. ompletion date bugust 19, 2015	ed w

08-13-2015

PRINTED: 08/04/2015 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING \_ AND PLAN OF CORRECTION 07/10/2015 B. WING 245387 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 ST OLAF RESIDENCE PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PRÉFIX DEFICIENCY) TAG F 314 Continued From page 39 F 314 the peri area; and scrubbed the mattress. The NA-A continued with the bath. R20 had purple discoloration (in varying shades) from upper thighs (above gluteal fold) and included the buttocks. NA-A cleaned stool from the peri folds twice with a washcloth and then used that wash cloth to pat an area of denuded skin on the left upper buttocks approximately 3.5 to 4.0 centimeters (cm) x 2.5 cm with crusted area of yellow debris. The open area did not appear to be blanchable during the cares. NA-A applied AD ointment to the area. R20 stated she had a history of open areas and the cream had healed them. The resident stated that she should be checked and changed every two hours. - On 7/8/15, at 12:00 p.m. R20 remained in an upright position with the head of bed (HOB) at 35 to 45 degrees (upright). - On 7/8/15, at 2:50 p.m. R20 remained upright with HOB 35 to 45 degrees. R20 was admitted to the facility 5/1/13, with diagnoses of congestive heart failure, malunion fracture of the right ankle, abscess and cellulitis of the right leg and diabetes mellitus type II, had a history of pressure ulcers, and stroke with hemiparesis (inability to move half the body). The annual Care Area Assessment (CAA) dated 8/20/14, indicated R20 had a cognitive loss, had a recent decline in activities of daily living (ADL) and required assistance in all ADL. R20 refused care one to three times in the look back period and had a history noncompliance with treatments. R20 was at risk for pressure ulcers related to

MD with changes.

limited mobility, incontinence, and nutritional status. Staff should assist with repositioning, incontinence cares, monitor for decline, and notify

TATEMENT	OF DEFICIENCIES	((()))			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
ND PLAN OI	F CORRECTION	245387	B. WING			07/1	0/2015
	ROVIDER OR SUPPLIER	245307		STF 291	REET ADDRESS, CITY, STATE, ZIP CODE  2 FREMONT AVENUE NORTH  NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	Continued From p	age 40	F	314			1
	a history of pressureduction mattress signs and sympton to incontinence ar assisted with reporthe doctor and the needed. The care check and change related to resident weeks due to a set her neck.  A review of the W - On 4/1/15 through revisit date), all districts wound, the left buttock wound, the left buttock wound - On 5/13/15, she deteriorated due Optimize nutrition no change.  - On 5/27/15, she deteriorated due Optimize nutrition no change.  - On 6/10/15, she improved. Sheer on 6/10/15).  - On 6/24/15, she at least 197 days	ed 8/26/14, indicated R20, had are ulcers, had a pressure s, and should be monitored for ms of skin break down related ad immobility. R20 was to be sitioning, and staff should notify wound team to follow as plan lacked new directions to e or reposition every two hours, as wish to stay in bed for six elf-diagnosed "pulled muscle" in cound Clinic Notes as follows: gh 4/29/15, (time limited by last becomentation refers to a right here was no documentation of a d. Her wound of right shin to generalized decline of patient to nutritional compromise.  The sheer wound of right shin to nutritional compromise.  The sheer wound of right buttock her wound of right buttock here wound of right inferior shin wound of right buttock here wound of right inferior shin wound of right inferior shin wound of right buttock here wound of right inferior shin and duration, venous insufficiency address right buttock).	d of				
	The Nursing Pro 4/29/15, going for On 4/29/15, ur	gress Notes were reviewed from	at				

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		245387	B. WING			07/-	10/2015
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP COI 912 FREMONT AVENUE NORTH 11NNEAPOLIS, MN 55411	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AID DEFICIENCY)	SHOULD BE	COMPLETION DATE
F 314	and left buttock are were written. Howed dated 4/29/15, indiright buttock.  On 5/25/15, untirindicated a call plate to inform of complishoulders and R20 Tylenol (a mild ananursing home staff received a new or used to control paof neck pain on 6/bed.  On 6/27/15, at 1 bath, skin noted a - On 7/8/15, at 2: reported the open nurse (LPN)-C as was a trained merput the cream on she had not report that she was not assessment.  On 7/9/15, at 6: noted, "[R20] was with a pillow to prand said 'No honer-approached are to prevent further repositioning." The intervened.  On 7/9/15, an ure R20 had an open measures approached and an open measures approached an open measures approac	ea wound and no new orders ever, the Wound Clinic notes cated a pressure ulcer on the med nursing progress note aced to nurse practitioner (NP) aint of pain in neck and had been using as needed algesic). R20 indicated to the f that had not helped and R20 der for Tramadol (a narcotic in). R20 continued to complain 22/15, 6/23/15, and remained in 15 p.m. R20 received a bed	d d	314			

St Olaf R

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 '		CONSTRUCTION		E SURVEY MPLETED
AND PLAN C	F CORRECTION					07	/10/2015
	TOWNS OF SURE IFF	245387	B. WING		REET ADDRESS, CITY, STATE, ZIP CC		11012010
	PROVIDER OR SUPPLIER  RESIDENCE			291	2 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 314	of open area, unable placed to NP, mes area. Also placed and left open at the NP. Have discussion to relieve pressure bigger. R20 stated around and that shas refused getting sling and lift. R20 decision. Benefits getting up were diprogress note was which ok'd the Statement of open are cares. The note wintervened. A review of the windicated:  A review of the windicated:  On 4/29/15, a windicated: On 6/20/15, did extremity (RLE) addressed. On 6/27/15, becaute the control of the windicate of the windicate of the windicated: The quarterly Mindicate of the windicate	age 42 ple to connect with any. call is age left informing of open in wound book. Area cleansed is time, awaiting call back from ed the need for R20 to position ed the need for R20 to position ed that she does move herself hould be enough. Res [resident in the great was a performed in the morning with does not get out of bed per her of changing position and iscussed." Imbedded in the sa new order from the NP anding Orders to apply barrier ea on coccyx every shift with was made after surveyor staff ew of the Physician Orders and donot support the statement of cound care documentation book wound progress note indicated on right shin and left buttock and bath, skin intact.  Thave wound on right lower and no other wounds were do bath, skin intact.  Inimum Data Set (MDS) dated and did not reject cares. R20 we assist of two staff for bed mechanical lift for transfers, to life in the unit. R20 was always did not have a pressure ulcer.	ad	314			

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE	SURVEY
ND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			
		245387	B. WING		OF OTHER TIP COD	THE RESERVE THE PERSON NAMED IN COLUMN 2 I	0/2015
	PROVIDER OR SUPPLIER		:	291	REET ADDRESS, CITY, STATE, ZIP COD 2 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	ALVOR DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 314		age 43 rt sheet for 7/9/15, indicated	F.	31.4			
	prn Tramadol at 2: repositioned side t	00 a.m., legs pain, and					
	indicated: on 7/9/1 new documentation nursing progress indicate the new le	-hour Nursing Report book 5, at 1:30 p.m. there was no on in the wound care book, the notes, or 24 hour report form to eft buttock wound. (There was open area observed during		A PARTIES AND A CONTRACTOR OF THE PARTIES AND A CONTRACTOR OF			
	told about the oper report, "let me go less than one min write anything down and I looked at he think it's from pre repositioned, white told her it is a down but she refused." buttocks. The ras red area with madermatomes, a down that might be. LP	r p.m. LPN-B stated she was en area in her nursing shift get my sheet." LPN-B returned nute later and stated "I did not wn I guess. I talked to R20 todayer. I told her 'it is red, and I do ssure.' She refused to be ch she does frequently, and I ctors order to be weighed daily, LPN-B stated she did view the sh was described to her as a vercular shapes, that crossed liscussion was had about what 'N-B stated she does get hot, neat rash, I didn't notice it today, ook."	у				
	(DON) stated "Ly	6 p.m. the director of nursing will need to review the ack of documentation that you and wounds)."	***************************************				
	document on the	:25 a.m. NA-A stated she did no e skin assessment sheet becaus ficial bath day. But she did tell th not a new wound, it has looked	se i			and the same of	

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(X3) DATE SURVEY

STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED
		245387	B. WING			07/	10/2015
	ROVIDER OR SUPPLIER			291	EET ADDRESS, CITY, STATE, ZIP CODE 2 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411		<b>Y</b>
(X4) ID PREFIX TAG	VENCH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
F 314 F 323 SS=D	that it had been he book.  The Pressure Ulcomanagement police 9/13/11, indicated prevention, identife documentation of wounds. Avoidable presoresident develope facility did not donevaluate the pressure ulcer risolefine and inconsistent with reand recognized solution and interventions; and revise the interventions; and revise the interventions and interventions.	that." The NA-A was not aware ealed according to the wound ers/Skin integrity/Wound by dated 4/1/08, and last revised: A system is in place for the ication, treatment, and pressure and non-pressure sure ulcer means that the ed a pressure ulcer and that the one or more of the following: resident's clinical condition and ek factors; mplement interventions that are esident needs, resident goals standards of practice; evaluate the impact of the dor interventions as appropriate.  OF ACCIDENT ERVISION/DEVICES  ensure that the resident mains as free of accident hazards		= 323			
	as is possible; at adequate super prevent accident	nd each resident receives vision and assistance devices to ts.					
	by: Based on obse	MENT is not met as evidenced rvation, interview and document by failed to failed to ensure a lice was utilized in a safe manne					

		& MEDICAID SERVICES	(Y2) MI II	TIPI F	CONSTRUCTION	(X3) DATE	SURVEY
TATEMENT	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	PLETED
		245387	B. WING			07/	10/2015
	ROVIDER OR SUPPLIER	245367		S'	TREET ADDRESS, CITY, STATE, ZIP CODE 912 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411	ON	(X5)
(X4) ID PREFIX TAG	CAOU DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	~D BF	COMPLETION DATE
F 323	addition, the facilit toilet were in good resident (R24) and maintained in a saresidents (R24, R Findings include:  Mechanical lift: On 7/8/15, at 7:5 morning cares. R nursing assistant washed R5's upproving the leggeneeded much en of bed. R5 was of the chair, just geout during all mopositioned in from R5 put her hand secured the stra R5 appeared vel'm scared." NAto calm R5. R5 stand" and arms EZ stand with heappeared distre NA-G was able transferred R5 time R5 immediately on 7/9/15, at 7: a wheelchair, w Staff stated R5 morning cares at 9:08 a m for the color of the calm R5.	(R5) reviewed for accidents. In y failed to ensure grab bars in governating condition for 1 of 1 wheelchair armrests was afe operating manner for 2 of 2	e g pt f in	323	Resident # 5 has a new comprehensive assessment completed relate her decline in transfers and mobility and significant chan MDS has been completed.  Any residents a Olaf Residence who uses a mechanical dev for transfer will the transfer completed in a manner.  Nursing staff we ducated on pruse of mechan lifts for resider transfers. Nurs staff should re any change in resident transfability to unit so new assess and proper equipment ca implemented.	ed to  ge  t St. (SOR)  fice have safe  fill be coper ical it sing port  fer nurse sment n be	

CHIVILI	10 TOTT WILD TOTTIL					WO DATE	יייייייייייייייייייייייייייייייייייייי
STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245387	B. WING			07/	10/2015
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				12 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	bipolar disorder, in pain) and obesity i Resident Admissio	cluded paranoid schizophrenia, continence, lumbago (low back ndicated on the undated on Record.	F	323	<ul> <li>DON/Designee to check 24 hour be and review for a changes in resident transfers and mobility change</li> <li>DON/designee to check the properties of the prop</li></ul>	oard ny dent s.	
	indicated R5 used limitations, was at gait, transferred in assist as needed.  R5's care plan dat independent with I [wheelchair] locon distance (a few ste	sessment (CAA) dated 1/6/15, a wheelchair, had physical risk for falls due to unsteady dependently and for staff to ed 1/9/15, indicated R5 was ped mobility, transferring, w/c notion, walks very short eps) with unsteady gait and al assist with wheelchair	A Company of the Comp	ALAMA NA	audit to monitor compliance 2x a week for one m then once week two months, or directed by QA.  Findings of aud be reviewed at Q month x 3.  Completion dat August 19, 201  Resident 24 and	r a onth, ly for as A. lit will QAA e by:	
	4/7/15, indicated fimpairment, was itransfers, and wall Review of physician indicated R5 was gets around in a way	mum Data Set (MDS) dated R5 had moderate cognitive independent with bed mobility, king.  an progress notes dated 6/4/15, very limited in her ambulation, wheelchair due to chronic DJD at disorder] of the knees and	A CONTRACTOR OF THE CONTRACTOR		experienced no negative effects the deficient properties to be affected by the deficient praction of Resident #24's aluminum grate	s from actice. ave the ce.	
	LPN-A stated the can get R5 up wh hollers more with they tried the Hoy work.	ew on 7/8/15, at 8:01 a.m., EZ stand was the only way they ich she generally refuses but the hoyer. LPN-A further stated er awhile ago and it did not	NATIONAL PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPE		was secured to bathroom wall maintenance o 9, 2015.	by	
	During an interview stated the Hoyer	ew on 7/8/15, at 8:08 a.m., NA-C tipped over one time. R5 was	i				17 17 17

