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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KU29

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00494

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245028**
2.STATE VENDOR OR MEDICAID NO.
(L2) **299242600**

3. NAME AND ADDRESS OF FACILITY
(L3) **HIGHLAND CHATEAU HEALTH CARE CENTER**
(L4) **2319 WEST SEVENTH STREET**
(L5) **SAINT PAUL, MN** (L6) **55116**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2004**

6. DATE OF SURVEY **01/30/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **64** (L18)

13.Total Certified Beds **64** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Suesanne Reuss, Supervisor 01/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 02/17/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/22/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5028

March 4, 2015

Ms. Erin Shvetzoff Hennessey, Administrator
Highland Chateau Health Care Center
2319 West Seventh Street
Saint Paul, Minnesota 55116

Dear Ms. Shvetzoff Hennessey:

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 January 13, 2015 the above facility is certified for or recommended for:

64 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 64 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,

Anne Kleppe

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

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 17, 2015

Ms. Erin Shvetzoff Hennessey, Administrator
Highland Chateau Health Care Center
2319 West Seventh Street
Saint Paul, Minnesota 55116

RE: Project Number S5028025

Dear Ms. Shvetzoff Hennessey,

Enclosed please find updated CMS forms 2567B for Health and Life Safety Code post-certification revisit findings for Highland Chateau Health Care Center. The forms reflect a correction date of 1/13/2015 (vs 1/15/2015, previously mailed to you). If you have any questions, please let me know.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4124 Fax: (651) 215-9697
Email: anne.kleppe@state.mn.us

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 30, 2015

Ms. Erin Shvetzoff Hennessey, Administrator
Highland Chateau Health Care Center
2319 West Seventh Street
Saint Paul, Minnesota 55116

RE: Project Number S5028025

Dear Ms. Shvetzoff Hennessey:

On December 18, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 4, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On January 30, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 26, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 4, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 15, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 4, 2014, effective January 15, 2015 and therefore remedies outlined in our letter to you dated December 18, 2014, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

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

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245028	A. Building B. Wing	1/30/2015

Name of Facility	Street Address, City, State, Zip Code
HIGHLAND CHATEAU HEALTH CARE CENTER	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116

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 **F0241** Reg. # **483.15(a)** LSC	Correction Completed **01/13/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **01/13/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **01/13/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **01/13/2015**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **01/13/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **01/13/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **01/13/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	02/17/2015	16022	01/30/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/4/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245028	A. Building B. Wing **01 - MAIN BUILDING 01**	1/26/2015

Name of Facility	Street Address, City, State, Zip Code
HIGHLAND CHATEAU HEALTH CARE CENTER	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0050	**01/13/2015**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PS/AK	**Date:** 01/30/2015	**Signature of Surveyor:** 12424	**Date:** 01/26/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 12/4/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KU29

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00494

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245028**
2.STATE VENDOR OR MEDICAID NO.
(L2) **299242600**

3. NAME AND ADDRESS OF FACILITY
(L3) **HIGHLAND CHATEAU HEALTH CARE CENTER**
(L4) **2319 WEST SEVENTH STREET**
(L5) **SAINT PAUL, MN** (L6) **55116**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2004**

6. DATE OF SURVEY **12/04/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **64** (L18)

13.Total Certified Beds **64** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Vidya Tomar, HFE NE II 01/08/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 01/16/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4547

December 18, 2014

Ms. Erin Shvetzoff Hennessey, Administrator
Highland Chateau Health Care Center
2319 West Seventh Street
Saint Paul, Minnesota 55116

RE: Project Number S5028025

Dear Ms. Shvetzoff Hennessey:

On December 4, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: susanne.reuss@state.mn.us
Telephone: (651) 201-3793
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 13, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 4, 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 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 June 4, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

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

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist

Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. BUILDING _____ B. WING _____	12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CHATEAU HEALTH CARE CENTER	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	**Preparation, submission and implementation of this Plan of Correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.**	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R27), reviewed for dignified treatment, was treated in a way that maintained dignity with activities of daily living. Findings include: R27's most recent Minimum Data Set (MDS), dated 8/14/14, revealed R27 was cognitively intact and required physical assistance of one staff for transfers, toileting and dressing.	F 241	• **F241** **Resident #27 care plan has been reviewed and updated to reflect current assistance needs. Resident #27 has had no further complaints about wait times for cares** **All residents are at risk for treatment lacking dignity and respect as an individual.** **Education provided to staff on care and treatment to each resident in a timely manner and with respect and dignity as an individual.** **Audits by DON/designee of call light response times will be done and reviewed, checking timeliness and follow up as needed. Audits will be reviewed at QAA for 3 months.** **Deficient practice to be corrected by 1/13/2015.**	1/13/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 12/29/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. BUILDING _____ B. WING _____	12/04/2014

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F 241	Continued From page 1 On 12/1/14 at 6:13 p.m. R27 reported; did not feel staff treated her with dignity and respect because of having to wait so long for help. R27 added having to wait a half hour to get help from staff to get off the toilet. R27 added she waited a long time for help in being transferred into bed, dressed and undressed. When asked how that made her feel, R27 responded "Like I'm not even here, like their playing games with a human being. I'm human but I don't get treated like human. I just get treated like a wall flower or something." R27's care plan for impaired mobility related to weakness and Parkinson's, last revised 6/9/14, directed staff to provide assistance of one staff for transfers and ambulation. The fall prevention care plan, last revised 11/19/14 directed staff to have two staff assist with getting up in the morning. The self care deficit care plan, last revised 9/25/11, directed staff to provide assistance of one staff for dressing. On 12/2/14 at 3:25 p.m. a nursing assistant on R27's unit, (NA)-E, reported residents waited a long time for call lights to get answered when only three nursing assistants were on second floor. NA-E explained if resident required assistance of 2 or 3 staff for cares, that did not leave a nursing assistant to help answer call lights. NA-E reported sometimes residents complained about having to wait for help. On 12/2/14 at 3:25 p.m. a nursing assistant, (NA)-D, on R27's unit reported residents frequently had to wait a long time for call lights to get answered, particularly when three nursing assistants were scheduled on the second floor,	F 241		

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F 241	Continued From page 2 instead of four. NA-D added residents had many physical and mental issues and required timely assistance from staff. On 12/4/14 at 2:06 p.m. a nursing assistant working on R27's unit, (NA)-A, reported regularly residents have to wait a long time for help with using the toilet. R27 used to be able to sit on the toilet alone after transfer assistance, but recently she has not been allowed to be left in there alone. NA-A reported R27 usually would yell when she needed something but has also needed to wait for staff to help with cares. On 12/4/14 at 2:08 p.m. a nursing assistant working on R27's unit, (NA)-B, reported residents often needed to wait for help if only three nursing assistants worked on second floor. NA-B explained if nursing aides helped one resident onto the toilet and then another resident on the unit needed help, then the one on the toilet might need to wait for enough staff to be available for staff to return and finish helping them with toileting. A review of R27's call light log for 11/4/14 through 12/4/14 revealed the call light was activated for over twenty minutes before staff arrived to help on five occasions. Three of those occasions indicated the call light was activated from the bathroom. Two indicated the call light was activated from the bedroom.	F 241		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280		

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F 280	Continued From page 3 participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to review and revise the plan of care related to central venous catheter (CVC) hemodialysis site for 1 of 1 resident (R42) care plan reviewed. Findings include: R42's care plan related to hemodialysis treatment was not revised to include the monitoring for potential infection and bleeding of current CVC site. During observations on 12/03/14, at 2:00 p.m. R42 was sitting in her wheelchair in her room and was watching television. R42 stated she went to a dialysis clinic three times per week to receive life sustaining treatment. When asked regarding	F 280	• **F280** **Resident #42 has had her plan of care integrated to include monitoring for infection and bleeding of CVC dialysis site and graft care removed from dialysis care plan.** **All residents receiving dialysis services have the potential to be affected by this practice.** **Nurse managers and MDS coordinator have been educated on need for integrated plans of care to reflect dialysis site evaluation and monitoring.** **Nurse managers have reviewed all residents receiving dialysis services to ensure the plan of care reflects site management and monitoring.** **Audit by DON/designee of all dialysis patients charts to assure plan of care reflects site management and monitoring will be ongoing.** **Audits will be reviewed at QAA for three months to ensure coordination of dialysis services.** **Deficient practice to be corrected by 1/13/2015.**	1/13/15

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F 280	Continued From page 4 her dialysis site, R24 pointed to her right upper chest stating, "here is the catheter". The site had a dressing on it. When asked how frequently the staff monitored her site for infection and bleeding, R24 stated, "the nurses don't look at it or do anything to it." During record review on 12/03/14, the dialysis plan of care, dated 10/19/14, revealed R24 went to dialysis three times per week due to End Stage Renal Disease (ESRD). The interventions included monitor lab, check vital signs, remove pressure dressing after dialysis per order and if bleeding occurs from the site apply pressure, if bleeding continues transport R24 to the emergency room. check for bruit/thrill (to monitor a graft or fistula's patency) every shift, do not draw blood or take blood pressure in the arm with graft. Although a hand written undated note under the social service's plan of care indicated R24's subclavian dressing changes occurred at the dialysis site, there was no documentation whether the nursing staff monitored and recorded R42's CVC site integrity during each shift to limit/prevent infections, bleeding concerns and potential of dislodging of CVC catheters. On 12/04/12, at 10:00 a.m. Registered Nurse (RN)-C indicated R42 did not have a fistula or graft and the only site R42 had was the subclavian site for dialysis. After reviewing R42's current dialysis plan of care, RN-C stated, the dialysis plan of care needed revision to remove graft care and add CVC care and monitoring. RN-C reviewed the medication and treatment records to see if the nursing staff was documenting CVC monitoring on these records and found there was no documentation regarding the CVC site monitoring. RN-C stated he would	F 280		