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	COMP	PLETED
		245387	B. WING			07/1	0/2015
	PROVIDER OR SUPPLIER RESIDENCE			29	REET ADDRESS, CITY, STATE, ZIP CODE 12 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	down and that is wistated she was told legs were from whe stated it takes two will fight them, will so they could wash she was in the bed NA-G verified R5 with stand, stating "we maybe they need ton't know." NA-G nursing assistant to R5 was assist of two one for wheelchair During an interview stated R5 will fight does let staff compaudit should be co 7/4/15 R5 refused not done. LPN-A stated the EZ stand and it and she cooperate works well."  During an interview LPN-A furthe Hoyer never the transfer R5, just to she fell. LPN-A furthe Hoyer never the transfer herself from this."  During an interview stated R5 was now changing it yesterd	time, so she was lowered hy they don't use it. NA-G if the bruises on her arms and en R5 recently fell. NA-G or more staff to help R5, she not let them roll her to the front in her back and bottom when it, so they use the EZ stand. If was slipping out of the EZ report it, they are aware of it, to get a different EZ stand, I then showed surveyor the reatment sheet which indicated we for transfers and assist of		323	<ul> <li>The brown and black matter around the bottom of the grab bar (where it meets the tile) was cleaned and sanitized by housekeeping on July 9, 2015.</li> <li>Wheelchair armrests will be repaired or replaced for residen 24, and 46 by completion date of August 19, 2015.</li> <li>In addition to the maintenance repair logs at each nursing station for notification to maintenance of needed repairs, maintenance will all conduct five weekly environmental room audits that include wheelchair preventative maintenance and safety review.</li> <li>Maintenance will maintain these records for a period of 12 months.</li> </ul>	so 'n	

STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		SURVEY
		245387	B. WING			the state of the s	0/2015
	PROVIDER OR SUPPLIER  F RESIDENCE			291	EET ADDRESS, CITY, STATE, ZIP COD 2 FREMONT AVENUE NORTH INEAPOLIS, MN 55411	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	are assessed by the The assessment for LPN-A stated "it wit."  - At 8:13 a.m. LPN and was requestined to the At 8:21 a.m. DON assessed by physical deemed not safe to use the Hoyer.  - At 9:31 a.m. the stated there is no stand and that nuruse of the Hoyer in the the the the there is the stated there is no stand and that nuruse of the EZ stand and the there is no stand and that nuruse of the EZ stand for the passessment. PTD use of the EZ stand for the passessed for the passessed for EZ stand for	age 48 herapy for use of the EZ stand. or the EZ stand was requested. as before my time, I will look for I-A stated he could not find it g medical records to look for it. N further stated R5 was ical therapy yesterday and o use the EZ stand so staff now physical therapy director (PTD) assessment to use the EZ rsing or therapy can change to f transfers are unsafe, but that rders for the EZ stand stated "I didn't know about the nd, we never recommended it." A-H stated they have used the hast two to three weeks and that ng, "we told the nurses." D stated they have always stand safety but do follow what stated for transfers.  ew on 7/10/15, at 8:56 a.m.		323			
	I PN-A stated the	nursing assistant care sheet fo , indicated to use the EZ stand	<b>F</b>	-			
	dated 4/1/2008 di in lift use and saf according to mar	ility policy, Lift - Sit to Stand irected that staff must be trained ety precautions and transfer aufacture direction guidelines. It direction for assessment of use.	d				
	Grab bar: On 7/6/15, during aluminum grab b	g room observation R24's ar on right side of toilet was not	i .				

PRINTED: 08/04/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CO	ONSTRUCTION	(X3) DATE COMP	LETED
		245387	B. WING				0/2015
	ROVIDER OR SUPPLIER	2.000.		2912	ET ADDRESS, CITY, STATE, ZIP CO FREMONT AVENUE NORTH NEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 323	forth and had brow bottom of grab ba  During an environ p.m. the maintena would come back regional manager housekeeping wo bathroom and stacleaning.  R24 was admitted diagnoses of hypand leg amputation Care Area Asses dated 7/3/14, indivaried from indepindicated R24 has amputation (LBK needed. CAA incassist with toileti R24 was at risk psychotropic mediagendent with (ADL's) which in dress, bathe, an wheelchair and required set up	it was loose, moved back and wh/black matter around the rewhere it met the tile.  mental tour on 7/8/15, at 1:00 unce manager (MM) stated he to re-anchor the grab bar. The housekeeping (RMH) stated uld clean and disinfect the life would be re-educated on to the facility on 6/25/14, with ertension, urinary incontinence on below the knee.  sment (CAA) analysis of finding icated R24's level of assistance bendent to assist of one. CAA and new left below the knee.  A), staff was to assist as licated R24 directed staff to ng. In addition CAA indicated for falls related to usage of dication and new LBKA.  2/13/15, indicated R24 was a all activities of daily living accluded ability to transfer, toilet, and move around corridor with walker with prosthetic and as requested.	, gs	323	DON/design audit to more compliance week for one then once we two months directed by Findings of will be revise QAA Q mone Completion August 19,	nitor 2x a e month, reekly for , or as QAA. audits ewed at oth x 3.	
	supervision, set and corridor. M	Pata Set (MDS) dated 3/30/15, was cognitively intact, required up help only for walking in roo DS also indicated R24 was not able to stabilize without staff moving from seated to standing					A A A A A A A A A A A A A A A A A A A

PRINTED: 08/04/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

245387  NAME OF PROVIDER OR SUPPLIER  ST OLAF RESIDENCE  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  2912 FREMONT AVENUE NORTH  MINNEAPOLIS, MN 55411	(X5) COMPLETION
2912 FREMONT AVENUE NORTH	(X5) COMPLETION
	(X5) COMPLETION
(X4) ID PRÉFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRÉCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
F 323 Continued From page 50 position, walking, and turning around and had lower extremity impairment on one side.  Wheelchair armrest: R24's wheelchair armrest on the right side was missing a large area of cushion which exposed the top of a screw on the right armrest right where the resident's arm would have been placed.  During an environmental tour on 7/8/15, at 1:00 p.m. the maintenance manager (MM) stated he would replace the armrest.  Care Plan dated 2/13/15, indicated R24 was independent with all activities of daily living (ADL's) which included ability to transfer, toilet, dress, bathe, and move around corridor with wheelchair and walker with prosthetic and required set up as requested.  R46's wheelchair was observed on 7/7/15, at 9:25 a.m. to have right armrest missing.  During an environmental tour on 7/8/15, at 1:00 p.m. RMH verified and stated he would get a replacement.  R46 was admitted to the facility on 5/28/14, with diagnosis of dementia, hemiplegia or and hemiparesis obtained from the quarterly MDS dated 6/11/15. In addition the MDS indicated R46 required extensive one person assist with bed mobility and activities of daily living and required extensive assist of two with transfers. R46's previous MDS dated 3/12/15, indicated R46 had moderate impaired cognition.  On 7/8/15, at 2:25 p.m. housekeeping site	

TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245387	B. WING			07/1	0/2015
	ROVIDER OR SUPPLIER			29	REET ADDRESS, CITY, STATE, ZIP CODE 12 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) GOMPLETION DATE
F 323	any of the environment indicated he wanter retrain them. HSS room and saw a puthe maintenance lestation. HSS state and every month of week.  - At 2:42 p.m. MM maintenance probects of the control of the	stated they were not aware of mental problems observed and ed to meet with his staff to also stated if staff went into a roblem, they were to record it in og located on each floor's nurse d he checked logs twice a day, did spot checking, one floor per stated he relied on logs to get elems fixed.  La.m. MM stated he did not environment unit spot checks. I indicated they had preventative at had no logs or documentation elicy revised 2/14, indicated they to promote safety, dignity, and ife for its residents by providing that is free from any hazards for		323			
F 329 SS=E	appropriate super prevent avoidable indicate who was resident care equ promote safety. 483.25(I) DRUG	has control and by providing rvision and interventions to accidents." The policy did not responsible for ensuring alipment was in good repair to REGIMEN IS FREE FROM DRUGS		F 329			
	unnecessary dru- drug when used duplicate therapy without adequate	drug regimen must be free from gs. An unnecessary drug is any in excessive dose (including y); or for excessive duration; or e monitoring; or without adequat s use; or in the presence of	-				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE COMF	SURVEY
		245387	B. WING			07/1	0/2015
NAME OF F	PROVIDER OR SUPPLIER	,		SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	should be reduced combinations of the Based on a compre resident, the facility who have not used given these drugs at therapy is necessa as diagnosed and crecord; and resider drugs receive grad behavioral intervent contraindicated, in drugs.  This REQUIREME by: Based on observation review, the facility is side effects for Ser 1 of 5 residents (Rimonitor adverse side (R41, R3), failed to pharmacist recomme (R41) and failed to for 1 of 5 residents unnecessary media.  Findings include:  R37 did not received.	nces which indicate the dose or discontinued; or any e reasons above.  The hensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical nts who use antipsychotic ual dose reductions, and ations, unless clinically an effort to discontinue these  NT is not met as evidenced tion, interview and document failed to ensure monitoring of traline (an antidepressant) for 37). In addition, facility failed to de effects for 2 of 5 residents of follow through with mendations for 1 of 5 residents implement a physician order (R46) reviewed for		329	Resident #37, #41, and #3 have had a medication review consultant pharmacist, documentation of side effects and adverse reactions monitoring are in place. Completion date: August 11, 2015. Residents #: #41, and #3 did no experience any negative effects from this deficient practice.  Any resident receiving an antidepressant or antipsychotic has the potential to be affected by the deficient practice.  Other residents the are receiving psychotropic medications are being monitored for side effects.  Licensed nurses a TMA's will be educated on unnecessary drug policy.  DON/designee will audit to monitor compliance 2x a	37, t om i- at	
and the second	at 8:08 a.m. to 10:0	ou a.m. H3/'s was observed			compliance 2x a		

PRINTED: 08/04/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '			TE SURVEY MPLETED	
		245387	B. WING			10/2015	
	PROVIDER OR SUPPLIER FRESIDENCE			STREET ADDRESS, CITY, STATE, ZIP C 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	ODE		
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F 329	would go into room food.  On 7/9/15, at 8:08 asked about his m stated he was stabneither a parasite. all the medications  R37's psychotropic Assessment (CAA received an antide diagnoses of depradminister medication effectiveness at R37's psychotropic 12/30/14, indicate antidepressant rel The care plan dire medication per ordeffectiveness and R37's diagnoses in depression obtain Data Set (MDS) diagnoses in depression obtain Data Set (MDS) diagnoses in depression obtain Data Set (MDS) diagnoses in depression.  On 7/9/15, at 10:0 when asked if she R37 and she knew stated she worked out the call light of the stated she worked out the stated she worked ou	a.m. when approached and edications and his mood R37 ble, was not flying high and was R37 indicated he was aware of the has currently taking.  It drug use Care Area blood to the ession and directed staff to attions per orders and monitor and or side effects.  It drug use care plan dated to R37 received an ated to diagnosis of depression ected staff to administer ders and to monitor for for side effects of medications.		week for one maken once week two months, on directed by QA  Findings of au will be reviewed QAA Q month  Completion day August 19, 20.  Pharmacy Recommendat for resident #4 been forward physician and physician has addressed the recommendate have had their recommendate forwarded to physician for up.  System for communicating pharmacist recommendate monitoring for up has been reviewed and revised.	kly for r as AA. dits ed at x 3. ate by: 15 tions 41 have to the ithe sions. Its with tions r tions the follow are follow are follow		

PRINTED: 08/04/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

NAME OF PROVIDER OR SUPPLIER  ST OLAF RESIDENCE    SUMMARY STATEMENT OF DEFICIENCIES   SIRECTADDRESS, CITY, STATE, ZIP CODE 2912 REMONT AVENUE NORTH MINNEAPOLIS, MN 55411   PREPIRE   SUMMARY STATEMENT OF DEFICIENCIES   PROVIDERS PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRECULATORY OR LSC DEMITTYMS INFORMATION)   PREPIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRECULATORY OR LSC DEMITTYMS INFORMATION)   PROVIDER PLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY   CANCER OF THE APPROPRIATE DEFICIENCY   C	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE	SURVEY	
STREET ADDRESS, CITY, STATE, ZIP CODE 2912 PREMONT AVENUE NORTH MINNEAPOLIS, MN S5411  PREFIX TAGS  F 329 Continued From page 54 and in fact he made her laugh at times and did not have any problems with behaviors and stayed in his room most of the time.  On 7/9/15, at 10:15 a.m. licensed practical nurse (LPN)-A went through the medical record showed surveyor June 2015 Treatment Administration Record (TAR) sheets which had side effect monitoring. When asked to show July TAR side effects documentation LPN-A stated the would be in the nurses Treatment book10:18 a.m. LPN-A went through R37's TAR and the Medication Administration Record (MAR) verified R37' did not have documentation to both records where side effects were being monitored. LPN-A stated he would add it and thought someone may have forgotten to add it to the July TAR.  On 7/9/15, at 1:49 p.m. the consultant pharmacist (CP) stated she would have expected the facility to do some kind of documentation of side effects monitoring. When shown a copy of the side effects monitoring the facility used she stated the facility was supposed to follow the facility policy. She further stated she had done the last review in mid-June and was yet to do this month and would have caught the irregularity.  On 7/9/15, at 9:48 a.m. the director of nursing (DON) stated the orders were printed by Merwin Pharmacy and then the nurse did a first and second check to ensure everything was there. DON acknowledged the side effect monitoring should have been in place.	AND PLAN O	F CORRECTION	INEIAT ILIOVI IQIA IAOMINELI.	A. BUILD	IIYG			
ST OLAF RESIDENCE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPRICENCY WILST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 329  Continued From page 54 and in fact he made her laugh at times and did not have any problems with behaviors and stayed in his room most of the time.  On 7/9/15, at 10:15 a.m. licensed practical nurse (LPN)-A went through the medical record showed surveyor June 2015 Treatment Administration Record (TAR) sheets which had side effect monitoring. When asked to show July TAR side effects documentation LPN-A stated it would be in the nurses Treatment book10:18 a.m. LPN-A went through R37's TAR and the Medication Administration Record (MAR) verified R37 did not have documentation in both records where side effects were being monitored. LPN-A stated he would add it and thought someone may have forgotten to add it to the July TAR.  On 7/9/15, at 1:49 p.m. the consultant pharmacist (CP) stated she would add it and thought someone may have forgotten to add it to the side effects monitoring the facility used she stated the facility was supposed to follow the facility policy. She turther stated she had done the last review in mid-June and was yet to do this month and would have caught the irregularity.  On 7/9/15, at 9:48 a.m. the director of nursing (DON) stated the orders were printed by Merwin Pharmacy and then the nurse did a first and second check to ensure everything was there. DON acknowledged the side effect monitoring should have been in place.			245387	B. WING		DEST ADDRESS CITY STATE 7IP CODE	THE RESERVE OF THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAME	0/2015
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R41 did not receive adequate monitoring for adverse side effects for the use of olanzapine	F 329	and in fact he made not have any probin his room most of the control of the contr	de her laugh at times and did lems with behaviors and stayed of the time.  5 a.m. licensed practical nurse rugh the medical record showed to Treatment Administration eets which had side effect asked to show July TAR side ation LPN-A stated it would be innent book.  A went through R37's TAR and diministration Record (MAR) not have documentation in both de effects were being monitored would add it and thought are forgotten to add it to the July of documentation of side effects in shown a copy of the side gother facility used she stated the osed to follow the facility policy. It is a syet to do this month and wou irregularity.  By a.m. the director of nursing the orders were printed by Merwing the nurse did a first and the ensure everything was there. It is also the side effect monitoring the in place.	n st s e in ld	329	nurses and TMA's related to facility expectations for communication related to pharmare recommendations and follow up with physician.  DON/designee will audit to monitor compliance 2x a week for one more then once weekly two months, or an directed by QAA. Findings of audit will be reviewed QAA Q month x and Completion date August 19, 2015. Resident #46 or for trazodone has been clarified with physician and River receiving medications according to physician order. Orders for othe residents are transcribed accurately duriend of month changeover of	cy s h II  nth, / for s at 3. by: ders ave ith R46 is	

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _			
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F 329	R41 had an order orally at bedtime, (Celexa-antidepre daily, mirtazapine mg one tablet oral (antidepressant) 5 bedtime as neede (Ativan-antianxiety tablet orally three tablet orally every R41's psychotrop 3/4/15, indicated medication due to anxiety and direct and to monitor for R41's psychotrop 3/8/15, indicated medication, direct medication per pleffectiveness of reflectiveness of reflectiveness of documentation completed.  R41's diagnoses disorder obtained 6/3/15.	ders dated 7/31/14, revealed for olanzapine 5 mg one tablet citalopram ssant) 20 mg one tablet orally (Remeron-antidepressant) 15 ly at bedtime, Trazodone of mg one tablet orally at dand lorazepam of old mg one tablet orally at dand lorazepam of old mg one tablet orally one times daily and 0.5 mg one four hours as needed (PRN). It medication use CAA dated R41 received psychotropic of diagnosis of depression, and effectiveness in drug use care plan dated R41 received psychotropic ted staff to administer per order order of the medication and side effects. It is psychotropic side effects and effectiveness in the diagnosis of depression order and to monitor for medication and side effects. It is psychotropic side effect of the may and June 2015 that is by [blood pressure] every down the record lacked evidence of that orthostatic by swere included depression and anxied of from the quarterly MDS dated	ty	329	Licensed nurses TMA's have been educated in regat to transcription of discontinued mediand monthly changeover of medication sheef DON/designee waudit to monitor compliance 2x a week for one modes then once weekly two months, or a directed by QAA Findings of audit be reviewed at C Q month x 3. Completion date August 19, 2015	rds f f ds ss. iill nth, y for ss t will AAA	
	to Nursing dated	ultant Pharmacist Communication 6/16/15, indicated side effect obstatic BP) needed to be	J11		Facility (D: 00260 ) If COD	tinuation she	

PRINTED: 08/04/2015

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 07/10/2015 B. WING 245387 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 ST OLAF RESIDENCE PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES PREFIX DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PRÉFIX DEFICIENCY) TAG F 329 Continued From page 56 F 329 completed according to the physician's order to monitor side effects. On 7/8/15, at 8:25 a.m. R41 was observed lying in bed sleeping with parenteral (intravenous) nutrition hooked up to her hanging next to her bed. On 7/8/15, at 12:30 p.m. R41 was observed lying in bed, dressed with shoes on. R41 stated she had a nice lunch, "it was very good." On 7/9/15, at 8:50 a.m. LPN-D verified orthostatic BP's should be completed as ordered, "they should be done by the nurses." - At 1:54 p.m. the DON stated she expected staff to follow facility policy and/or physician orders for orthostatic blood pressures. - At 2:09 p.m. the CP stated she noted last months orthostatic blood pressure were not done, and had emailed recommendations to nursing reminding them. "I would expect that they complete them." R3 did not receive adequate side effect monitoring for the use Seroquel (Quetiapine Fumarate-used depression). On 7/8/15, at 7:24 a.m. R3 was observed in dining room watching television and no behaviors were noted at that time.

R3 was admitted to the facility on 2/21/12, admission diagnoses included schizo-affective, delusional disorder and vascular dementia.

The Physician Orders dated 11/8/13, indicated R3 had Seroquel 300 mg, two tablets at bedtime and

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		245387	B. WING			07/1	0/2015
	ROVIDER OR SUPPLIER			291	REET ADDRESS, CITY, STATE, ZIP CODE 2 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411		
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F 329	depression) 500 m The CAA analysis indicated R3 was of with treatable med disease and had in transitions.  Care plan dated 3 antipsychotic med schizoaffective and risk for falls related psychotropic med assist with transfer.  The TAR for Aprill, reviewed. The recipiewed. The recipiewed as to be done for However, the treat June 2015 lacked of the monthly or for side effects from A review of the corect of medical revealed a requeressure.  On 7/9/15, at 8:5 reviewed treatments blood pressures.	obipolar disorder and manically, two tablets at bedtime.  of findings dated 11/12/14, on antipsychotic medication lical condition such as heart impaired balance during  ///15, indicated R3 received lication related to dippolar disorders. R3 was at door to impaired mobility and lication use evidenced by total ers.  May and June 2015 was cord also included "orthostatic re] every month lie/sit/stand" or side effect monitoring. Interest record for April, May, and dof evidence of documentation thostatic BP's being monitored form the antipsychotic medication consultant pharmacist monthly tion regimen dated 6/16/15, st for an orthostatic blood  5 a.m. when asked LPN-A ent sheets where orthostatic were supposed to be		329			
	being monitored/ June. On 7/9/15, at 2:4	confirmed that they were not documented in April, May and Documented in Ap	A CONTRACTOR OF THE CONTRACTOR				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED	
		245387	B. WING			07/	10/2015
	PROVIDER OR SUPPLIER FRESIDENCE			2	TREET ADDRESS, CITY, STATE, ZIP CODE 912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411	Americanistical	
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F 329	side effects after a pressures were on expected to be don when she looked by recommendation that treatment sheet but On 7/9/15, at 1:54 process for orthostate orders for orthostate The unnecessary depolicy dated 4/1/08"5. Monitor side of resident experience status, it may be a side indicated." In additious Drugs-Antipsychotic directed staff to moside effects of the assertion of the side effects of the side of the side effects of the side	uld be general to monitor for fall. Orthostatic blood treatment sheets and e. CP noted in June 2015 ack at May 2015 sheet, made they be done. They were on the monitoring was omitted.  D.m. DON stated she expected y policy and/or physician		329			
	from Cardinal Healingatients would be a hypotension (a fall in changing positions) orthostatic hypotentoressure) associated and, in some patienthe initial dose-titratits adrenergic antaghypotension, dizzin loss of consciousne pressure) may lead	s package insert for Seroquel th dated 5/2/13, indicated at risk for orthostatic in blood pressure when a "Quetiapine may induce sion (form of low blood and with dizziness, tachycardia arts, syncope, especially during tion period, probably reflecting gonist properties. Orthostatic ess, and syncope (temporary ess caused by a fall in blood to falls. Quetiapine should be caution in patients with					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X	3) DATE SURVEY COMPLETED
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F 329	myocardial infarction heart failure or concerebrovascular disconditions that affee the brain, causing I affected areas of the would predispose production, hypocanti-hypertensive of Failure to follow the recommendations of the Regimen Review in monthly medication 6/16/15, along with recommendations of the Recommendation of the production	allar disease (history of on or ischemic heart disease, duction abnormalities), sease (refers to a group of ct the circulation of blood to imited or no blood flow to be brain) or conditions which obtains to hypotension volemia and treatment with nedications)."  ough with pharmacist for R41:  Re Record of Medication andicated the CP had completed a reviews from 1/13/15 through any findings.  provided by the CP on 7/9/15, and indicated "her [R41] are Celexa 20 mg daily, Zyprexa emeron 15 mg at bedtime, at bedtime prn and Ativan 0.5 by & 0.25 mg prn. She receives and the Trazodone less a trial reduction of one of these propriate at this time? Or ingoing need for 2 elexa & Remeron) as well as eds (Remeron, Trazodone, it records revealed the ad never been forwarded to	F			
70.		on 7/9/15, at 10:54 a.m. the Consultant (HDC) verified				7 (2)

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		245387	B. WING			07/1	0/2015
	E OF PROVIDER OR SUPPLIER  DLAF RESIDENCE			2	TREET ADDRESS, CITY, STATE, ZIP CODE 912 FREMONT AVENUE NORTH AINNEAPOLIS, MN 55411		
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F 329	pharmacist on 4/15 letter from the phar was addressed."  During an interview CP stated she had review on 4/15/15 a Communication to CP stated she will ganswer and/or wou physician had been addressed immedia done so yet as R41 May.  Facility failed to imp R46: The Physician Order for CR41 had an order for ally every mornin tablets (20 mg) ora HCL 50 mg tab, 1/2 and Trazodone HC tab (25 mg) orally t 2:00 am.  R46's delirium and CAA dated 9/12/14 cognition in the pascognitive impairmemedication due to communication of the communication of the pascognitive impairmemedication due to communication of the communication of the pascognitive impairmemedication due to communication of the pascognitive impairmemedication of the pascognitive impairmemedication due to communication of the pascognitive impairmemedication of the pascognitive	nendations made by the 1/15, but "we can't find the macist and am not sure if it on 7/9/15, at 2:09 p.m. the completed her medication and a Consultant Pharmacist Nursing letter had been sent. give the physician 60 days to ld address it sooner if the in and/or if it needed to be ately. CP stated she had not had been in the hospital in olement a physician order for ers dated 7/31/14, revealed or olanzapine 10 mg one tablet g, olanzapine 10 mg, two lly at bedtime, Trazodone 2 tab (25 mg) orally at bedtime L 50 mg tab, may repeat 1/2 imes one as needed before psychotropic medication use, indicated R46 had changes in st quarter, had moderate nt and used psychotropic depression, anxiety and	TO THE TAX A PART OF THE TAX A	329			
711/A	administer medicat monitor for effective notify physician of o	The CAA directed staff to tions per physician orders and eness and side effects and changes.  ted 9/16/14, indicated R46 was	and the same of th				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 329	Prozac (antidepres medication effective Meview of a Consu Communication to indicated "her [R46 10 mg twice daily a bedtime, may reperused the repeat do Trazodone to 25 m to evaluate ongoing contra-indications to response to recommindicated "DC [discommedicated "DC [discommedicated "DC [discommedicated "DC [discommedicated the medication reviews 6/16/15, along with recommendations/ noted in November none for 1/13/15 the Review of the MAF scheduled Trazodome dose with R46's diagnoses in depression obtained atted 6/11/15.  On 7/8/15, at 8:14 pushed in a wheeled	depressant), Zyprexa, and sant) and to monitor for eness and side effects.  Itant Pharmacist Physician dated 9/16/14, if medications include Zyprexa and Trazodone 25 mg at at X 1 [times one]. She has not se. Could a reduction of g at bedtime prn sleep be tried g need? or please document to such and attempt." Physician mendation signed 11/18/14, continue] scheduled trazodone & keep prn as written." The 13/15, by nursing.  Ord of Medication Regimen the CP had completed monthly is from 10/14/14 through any findings. An irregularity was and December 2014, but		329			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	1		E SURVEY PLETED
		245387	B. WING		07/	10/2015
	PROVIDER OR SUPPLIER  RESIDENCE		·	STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	7/9/15, at 8:20 a.m. her wheelchair in he On 7/9/15, at 12:59 physician order was been addressed un on the MAR in Marc verified R46 had be trazodone medicatic error, it is what it is.	ungry for breakfast. On R46 was observed sitting in er room singing loudly.  p.m. LPN-F verified the es signed 11/18/14, had not til 1/13/15, and then "put back th for some reason." LPN-F en receiving the scheduled on, and stated "It's a med"	F 32	9		
	asked for a Trazodo November and Dec "got done" in Janua as PRN Trazodone, usually check the M Review of the facilit Drugs-Antipsychotic directed staff to moside effects of the a					
F 332 SS=D	483.25(m)(1) FREE RATES OF 5% OR  The facility must en medication error rat  This REQUIREMEN by: Based on observat review, the facility fa		F 33	2		
n vm2+/-	review, the facility fa	ailed to ensure residents were	-			

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	l` ′		E CONSTRUCTION		PLETED
		245387	B. WING			07/	10/2015
	PROVIDER OR SUPPLIER FRESIDENCE			29	TREET ADDRESS, CITY, STATE, ZIP CODE 912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 332	admission diagnos spinocerebellar dis adult failure to thriv communicate with The quarterly Minin 4/15/15, indicated minimally depression assist of two staff and extensive assist of two staff and extensive assist of daily like. The annual Care A 1/14/15, indicated for hydration, tube. On 7/9/15, at 9:30 administration via Licensed practical hand hygiene, che tube with an air buthen administered prepared omepraze medication, Senna carvadopa/levodop Parkinson like synwithout fluid flush and Jevity 1.5 8 oz they give a 60 Milliand a 60 ml flush (ml), as part of the the day. LPN-B ve between individua	to the facility 2/24/11, with his of quadriplegia, aphasia, sease (gun shot wound), and ve. R28 was able to a talking computer.  mum Data Set (MDS) dated R28 was cognitively intact, ed, and required extensive for bed mobility, and transfers; st of one staff for all other ving.  Area Assessment (CAA) dated R28 was dependent upon staff feeding and medications.		332	Resident #28 was assessed and had ill effects from thi deficient practice.  There are current no other residents the facility that arreceiving medications throughout the facility that arreceiving medications throughout the facility that arreceiving medications throughout the facility that arreceiving medication on tube feeding medication on tube feeding medication administration polymers.  DON/designee with audit to monitor compliance 2x at week for one monther once weekly two months, or a directed by QAA.  Findings of audit will be reviewed QAA Q month x 3.  Completion date August 19, 2015	s y y s at e ugh on blicy. II nth, y for s s at	

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	245387	B. WING			07/1	0/2015
PROVIDER OR SUPPLIER RESIDENCE			29	912 FREMONT AVENUE NORTH		,
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
On 7/9/15, at 11:23	a.m. the director of nursing	F3	32			
in-between medica standard of practice	tions, since that was the e.	NAME OF THE PROPERTY OF THE PR			provides successful and	
Medications dated 2/15/13, lacked the	4/1/08, and last revised current standard of practice	All the state of t			The transfer of the second	
dated 4/1/08, indica administer all media safe and effective r 483.25(m)(2) RESI	ated It is the facility's policy to cations and treatments in a manner.  DENTS FREE OF	F 3	333			
		The state of the s				
by: Based on observative review the facility fa	tion, interview and document ailed to ensure 1 of 3 residents	The state of the s				
Findings include:						
(LPN)-E administer units" with dinner a "total of 26 units of not allow dry time for the swab and then insulin, LPN-E then	red "scheduled Novolog 14 nd sliding scale 12 units for a Novolog insulin." LPN-E did or the alcohol skin prep, used immediately injected the a took off her gloves, and					
	PROVIDER OR SUPPLIER  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From pa  On 7/9/15, at 11:23 (DON) verified she in-between medical standard of practice  The Gastrostomy T Medications dated a 2/15/13, lacked the for medication adm  The Medication Adr dated 4/1/08, indical administer all medic safe and effective in 483.25(m)(2) RESI SIGNIFICANT MED  The facility must en any significant med  This REQUIREMEN by: Based on observation review the facility fa (R14) was free of in  Findings include:  On 7/6/15, at 5:44 p (LPN)-E administer units" with dinner an "total of 26 units of not allow dry time fo the swab and then insulin. LPN-E then	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 64  On 7/9/15, at 11:23 a.m. the director of nursing (DON) verified she would expect flushes in-between medications, since that was the standard of practice.  The Gastrostomy Tube-Administration of Medications dated 4/1/08, and last revised 2/15/13, lacked the current standard of practice for medication administration via tube feeding.  The Medication Administration from a Cart policy dated 4/1/08, indicated It is the facility's policy to administer all medications and treatments in a safe and effective manner. 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 3 residents (R14) was free of insulin medication errors.	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 64  On 7/9/15, at 11:23 a.m. the director of nursing (DON) verified she would expect flushes in-between medications, since that was the standard of practice.  The Gastrostomy Tube-Administration of Medications dated 4/1/08, and last revised 2/15/13, lacked the current standard of practice for medication administration via tube feeding.  The Medication Administration via tube feeding.  The Medication Administration from a Cart policy dated 4/1/08, indicated It is the facility's policy to administer all medications and treatments in a safe and effective manner.  483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 3 residents (R14) was free of insulin medication errors.  Findings include:  On 7/6/15, at 5:44 p.m. licensed practical nurse (LPN)-E administered "scheduled Novolog 14 units" with dinner and sliding scale 12 units for a "total of 26 units of Novolog insulin." LPN-E did not allow dry time for the alcohol skin prep, used the swab and then immediately injected the insulin. LPN-E then took off her gloves, and	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 64  Con 7/9/15, at 11:23 a.m. the director of nursing (DON) verified she would expect flushes in-between medications, since that was the standard of practice.  The Gastrostomy Tube-Administration of Medications dated 4/1/08, and last revised 2/15/13, lacked the current standard of practice for medication administration via tube feeding.  The Medication Administration from a Cart policy dated 4/1/08, indicated It is the facility's policy to administer all medications and treatments in a safe and effective manner.  483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 3 residents (R14) was free of insulin medication errors.  Findings include:  On 7/6/15, at 5:44 p.m. licensed practical nurse (LPN)-E administered "scheduled Novolog 14 units" with dinner and sliding scale 12 units for a "total of 26 units of Novolog insulin." LPN-E did not allow dry time for the alcohol skin prep, used the swab and then immediately injected the insulin. LPN-E then took off her gloves, and	ROUNDER OR SUPPLIER  245387  3. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411  SUMMARY STATEMENT OF DEFICENCIES (EACH DEFICIENCY MUST BE PRIECCED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 64  On 7/9/15, at 11:23 a.m. the director of nursing (DON) verified she would expect flushes in-between medications, since that was the standard of practice.  The Gastrostomy Tube-Administration of Medications dated 4/1/08, and last revised 21/5/13, lacked the current standard of practice for medication administration via tube feeding.  The Medication Administration irom a Cart policy dated 4/1/08, indicated it is the facility's policy to administer all medications and treatments in a safe and effective manner.  483.26(m/2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 3 residents (R14) was free of insulin medication errors.  Findings include:  On 7/6/15, at 5:44 p.m. licensed practical nurse (LPN)-E administered "scheduled Novolog 14 units" with dinner and sliding scale 12 units for a "total of 26 units of Novolog insulin." LPN-E did not allow dry time for the alcohol skin prep, used the swab and then immediately injected the insulin. LPN-E then took of ther gloves, and	### PROVIDER OR SUPPLIER  ### 245397  ###

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STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245387	B. WING				0/2015	
	PROVIDER OR SUPPLIER  RESIDENCE			2912	EET ADDRESS, CITY, STATE, ZIP COD 2 FREMONT AVENUE NORTH INEAPOLIS, MN 55411	E		
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 333	tipped it in without when the alcohol s medications it was of Novolog insulin Novolog administed R14 was admitted re-admission 11/2 cerebrovascular a (inability to use the mellitus, periphera insufficiency.  The annual Care / 3/18/15, indicated had minimal depression decision making staff for bed in and extensive asswas totally dependent one staff for toilet extensive assistatione staff for toilet extensive assistation administration provided (onli provided).  On 7/9/15, at 10::	gloves. R14 did not complain awab was used. While checking noted that the scheduled dose was 12 units, and the total gred should have been 24 units. To the facility 8/5/02, with 5/14, with diagnoses including ecident with left hemiparesis at left side of the body), diabetes at neuropathy and renal.  Area Assessment (CAA) dated R14 was cognitively intact and ession. In addition the CAA uired extensive assistance of nobility, transfers, and toilet use sistance of one for dressing and dent on staff for locomotion.  Inimum Data Set (MDS) dated IR14 had no issues with a modified independence with skills and had no depression. The dR14 was totally dependent of the use, two staff for transfers, and noce of one staff for all other living (ADL).  On a.m. R14's face sheet and ation record were requested, but y oral medication sheets were	F	333	F333  Resident #14 is receiving insured by physical and a receiving insured could be affect this deficient practice. Consumer commendation or all residents receiving insured insulin administration.  Education proto licensed number of the compliance of the compliance of the compliance of the compliance of the concerve week for one of the concerve of the concerve of the concerve of the completion of the com	lin as ysician.  lin ted by sultant review ders for  lin. ovided urses on  a. e will tor ax a month, ekly for or as AA. udits yed at in x 3. late by:		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245387	B. WING		07/	10/2015
	PROVIDER OR SUPPLIER RESIDENCE		2	TREET ADDRESS, CITY, STATE, ZIP CO 912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 333	indicated Medication physician ordered a following profession licensed profession order to make sure and time of administ 483.35(i) FOOD PISTORE/PREPARE.  The facility must - (1) Procure food from the facility must - (2) Store, prepare, under sanitary considered satisfact authorities; and (2) Store, prepare, under sanitary considered satisfact authorities; and (2) Store, prepare, under sanitary considered satisfact authorities; and (2) Store, prepare, under sanitary considered sanitary considered sanitary considered on observation of the facility sanitation procedured possibility of food to potential to affect 3 served food out of equipment on the facility in the facility sanitation problem during the kitchen	stration policy dated 4/1/08, ons given by injection will be and will be administered and standards of practice by a nalCheck the physician's of the correct type, dosage, stration.  ROCURE, VSERVE - SANITARY  om sources approved or ctory by Federal, State or local distribute and serve food ditions  NT is not met as evidenced attion, interview and document failed to follow equipment res that would minimize the borne illness. This had the soon of 55 residents who were the kitchen and used the loors.  p.m. the following equipment is were observed and verified tour and the unit kitchenettes erved out of with the dietary	F 371		comes to en the to anitary vere t would f food have the ce ignee will cleaning or kitchen ire f will be i the tation	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTR			PLETED
		245387	B, WING			07/	0/2015
	PROVIDER OR SUPPLIER			2912 FREM	DRESS, CITY, STATE, ZIP CODE NONT AVENUE NORTH POLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (E CRC	PROVIDER'S PLAN OF CORRECT FACH CORRECTIVE ACTION SHOU DSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 371	The can opener sl base at end of the observed with dark that built-up above can opener was not cook had used it the head and stated "nand took a swipe of the blade and state up for staff to clear. The microwave in have heavy yellow spatters in the insiduor DSM asked through the window next to microwave during would have it clear. 3rd Floor Kitchene On 7/6/15, at 3:27 the 3rd Floor kitchene On 7/6/15, at 3:27 the 3rd Floor kitchene of a low stand the window next to microwave it was a food splashes, spamicrowave and he addition the toaste thick coat of bread-At 3:43 p.m. DSM covered with heav "Am not giving an but the residents hacknowledged the supposed to be more of the coat of the	the kitchen was observed to dried food splashes and de top and sides. During the se evening cook (C)-A if he had ted he had not used the his shift yet. DSM stated she ned.  Itte p.m. the microwave located on enette was observed seated on at the end of the kitchenette by the toaster. Upon opening the observed to have yellow red attered all over the inside of the avy build-up of food debris. In a was observed to have heavy derumbs built up.  I verified the microwave was y dried food debris. DSM stated excuse for it not being clean here are on the go." DSM microwave and toaster were aintained clean.  5 p.m., 7/8/15, at 2:12 p.m. observation the microwave with es, spattered inside the		771	<ul> <li>Dietary Service         Manager/designee         will audit to monite         compliance 2x a         week for one monithen once weekly         two months, or as         directed by QAA.</li> <li>Findings of audits         will be reviewed a         QAA Q month x 3.</li> <li>Completion date to the August 19, 2015</li> <li>The housekeeping staff of BSG         maintenance of         Green Bay Inc. wire clean dining and kitchenettes daily including equipm</li> <li>These areas will to the monitored by BSG supervisor/design on a daily basis a will be document on the temperature recording and cleaning log.</li> </ul>	or th, for t  y ent. pe G nee	

		OCCUPANTO OF TANCE IN	TIM (CX)	TIPI F	CONSTRUCTION	(X3) DATE	SURVEY
TATEMENT IND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING				LETED
		245387	B. WING			07/1	0/2015
	PROVIDER OR SUPPLIER	245301	<b>3.</b> 11.10		REET ADDRESS, CITY, STATE, ZIP CODE	) 01/1	0/2010
					12 FREMONT AVENUE NORTH		
ST OLAF	RESIDENCE			MI	NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 371	1st Floor Kitchener On 7/6/15, at 3:35 with DSM the microwave was 2nd Floor Kitchener On 7/6/15, at 3:38 refrigerator had m the door and on the microwave was areas including the refrigerator.  On 7/7/15, at 12:3 during a random or remained with dries patters inside.  On 7/7/15, at 12:3 during a random or remained with dries patters inside.  On 7/7/15, at 12:3 during the refrigerator.	age 68  Ite p.m. during the kitchenette tour owave was observed to have es spattered all over the inside with food debris. DSM verified is not kept clean.  Ite p.m. DSM verified the ultiple splashes of red juice on e bottom. In addition the overed with heavy yellow dried attered all over the inside. In asked who cleaned the floor and appliances DSM stated is responsible for cleaning the e microwaves and the  O p.m. and 7/8/15, at 7:17 a.m. observations the microwave ed yellow food splashes and  Sp. p.m. during a subsequent tour the microwave in the bserved to have heavy dried on hes, and spatter inside. DSM wave had not been cleaned as he initial kitchen tour on 7/6/15, ay cook (C)-B if she had used it she stated she had not used uring her shift. When asked who is passing a buck am going to and an ultimately am accountable	1	371	ED/designee will audit to monitor compliance 2x a week for one more then once weekly two months, or a directed by QAA.  Findings of audit will be reviewed a QAA Q month x 3.  Completion date August 19, 2015	for s s at 3.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245387	B. WING		07/-	10/2015	
	PROVIDER OR SUPPLIER  RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 425 SS=D	housekeeping verificated housekeeping verificated the house fridge, freezer and "we can add to it fo verified the bottom broken/cracked and be. In addition, he was red spills below the even though it had 7/6/15.  -At 8:53 a.m. the resurveyor stated he floors and verified to clean. He indicated deep cleaned that of the further stated he microwave cleaning pointed to the Temp Cleaning log.  Cleaning Instruction Oven, Refrigerators © 2010, directed stated after each be kept clean, sanificating least once every and leaks will be with to aster will be outside with detergat least once every and leaks will be with to aster will be outside with detergat least once will be with to aster will be outside with detergat least once every and leaks will be with to aster will be outside with detergat least once will be with to aster will be with the toaster will be outside with detergat least once were will be with the toaster will be with the toas	a.m. the regional manager of fied inside the microwave on ried food splashes and ried food splashes and red who was responsible for ment he showed surveyors a vall by the fridge which exceping staff cleaned the eye wash station. He stated in the microwave he also crispy drawer was dindicated maintenance would verified the refrigerator still had door seal of the fridge door been marked as cleaned since gional manager approached had gone through all the other he microwaves were not he was going to have them all day and daily moving forward. It would be adding the goto the empty column as he because Reading and saff "The can opener will be use. The microwave oven will tized and odor free. The washed thoroughly inside and ent and followed by a sanitizer month, or as needed. Spills ped up as they are noticed. Cleaned after each use."	VI				
			1				

		IDENTIFICATION NUMBER:	' '	NG	(X3) DATE SURVEY COMPLETED	
		245387	B. WING		07/	10/2015
	PROVIDER OR SUPPLIER FRESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 425	drugs and biologica them under an agre §483.75(h) of this punlicensed personn law permits, but on supervision of a lice. A facility must prove (including procedur acquiring, receiving administering of all the needs of each of the facility must erralicensed pharmacon all aspects of the services in the facility. This REQUIREMENTS.	ovide routine and emergency als to its residents, or obtain element described in part. The facility may permit nel to administer drugs if State ly under the general ensed nurse.  Ide pharmaceutical services es that assure the accurate ly, dispensing, and drugs and biologicals) to meet resident.  Imploy or obtain the services of cist who provides consultation e provision of pharmacy ity.	F 4	P425 Resident #51, #1 and #69 were assessed and ha not been affecte this deficit pract All residents receiving insulin could be affecte this policy and competency for licensed nurses insulin administration h been completed Education provi to licensed nurs insulin administration. DON/designee w audit to monitor compliance 2x a week for one mo then once week	ave d by ice. d by all r/t as ded es on	
	review, the facility f technique was used 3 of 3 residents (RS insulin administration Findings include: R51's injection was p.m. licensed pract Novolog (medication 5 units (U) insulin in cleaning the skin. V she was not injection	tion, interiview and document ailed to ensure proper d for insulin administration for 51, R14, R69) observed for on.  Tobserved on 7/6/15, at 5:30 ical nurse (LPN)-E injected in used to control blood sugar) into resident R51 without When asked how she insured ing staph or orther skin germs ous tissue LPN-E stated, "He		then once week two months, or directed by QAA Findings of aud will be reviewed QAA Q month x Completion date August 19, 2015	as as at at 3. by:	

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION DING		TE SURVEY MPLETED
		245387	B. WING		07	/10/2015
	PROVIDER OR SUPPLIER F RESIDENCE			STREET ADDRESS, CITY, STATE, ZI 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	P CODE	1012010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 425	has skin sensitive, Several residents of can prove it with Ranot let the alcohol of sting of the penetral sensative skin. LPN and carried the need R14's insulin injection 5:44 p.m. LPN-E at Novolog 14 U" with for a "total of 26 U onot allow dry time for the swab and then insulin. LPN-E then carried the needle to tipped it in without gwhen the alcohol swab and then injected the did not allow dry time LPN-E did ubut then injected the did not allow dry time LPN-E then took of needle to the sharp without gloves. R69 alcohol swab was under the did not allow dry time LPN-E then took of needle to the sharp without gloves. R69 alcohol swab was under the did not allow dry time LPN-E then took of needle to the sharp without gloves. R69 alcohol swab was under the did not allow the did not allow the to dry "evaporate" for the Insulin Adminis	and don't [sic] like alcohol. lon't like the alcohol swab. I 14." LPN-E verified she had dry to see if that reduced the ation of the needle on N-E then took off her gloves, adle to the sharps container. On was observed on 7/6/15, at dministered "scheduled dinner, and sliding scale 12 U of Novolog insulin." LPN-E did or the alcohol skin prep, used immediately injected the took off her gloves, and on the sharps container and gloves. R14 did not complain wab was used.  On was observed on 7/6/15, at ave R69 2 U of Novolog ise an alcohol swab for R69, is insulin immediately. LPN-E her for the alcohol skin prep. If her gloves, and carried the secontainer and tipped it in a did not complain when the sed.  O.m. LPN-E did verify that for the effective, it must have time from the skin.  a.m. the director of nursing distated, "I would expect		425		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245387	B. WING			07/1	0/2015
	PROVIDER OR SUPPLIER RESIDENCE			29	TREET ADDRESS, CITY, STATE, ZIP CODE 112 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 428 SS=D	angle  The Infection Control 4/1/08, indicated/ designed and implessafe, sanitary and of the transmission of distransmission of distransmis	er the insulin at a 90 degree rol (General) policy dated An infection control program is emented in order to provide a comfortable environment and development and ease and infection. REGIMEN REVIEW, REPORT	A CONTRACTOR OF THE CONTRACTOR	428			
	by: Based on observareview, the facility pharmacist identific implementation of residents (R46, R3 medications.  Findings include: On 7/8/15, at 8:14 wheelchair by an a	ation, interview and document failed to ensure the consultant ed irregularities for physician orders for 2 of 5 physician orders for 2 of 5 reviewed for unnecessary a.m. being pushed in a aide out of her room, dressed 5 stated to surveyor she was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245387	B. WING			07/10/2015
	PROVIDER OR SUPPLIER FRESIDENCE			STREET ADDRESS, CITY, S' 2912 FREMONT AVENUE MINNEAPOLIS, MN 55	NORTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATI FICIENCY)	(X5) COMPLETION DATE
F 428	hungry for breakfast On 7/9/15, at 8:20 in her wheelchair ir R46's diagnoses in depression obtained Data Set (MDS) da and psychotropic in 9/12/14 indicated F the past quarter, ha impairment and us due to depression, disorder. The Care directed staff to ad physician orders an and side effects an R46's care plan da on Trazodone (anti (antipsychotic) and to monitor for med effects.  The Physician Ord R41 had an order orally every mornir tablets (20 mg) ora 50 mg tab, 1/2 tab trazodone HCL 50 mg) orally times or Review of a Const Communication to indicated "her (R44 10 mg twice daily a bedtime, may reper repeat dose. Could	a.m. R46 was observed sitting her room singing loudly.  Icluded dementia, anxiety and ad from the quarterly Minimum sted 6/11/15. R46's delirium hedication use CAA dated R46 had changes in cognition in ad moderate cognitive ed psychotropic medication anxiety and psychotic Area Assessment (CAA) minister medications per and monitor for effectiveness and notify physician of changes.  Ited 9/16/14, indicated R46 was depressant), olanzapine I Prozac (antidepressant) and ication effectiveness and side  ers dated 7/31/15, revealed for olanzapine 10 mg one tableting, olanzapine 10 mg, two ally at bedtime, trazodone HCL (25 mg) orally at bedtime and mg tab, may repeat 1/2 tab (25 ne as needed before 2 am.		Reside have he medical review consulting pharm appropreson have be all reside prescripsychemedical risk for practical pharm review reside psychemedical pharm review reside propreson that delicate a pharm consulting physi	red by Itant acist and priate mendations been made. didents who are ribed otropic ations are at or this deficient ce. Consultant hacist is to with DON all ents on otropic ation to assure ose reductions been mended within list 12 months. brovided tion to the	

PRINTED: 08/04/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245387	B. WING		07/	10/2015
	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2912 FREMONT AVENUE NOR MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	(EACH CORRECTIVE AC	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 42	ongoing need? or contra-indications Physician respons 11/18/14 indicated trazodone @ [at] If needed] as writter by nursing.  Review of the Med (MAR) indicated F trazodone 25 mg 2015, although the scheduled trazodo 1/13/15.  Review of the Review indicated had completed m 10/14/14 - 6/16/11 recommendations noted in Novemb none for 1/13/15  During an intervict licensed practical physician order waddressed until 1 MAR in March for R46 had been remedication, statilis."  During an intervict control of the medication of the Review indicated had seen remedication, statilis."	to such and attempt." se to recommendation signed in "DC [discontinue] scheduled as [bedtime] & keep prn [as n." The order was noted 1/13/15 dication Administration Records at 6 received the scheduled at bedtime from March - July 8, se February MAR indicated the one dose was discontinued cord of Medication Regimen the consultant pharmacist (CP) onthly medication reviews from 5 along with any s/findings. An irregularity was er and December 2014, but - 6/16/15.  Sew on 7/9/15, at 12:59 p.m. Inurse (LPN-F) verified the was signed 11/18/14, was not /13/15 and then "put back on the resome reason." LPN-F verified ceiving the scheduled trazodoning "It's a med error, it is what it ew on 07/09/2015, at 1:54 p.m. sked for a trazodone reduction on the put of the was reduced, I usually the scheduled it was reduced.	e e	audit to compliance week for then or two modified the compliance will be QAA Q	esignee will o monitor ance 2x a or one month, nce weekly for onths, or as d by QAA. gs of audits reviewed at month x 3. etion date by: t 19, 2015	

CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
, , , , , , , , , , , , , , , , , , , ,		245387	B. WING			07/1	0/2015
	PROVIDER OR SUPPLIER			29	REET ADDRESS, CITY, STATE, ZIP CODE 12 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEEICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 428	Continued From pa	age 75	F	428		.aaanaa	
	R3 did not receive monitoring for the Fumarate-used de	adequate side effect use Seroquel (Quetiapine pression).					
	On 7/8/15, at 7:24 dining room watch were noted at that	a.m. R3 was observed in ing television and no behaviors time.					
, i	admission diagno	o the facility on 2/21/12, ses included schizo-affective, er and vascular dementia.					
	had Seroquel 300 Depakote (Divalp episodes related	ders dated 11/8/13, indicated R3 mg, two tablets at bedtime and roex-used to treat manic to bipolar disorder and manic ng, two tablets at bedtime.					
	indicated R3 was with treatable me	of findings dated 11/12/14, on antipsychotic medication dical condition such as heart impaired balance during					
	antipsychotic med schizoaffective and risk for falls relate	3/7/15, indicated R3 received dication related to nd bipolar disorders. R3 was at ed to impaired mobility and dication use evidenced by total ers.					
	reviewed. The re b/p [blood pressures to be done for the tree countries to	I, May and June 2015 was cord also included "orthostatic ure] every month lie/sit/stand" or side effect monitoring. atment record for April, May, and of evidence of documentation thostatic BP's being monitored	d	÷			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		E SURVEY PLETED
		245387	B, WING	Control of the Contro	07/	10/2015
,	PROVIDER OR SUPPLIER RESIDENCE			STREET ADDRESS, CITY, STATE, ZI 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 428	A review of the con record of medication revealed a request pressure.  On 7/9/15, at 8:55 areviewed treatment blood pressures we documented and cobeing monitored/dodune.  On 7/9/15, at 2:40 regulation to do ont monthly, but it show side effects after a pressures were on expected to be don when she looked be recommendation the treatment sheet but the commendation of the commendation of the unnecessary of policy dated 4/1/08"5. Monitor side resident experiences status, it may be a be review side effectindicated." In addit Drugs-Antipsychotodirected staff to moside effects of the	n the antipsychotic medication. sultant pharmacist monthly on regimen dated 6/16/15, for an orthostatic blood a.m. when asked LPN-A a sheets where orthostatic		428		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
		245387	B. WING			07/10/2015	
	PROVIDER OR SUPPLIER  RESIDENCE			STREET ADDRESS, CITY, STATE 2912 FREMONT AVENUE NOT MINNEAPOLIS, MN 55411	RTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIAT		
F 428	from Cardinal Heal patients would be a hypotension (a fall changing positions) orthostatic hypoten pressure) associate and, in some patier the initial dose-titra its adrenergic antachypotension, dizzin loss of consciousne pressure) may lead used with particular known cardiovascumyocardial infarctic heart failure or concerebrovascular disconditions that affethe brain, causing laffected areas of the would predispose p	s package insert for Seroquel th dated 5/2/13, indicated at risk for orthostatic in blood pressure when a "Quetiapine may induce sion (form of low blood ed with dizziness, tachycardia ats, syncope, especially during tion period, probably reflecting gonist properties. Orthostatic ess, and syncope (temporary ess caused by a fall in blood at to falls. Quetiapine should be reaution in patients with allar disease (history of the or ischemic heart disease, duction abnormalities), sease (refers to a group of the circulation of blood to imited or no blood flow to be brain) or conditions which extients to hypotension yolemia and treatment with	F4	28			
F 431 SS=D	2009, directed staff or the side effects of direction on monito pharmacist. 483.60(b), (d), (e) I LABEL/STORE DE	c Drugs policy revised April to monitor the effectiveness of the antipsychotics but lacked ring by the consultant DRUG RECORDS, RUGS & BIOLOGICALS	and the state of t	431			
	The facility must er	nploy or obtain the services of		and the second s			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	FIPLE CONSTRUCTION  NG		E SURVEY IPLETED
		245387	B. WING _		07/	10/2015
	PROVIDER OR SUPPLIER  FRESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' ( (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIORIES DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	a licensed pharmaco of records of receip controlled drugs in accurate reconciliat records are in order controlled drugs is reconciled.  Drugs and biological labeled in accordant professional princip appropriate accessor instructions, and the applicable.  In accordance with facility must store allocked compartment controls, and permit have access to the little three thre	ory and cautionary e expiration date when  State and Federal laws, the I drugs and biologicals in ts under proper temperature only authorized personnel to	F 4:	<ul> <li>No residents were affected by this deficient practice.</li> <li>All residents have potential to be affected by this practice.</li> <li>LN was immediated educated on standard of practice cart is locked at times, when they not administering medication.</li> <li>Education provide to licensed nurse and TMA's on standard of practice cart is locked at times when they not administering medication.</li> <li>ED/designee will audit to monitor compliance 2x a week for one monther once weekly two months, or a directed by QAA.</li> <li>Findings of audit will be reviewed a QAA Q month x 3</li> </ul>	tely tice ation all are gled stice ation all are gled stice ation all are g	
	on 1st Floor nurse c	art which held residents		<ul> <li>Completion date August 19, 2015</li> </ul>	oy:	

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245387	B. WING		07/	10/2015
ST OLAF	PROVIDER OR SUPPLIER F RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		10/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	pressure medication prescribed medication prescribed medication prescribed medication observation and the medications were madmitted resident at R26) on the unit that Findings include:  Medication carts: On 7/9/15, at 7:26 a continuous observed unlocked to the medication cartended in the unlowas located across the observation sever including nursing as front of the cart and station; NA-C went the R11, R31 and R7 we have opened the unwas fully extended co-At 7:32 a.m. license walked into the nurs across from the cartereturned to	a.m. to 7:32 a.m. during a ration the nurse cart was and unattended. The key lock and unauthorized staff saistants (NA)-A to stand in a walked back into the nursing station. During reral unauthorized staff saistants (NA)-A to stand in a walked back into the nursing back and forth and residents rent past the cart and could nlocked the cart as the knob outward.  ed practical nurse (LPN)-A sing station and sat directly the and at the same time LPN-B and stood in front of the cart. Immediately and asked about nattended cart LPN-B had left the cart open when upposed to lock it she stated my cart with me"  the director of nursing (DON) were supposed to follow facility what the policy was DON	F 4	31		

	OF CORRECTION	(X1) PHOVIDEN/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		E SURVEY PLETED
		245387	B. WING			07/	10/2015
	PROVIDER OR SUPPLIER  RESIDENCE			29	TREET ADDRESS, CITY, STATE, ZIP CODE 912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 431	manual dated 10/22 rooms, carts and su licensed nurse, the those lawfully author medications. Each medicine room or cat all times while on be left in a drawer of the first floor medic Apisol (Mantoux sol (TST) opened and container was not on the last admission and received the extendal of the contained a Novolog blood sugar) flex percontamination of the Novolog flex pen will opened for R26.	acy policy and procedure 2/2013, directed "1. Medication applies are locked, and only Consultant Pharmacist and prized are allowed access to nurse authorized to use art keys must carry these keys aduty. These keys are not to or loaned out for any reason"  s: cation refrigerator contained lution-tuberculin skin test dated 3/1/15. A second Apisol pen, but was dated 5/26/15. to the unit arrived on 7/3/15,	F4	<b>131</b>			
	The Medication Sto dated 10/22/13, indicontaminated or dethose in containers unlabeled or withour immediately remove according to facility	rage in the Facility policy cated10. Outdated, teriorated medications and that are cracked, soiled, or t secure closures are ed from stock, disposed of procedures for medication ordered from the pharmacy if a					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245387	B. WING _		07/	10/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 431 F 441 SS=D	15 July 2009, by Jh "Vials in use more of discarded due to pot degradation which  The package insert April 2015, By Novo cartridge or NovoLo FlexTouch is puncti temperatures below days, but should no heat or sunlight. A FlexTouch or cartric stored in the refrige FlexPen or NovoLo cartridges away fro Unpunctured Novo FlexTouch and Per until the expiration are stored in a refri NovoLog FlexPen of PenFill cartridges in clean and protected 483.65 INFECTION SPREAD, LINENS  The facility must es Infection Control Pl safe, sanitary and of to help prevent the of disease and infe  (a) Infection Contro The facility must es Program under wh	information Last revised on HP Pharmaceuticals LLC read, than 30 days should be possible oxidation and may affect potency."  It information last revised on 17 to Nordisk read, "Once a pog FlexPen or NovoLog ured, it should be kept at w 30°C (86°F) for up to 28 to be exposed to excessive NovoLog FlexPen or NovoLog dge in use must NOT be exator. Keep the NovoLog og FlexTouch and all PenFill and direct heat and sunlight. Log FlexPen or NovoLog nFill cartridges can be used date printed on the label if they igerator. Keep unused or NovoLog FlexTouch and and the carton so they will stay of from light."  N CONTROL, PREVENT  Stablish and maintain an arogram designed to provide a comfortable environment and development and transmission extion.  DI Program stablish an Infection Control light it -	F 4				
	of disease and infe (a) Infection Contro The facility must es Program under wh	ection. of Program stablish an Infection Control					

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION  NG	(X3) DATE COMF	SURVEY
		245387	B. WING		07/1	0/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	1 0771	0/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERICIENCY)	DBE	(X5) COMPLETION DATE
	(2) Decides what preshould be applied to (3) Maintains a reconstructions related to in (b) Preventing Spre (1) When the Infect determines that a reprevent the spread isolate the resident. (2) The facility must communicable dise from direct contact direct contact will track (3) The facility must hands after each dinhand washing is incorressional practic (c) Linens Personnel must har transport linens so a infection.  This REQUIREMENT by:  Based on observative review, the facility fainfection control mecares for 3 of 4 resireviewed for activities. R25 was continuous 7:31 a.m. to 8:06 a.	ad of Infection ion Control Program esident needs isolation to of infection, the facility must approhibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their rect resident contact for which licated by accepted	F 4	<ul> <li>Resident #25, #75, and #20 suffered nill effects from this deficient practice.</li> <li>All residents requiring assistant with ADL's have the potential to be affected by this deficient practice.</li> <li>Nursing staff has been educated on infection control policy including hawashing, and donning and doffin of gloves.</li> <li>DON/designee will audit to monitor compliance 2x a week for one mont then once weekly f two months, or as directed by QAA.</li> <li>Findings of audits will be reviewed at QAA Q month x 3.</li> <li>Completion date by August 19, 2015</li> </ul>	ce e and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			SURVEY PLETED
		245387	B. WING		07/	10/2015
	PROVIDER OR SUPPLIER RESIDENCE			STREET ADDRESS, CITY, STATE 2912 FREMONT AVENUE NOP MINNEAPOLIS, MN 55411	, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 441	to assisting R25 NA to wash her face af chest area; cleaned pain. Then cued R2 sweater and R25 w remained visible frobed. NA-B then proarmpits and under with a towel. Then leaving the room to the room went to the room went to the room went to the rhands. Came be pair of gloves applineck area and face -At 7:42 a.m. NA-B uncover her lower body, provided R25 applied cream on hip and under R25's be of powder never che same gloves miget to the other sidincontinent pad can two wash towels or used to do pericare removed R25's so extremities which if and feet then dried areas and then so gloves NA-B touch opened the dresse R25's pants and applicated the linen in the pathroom got applicated the linen in the pathroom got applicated the linen in the sweater and the same gloves near the bathroom got applicated the linen in the sweater and the same gloves near the bathroom got applicated the linen in the sweater and the same gloves near the bathroom got applicated the linen in the sweater and the same gloves near the bathroom got applicated the linen in the sweater and the same sweater and the sam	up water in a wash basin. Prior A-B cued R25 she was going ter she lay a towel on her dears asked R25 if she had 25 as she removed the ras able to help facial hairs om standing at the foot of the occeded to clean under R25's the breast and then dried R25 covered R25 stated she was a get lotion removed gloves left ne supply room never washed back briefly donned another ed lotion to R25 arms, hands,		441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					OMPLETED	
		245387	B. WING		07/1	0/2015
,	PROVIDER OR SUPPLIER RESIDENCE			STREET ADDRESS, CITY, STATE, Z 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 441	over R25's bedside sweater; used the adjusted R25's clocued R25 she was -At 8:05 a.m. NA-E then left the roome cups with some was brushed R25's teemouth never still wang -At 8:08 a.m. NA-E then came back to Con 7/8/15, at 8:10 changing gloves a was supposed to wash and washing and R75 was observed NA-D provided mashoes and socks or resident in wheeled toilet. NA-D washe provided peri-care and disposed in a resident off toilet at to wash hands and resident into wheeled toilet into dining had not washed had not washed had not washed had not werified had not washed had so washed had not was	ever washed her hands came assisted her to get her remote to raise the bed thing applied the transfer belt going to assist her to get up. By proceeded to comb R25's hair came back with two plastic ater set up the tooth brush and thas she cued her to open her rashed hands to this point. By took R25 to the dining room R25's room.  Take the pericares and stated wash her hands each time removed "I always do change gloves in my pockets and wash the director of nursing stated as to follow facility policy for	F	141		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245387	B. WING			07/10/2015	
,	PROVIDER OR SUPPLIER  RESIDENCE			STREET ADDRESS, CITY, STATE, 2 2912 FREMONT AVENUE NORT MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIAT	(X5) COMPLETION E DATE	
F 441	on 7/8/15 at 8:21 at (LPN)-A stated state wash hands with rehand sanitizer two hands. During resideach resident. The after they complete them out of their room.  On 7/9/15, at 1:50 washing DON state assistants were to washing.  R20 was observed dressing change w LPN-C. LPN-C put gauze bandage, the the same gloves. From the same gloves. From the same gloves, cleaned hands with donned gloves the room.  - At 7:55 a.m. LPN missed handwash indicated he cleaned hands with donned gloves the room.	age 85 after toileting resident.  a.m. licensed practical nurse of should remove gloves and esident's care. They can use times and then must wash dent care they wash hands for y should wash hands right e resident cares before bringing from.  p.m. when asked about hand ead she expected nursing follow facility policy on hand  and on 7/8/15, at 7:31 a.m. A ras observed for R20 with a non gloves to remove old en started a dirty linen bag with the room (did not wash hands wes). LPN-C returned with a land a roll of Kerlix. LPN-C in waterless hand sanitizer, the eaned the wound with saline, and a roll of Kerlix. LPN-C in waterless hand sanitizer, the eaned the wound with saline, and cut dressings to size before cover the wound. LPN-C then is, put supplies away and left al-C was asked about the ing opportunities, LPN-C seed his hands with hand afting on gloves. LPN-C verified is hands after removing gloves, e medication/supply room to the wound change.		1.4.1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED		
		245387	B. WING			07	/10/2015
	PROVIDER OR SUPPLIER RESIDENCE			29	REET ADDRESS, CITY, STATE, ZIP CODE 112 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	9:57 a.m. NA-A wa R20. NA-A donned basin with soap an while R20 washed to get a fitted shee them exited the rod- At 10:02 a.m. NA bag of laundry; the performing any ha - At 10:17 a.m. postoack of the body wleft, with great exewet in the peri area and then continued discoloration (in vathighs (above glute buttocks. NA-A cletwice with the sam wash cloth to pat a left upper buttocks centimeters (cm) yellow debris. NA-denuded area with removed the soile hands. When ask verified she had nothe facility policy.  R20 was admitted diagnoses of cong fracture of the right leg and a history of pressis hemiparesis (inabuthe Admission Re	sitioned in bed to ensure the vas cleansed. R20 was rolled rtion. NA-A noticed the bed was a. NA-A scrubbed the mattress d with the bath. R20 had purple arying shades) from upper eal fold) which included the eaned stool from the peri folds are area of denuded skin on the sapproximately 3.5 to 4.0 a 2.5 cm with crusted area of A applied an ointment to the of the soiled gloves. NA-A then d gloves and did not wash ed about hand hygiene, NA-A ot completed hand hygiene per late to the facility 5/1/13, with gestive heart failure, malunion at ankle, abscess and cellulitis d diabetes mellitus type II, had are ulcers, and stroke with sility to move half the body) per	a	441			

6125222921

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION  NG			SURVEY PLETED
		245387	B. WING _			07/1	10/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		THE PARTY OF THE P	
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NOF MINNEAPOLIS, MN 55411	RTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE
F 441	in the last seven da noncompliance with for pressure ulcers incontinence, and n assist with repositio monitor for decline,  The Care Plan date a history of pressure reduction mattress, signs and symptom to incontinence and assisted with reposithe doctor and the wneeded. The care p check and change or related to residents weeks due to a self her neck.  The quarterly Minim 5/18/15, indicated F no depression and of	d care one to three days in the ys and had a history in treatments. R20 was at risk related to limited mobility, utritional status. Staff should ning, incontinence cares, and notify MD with changes in d 8/26/14, indicated R20, had elucers, had a pressure and should be monitored for sof skin break down related immobility. R20 was to be stioning, and staff should notify wound team to follow as olan lacked new directions to be reposition every 2 hours, wish to stay in bed for six diagnosed "pulled muscle" in the stay in bed for six diagnosed "pulled muscle" in the stay in the st	F.4	41			
	mobility, a total med	assist of two staff for bed chanical lift for transfers, toilet is incontinent and did not er.					
	facility requires staff each direct resident hand-washing is inc professional practic conducted as per re CDC guidelines." The what staff was supp						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245387	B. WING		07/1	0/2015
	PROVIDER OR SUPPLIER RESIDENCE		1	STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	Hand Hygiene and Glove use directed be worn prior to co treatment station a surfaces (e.g., dial surfaces). Note: all station are considered Gloves should alway patients and betwee sites on the same one's hand instead acceptable. Glove need for hand hygical Examples of situationary changed:  1. After contact we considered the completing of the contact we considered the contact with the contact we considered the contact we contact with the contact we contact we contact with the contact we contact we contact we contact we contact with the contact we contact we contact with the contact we contact with the contact we contact we contact with the contact we contact with the contact we contact we contact with the contact we contact we contact with the contact we contact wi	Control (CDC) Protocol for Glove Use Observations  "1. In general, gloves should ntact with patients at the nd potentially contaminated ysis machine, environmental items/surfaces at the dialysis ared potentially contaminated, ays be changed between the clean and contaminated patient. Holding a glove in dof wearing it is not considered use does not preclude the tene after removing gloves, ions when gloves should be with blood or body fluids and tasks at one patient station another station and potentially contaminated	F 441			
F 465 SS≖E	483.70(h) SAFE/FUNCTION E ENVIRON The facility must p sanitary, and comf residents, staff and This REQUIREME by: Based on observa review, facility faile environment was re-	AL/SANITARY/COMFORTABL rovide a safe, functional, fortable environment for	F 46	5		
						darings of states were

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY
		245387	B. WING	i		07/1	0/2015
	PROVIDER OR SUPPLIER RESIDENCE			2	STREET ADDRESS, CITY, STATE, ZIP CODE 1912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		072010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE I	(X5) COMPLETION DATE
F 465	During an environm p.m. with the house (HSS), maintenance manager housekeer resources manager environmental conditions of the first floor dining cracks on the seats exposed the foam a croom table pedesta in the third floor din noted cracks. RMH chairs in the first flostated they would rether third floor dining infection control corpedestals were cleateach week.  On 7/7/15, R20's gray was observed with black debris on the stated housekeepin On 7/6/15, R25's to brown matter aroun RMH stated it would On 7/6/15, R80's be buildup of brown maluminum grab bar toilet. On the wall by was white material The faucet had con	ge 89  mental tour on 7/8/15, at 1:00 ekeeping site supervisor e manager (MM), regional ping, (RMH) and human r (HRM), the following eerns were noted and verified: ining observation two chairs in room were observed to have evinyl peeling off which underneath and three dining als were noted dirty. In addition ing room six chairs with also stated they would replace for dining room. He further eplace cushions or chairs in a room, as cracks were an incern. HSS stated table aned Monday and Thursdays and bar on right side of bed heavy buildup of brown to bar. During the tour RMH are would clean grab bar.  illet riser was observed to have and the sides. During the tour d be cleaned and disinfected.  athroom tile was observed with atter around the bottom of and dirty grout around base of elow soap dispenser, there sticking on the bathroom tile. stant dripping after verifying off. During the tour RMH stated		465	• There were no negative outcomes residents when the facility failed to ensure a clean and safe environment. • All residents have potential to be affected by this deficient practice. • The two chairs from first floor dining room and six chairs from third floor dining room identified as needin repairs have been repaired or replaced Completion date: August 19, 2015. • The three table pedestals in third floor dining room identified as dirty have been cleaned. • Dining room table pedestals are scheduled to be cleaned on Monday and Thursdays ever week.	to	
						_	3

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245387	B. WING			07/1	0/2015
	PROVIDER OR SUPPLIER FRESIDENCE			291	REET ADDRESS, CITY, STATE, ZIP CODE 2 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 465	housekeeping wou would have to re-act would not hit the bat on 7/6/15, R41's be sticky with build around toilet and urnissing on left corr from floor on wall gouring the tour RM cleaner and use do MM stated he would on 7/6/15, R24's be of the sink was obstuck to tile. Grout bar had heavy black bathroom had build carpet met tile, and Paint was missing door frame and wo RMH stated house mop thoroughly an carpet met tile. MM frame.  On 7/7/15, R31's rescrapes and gouge There was a maloc of magazines were and clothing was hwas had a buildup stated he would paassistants would c stated wheelchairs	get adhesive remover and Id clean the tile. MM stated he Idjust the faucet handle so it	F 4	165	<ul> <li>Housekeeping manager/designee will audit to monito compliance 2x a week for one month then once weekly for two months, or as directed by QAA.</li> <li>Findings of audits will be reviewed at QAA Q month x 3.</li> <li>Completion date: August, 19, 2015.</li> <li>Resident #20's grabar on the right side of the bed was cleaned and sanitized on July 7, 2015</li> <li>Resident 25's toile riser was cleaned and sanitized on J7, 2015.</li> <li>Resident #80's bathroom tile arout the bottom of the aluminum grab bawas cleaned and the dirty grout around the base of the toi was cleaned on July 7, 2015.</li> <li>Resident 41's bathroom floor was stripped, washed waxed on July 7, 2015. The plaster repair will be completed by August, 2015.</li> </ul>	n, br de zed t uly nd r he let uly	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		SURVEY PLETED
		245387	B. WING		07/	10/2015
	PROVIDER OR SUPPLIER RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CO 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
-	sticky, but was not stated housekeepir stated floor was clessed floor was approximate from the bottom. Do were in the processed from the bottom. Do were in the processed floor floor floor floor was cracked floor floor was cracked floor floor was cracked floor floor was cracked floor floo	or tile was observed to be very wet. During the tour RMH and would scrub floor top. HSS waned twice daily.  athroom door was observed dimately one and a half feet wing the tour MM stated they sof putting door plates on.  from was observed with iners dated 12/17, and another In the room were two walkers tored; bags, containers, and observed partially underneath in transition strip was missing sed and had black marks. Histated nursing assistants personal belongings and care of the equipment. RMH no transition metal plate to hold ites and would replace them.  I.M. HSS stated they were not environmental problems ated he wanted to meet with them. HSS also stated if staff did saw a problem, they were to intenance log located on each in. HSS stated he checked logs ery month did spot checking, stated he relied on logs to get ems fixed.		Resident #24's bathroom tile be and to the side of sink was thoroug cleaned of the w material noted. I room was mopp thoroughly and transition strip applied July 7, 2 Maintenance pai door frame and wooden door. Completion date August 19, 2015 Resident #31's r has had scrapes gouges on wall repaired. Compl date: August 19 The nursing assistants clear the resident's re including pickin clothes and magazines on J 2015. The whee has been cleane debris as of Jul 2015. Resident #5's fl tile was thoroug cleaned on July 2015.	of the ghly white The ed  015. inted  e: 5. room s and letion 1, 2007  ned com 1, 2007  luly 7, elchair ed of 1, 7, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	

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Ĭ	OTATELIEN	T OF DEED TO	MEDIONID OLIVIOLS	-	-		OMB NO	<u>). 0938-0391</u>
The same of the sa	AND PLAN	T OF DEFICIENCIES  DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
The second second			245387	B. WING			0.7	214 N 1004 E
	NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 07	1/10/2015
l	STOLAR	RESIDENCE				2912 FREMONT AVENUE NORTH		
	OIOLA	ILOIDLINGE				MINNEAPOLIS, MN 55411		
ľ	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		-		***	
	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY SULL	ID PREFI	v	PROVIDER'S PLAN OF CORRECTION	N	(X5)
	TAG	REGULATORY OR LS	SC IDENTIFYING INFORMATION)	TAG		(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIES	) BE	(X5) COMPLETION DATE
_						DEFICIENCY)	TIME	5AIL
					-			
	F 465	Continued From page	ge 92	F4	165	• Resident #64's		
		downstairs, sprayed	, disinfected and put it in	]		bathroom door plat		
		storage. They clean	ed it while resident was				е	
		sleeping.	www.cyobidayii waa			will be replaced by		
				ĺ		August 19, 2015.		
	[	On 7/9/15, at 7:44 a	.m. MM stated he did not	-		Resident 40's		
		keep a record of env	/ironment unit spot checks			multiple food		
		- At 8:03 a.m. MM in	dicated they had preventative			containers dated		ļ
	1	logs downstairs and	repairs were done on a			December 17, 2014		
	1	monthly basis. He ha	ad no logs or documentation			and other outdated		
		of prior repairs.	i			containers were		
		<u> </u>				removed from the		-
		Cleaning Instructions	s: Floors, Tables and Chairs			room. Unneeded		
		policies dated © 201	0, Facility daily cleans (every			equipment in the		
		room every day inclu	iding weekends) policy			room and bathroom		
		included: "clean with	disinfect toilets, handrails			were removed from		
		(by follets), sinks, ca	Il lights, door handles, light			the resident's room		A Colorest
	( )	Switches, table tops,	counter tops, vinyl chairs.		ļ	on July 7, 2015.		
	ί,	well mop all hard sui	faced floors. Spot clean		l	Missing transition		
		walls, doors and swit	ch plates. Report any			strip was replaced		
	,	maintenance probler	ns to supervisor."		ļ	and floor marks we	<b>'e</b>	
	1	Cleaning Instructions	: Floors, Tables and Chairs		-	removed on July 7,		
	l r	oncaring matriculons	0, Tasks performed when			2015.		
	ľ	horough cleaning po	licy included: "clean door			<ul> <li>Housekeeping and</li> </ul>		
		and door frames Wa	Ill washer all areas ceiling to			nursing staff will be		
	f	loor: including vertice	al walls to remove cob webs			educated to report		
	(	move any items awa	ly from wall). Clean chairs		Y Warmer	unsafe or unsanitar	У	
	r	ungs, legs, arms, ale	so bed frames, inside and		]	condition including		
	C	out of trash can. Bath	room: wash sink with cream		ĺ	messy rooms,		
	c	leanser, pipes unde	r sink, mirror, counter tops,			outdated food		
	a	bove light, top of me	edicine cabinet, all towel			containers in		
	r	acks, all dispensers	including toilet paper			resident rooms,		
	d	lispensers, toilet, har	ndrails, call lights, light			missing floor strips,		
	s	witches, baseboards	, dust mop wet mop floor."		ĺ	soiled floors and	ļ	
					-	missing floor tiles.	ĺ	
	C	leaning Instructions:	Floors, Tables and Chairs		-	• Completion date:	ļ	
	p	olicies dated © 2010	directed staff "Kitchen and		1	August 19, 2015.		
	a	ining room floors, tal	oles and chairs will be kept			August 13, 2013.	ĺ	
	cl	lean and sanitary Pr	ocedure: 3 Dining room		Ì			1

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

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION IG		(X3) DATE COM	E SURVEY PLETED
		245387	B. WING _			07/-	10/2015
	PROVIDER OR SUPPLIER F RESIDENCE			STREET ADDRESS, CITY, ST 2912 FREMONT AVENUE MINNEAPOLIS, MN 55	NORTH	Inches de la constante de la c	t or supplemental to the s
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD ED TO THE APPROP FICIENCY)	BE	(X5) COMPLETION DATE
F 465			F 46				
	meal. 4. Dining room appropriate) after end clean, hot soap may be brushed off chairs (wooden or ribe cleaned once at 483.75(b) COMPLY FEDERAL/STATE/LT The facility must oper compliance with all local laws, regulation accepted profession that apply to profess such a facility.  This REQUIREMENT by:  Based on observate review, the facility face (R6's) which had a sapplicable codes/ resident currently as the following information effect until October resident currently as	corate and provide services in applicable Federal, State, and cons, and codes, and with nal standards and principles is sionals providing services in NT is not met as evidenced tion, interview and document ailed ensure 1 of 1 resident toilet in the room met the egulations.	F 49	Direct audit week then moni  Main: Direct keep envir audit resid and resid and room twelv mont  ED/de audit comp week then two nodirect will be QAA  Comp	tenance ctor/designee v t five rooms tly x4 weeks, monthly x2 to itor compliance tenance ctor/designee v a record of conmental room ts to include lent room safet repair needs. tenance ctor/designee v tain completed a audit forms for re calendar ths. esignee will to monitor cliance 2x a to for one month once weekly for months, or as ted by QAA. ngs of audits re reviewed at Q month x 3. pletion date by list 19, 2015.	e. vill n ty vill i or	

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STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	I (VO) AU	II TIDI E			OMB NO	D. 0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING_	CONSTRUCTI	ION	(X3) DA	ATE SURVEY OMPLETED
		245387	B. WING	à				
NAME OF	PROVIDER OR SUPPLIER		1		REET ADDRES	S, CITY, STATE, ZIP COD	07	7/10/2015
ST OLA	F RESIDENCE			29	2 FREMONT	AVENUE NORTH	/ <b>C</b>	
(X4) ID	CLIMATADY			MI	NNEAPOLIS	6, MN 55411		
PREFIX TAG	LACO DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH C	/IDER'S PLAN OF CORRECTIVE ACTION SH EFERENCED TO THE AP DEFICIENCY)	OUT O DE	(X5) COMPLETION DATE
F 492	Continued From pag	NO ar						
	facility, whichever of that all waivers are so necessary by the De that all alternative mustached to a variance force and effect of a On 7/8/15, at 6:30 p. toilet in R6's sleeping entering room with sign the opposite left so interview when asked staff available to make assistance he needelong time R6 stated he pointed to it. R6 state using a sliding board	ccurs first. Please be advised subject to review as deemed subject to review as deemed spartment. Please remember easures of conditions ce or waiver shall have the licensure."  m. surveyor observed the garea to the right when nk next to it, and bed located ide of the room. During the dif the facility had enough the sure he got the care and did without having to wait for a lee used his toilet as he was did he transferred to the toilet and was able to use the attached to the well to easure the subject to the well to easure the subject to the	F	192	F492	The administrate provided the water for room #107 d January 20, 201 review and will at for a waiver rend Completion date August 19, 2015	liver ated 5 for apply ewal.	
a	amputation of leg and Tuarterly Minimum Da	nt physician's orders dated noses including traumatic morbid obesity. The ta Set (MDS) dated 5/6/15, imited assistance of one		The state of the s				
a S a w	dministrator stated "v he further stated he privacy curtain and h ay. The administrator	m. the administrator was ne R6's room 107, the we have a waiver for that." had asked R6 if he wanted ne stated no as it was in his stated she was aware that d she could get him a						
							N	
M CMS-2567(0	2-99) Previous Versions Obsc	plete		Щ				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245387

B. WING

07/08/2015

NAME OF PROVIDER OR SUPPLIER

ST OLAF RESIDENCE

STREET ADDRESS, CITY, STATE, ZIP CODE

#### 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

ST OLAF RESIDENCE		MINNEAPOLIS, MI				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGU OR LSC IDENTIFYING INFORMATION)	ID LATORY PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
K 000	INITIAL COMMENTS	K 000				
	FIRE SAFETY					
	A Life Safety Code Survey was conducted by Minnesota Department of Public Safety, Fire Marshal Division on July 08, 2015. At the time this survey, St Olaf Residence was found in substantial compliance with the requirement participation in Medicare/Medicaid at 42 CFF Subpart 482.41 (b), Life Safety from Fire, and 2000 edition of National Fire Protection Association (NFPA) Standard 101, "The Life Safety Code" (LSC), Chapter 19 Existing He Care.	es for R, and the				
	St Olaf Residence is a 4-story building with a basement. The original building was construin 1964, is separated from a church with a 2 fire rated barrier and was determined to be of Type I (332) construction. The facility is full sprinkler protected. The facility has a fire also system with smoke detection throughout the corridor system, in common areas and areas open to the corridor system and is monitored automatic fire department notification.	cted hour of y fire arm				
	The facility has a capacity of 80 beds and hat census of 56 at the time of the survey.	ad a				
	The requirement at 42 CFR, Subpart 482.41 is MET.	(b),				
ARORATOR	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTAT	IVE'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.