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F 280	Continued From page 5 add the CVC site monitoring to the treatment records for nurses to document and update R42's medical care team if there were any changes in her CVC site.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 3 residents reviewed for activities of daily living, R80 and R27 were bathed according to their plan of care. Findings include: R80's most recent Minimum Data Set, dated 9/18/14, collection revealed no concerns with memory/recall ability or cognitive skills for daily decision making. R80's care plan related to Self Care Deficit, last revised 9/23/14, directed staff to provide assist and supervision with shower. R80's November treatment record directed staff, "Bath/Shower once a week with skin check by nurse. Nurse to verify." Interview with R80 on 12/1/14 at 3:38 p.m., R80 was asked a question regarding bathing and responded, "If I don't get in on Monday, I don't get	F 282	• **F282** **Resident #80 and Resident #27 have received showers per their preferences.** **All residents are at risk of not receiving showers per preferences or schedule.** **Nursing staff educated on giving showers per resident preference, schedule or PRN need.** **Nursing staff educated on documenting on showers routinely as well as documenting refusals of care and offering a shower again if refused.** **Audits weekly by DON/designee to assure that showers are being completed per the resident's preference or in accordance with schedule.** **Audits will be reviewed at QAA for three months to ensure adherence to policy.** **Deficient practice to be corrected by 1/13/2015**	1/13/15

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F 282	Continued From page 6 it for that week, even if I really want it." R80 explained that he had not been bathed last week and was supposed to be bathed one time a week. A review of the November and December 2014 resident body audit forms, untitled bathing forms and November treatment record revealed R80 received showers on 11/3/14, 11/17/14 and 12/1/14 for the time period of 11/1/14 through 12/3/14. A review of Interdisciplinary Notes for 11/1/14 through 12/3/14 did not reflect R80 declined bathing at any point. On 12/3/14 at 8:00 a.m. the nurse manager for second floor, [RN]-B reported a body audit sheet should be completed to reflect if resident was bathed or refused. At 9:25 a.m. RN-B reported staff should offer a shower weekly on the scheduled day. If a resident chose not to have a shower at that time, the resident should be re-approached and offered different choices. RN-B confirmed there was no evidence of showers being given, outside of 11/3/14,11/17/14 and 12/1/14. RN-B could not explain the circumstances surrounding R80 not receiving a shower each week. Although, on 12/4/14 at 8:15 a.m., the director of nursing [DON] reported an aide [NA]-C had been called and reported she showered R80 on 11/10/14, the DON confirmed this was not reflected in R80's medical record. R27's MDS, dated 8/14/14, was reviewed and revealed R27 was cognitively intact. A review of	F 282		

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F 282	Continued From page 7 R27's care plan titled "Self Care Deficit related to: weakness, Parkinson's and dementia", last revised 9/25/11, directed staff "Assist with bathing" A review of R27's November and December medication administration record directed staff to ensure R27 used a prescription shampoo (Selenium Sulfate Lotion 2.5%) with showers once weekly. During interview on 12/1/14 at 6:09 p.m., R27 was asked about her shower/bathing schedule. R27 responded that ideally she would like a shower every night, but decided to go along with just once a week because she does'nt like waiting. During interview on 12/4/14 at 8:25 a.m. R27 reported that sometimes she was noteven showered weekly and had missed a weekly shower recently. R27 explained that she was told the shower would need to be skipped because there wasn't enough staff to assist her. A review of the November and December treatment and medication administration records, body audits and untitled bath forms for 11/1/14 through 12/3/14 revealed R27 received a shower on 11/7/14, 11/14/14 and 11/28/14. No form was provided that reflected a refusal of shower. A review of interdisciplinary notes for 11/1/4 through 12/3/14 revealed R27 did not decline a shower. On 12/4/14 at 9:41 a.m. the director of nursing [DON] confirmed she had provided all records of	F 282		

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F 282	Continued From page 8 R27's bathing for November and December. At 12:09 p.m. the DON reported the nursing assistant should know to shower R27 because of the shower schedule. The nurse should ensure the shower was completed. If the shower was not completed due to a refusal the nurse should attempt an intervention to ensure the resident showered and if unsuccessful offer alternatives. The nursing staff on the next shift should be made aware of missed showers in order to try an alternate time. The nurse manager should be aware of missed showers.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to review and revise the plan of care related to central venous catheter (CVC) hemodialysis site for 1 of 1 resident (R42) to provide necessary care and services. Findings include: R42's care plan related to hemodialysis treatment was not revised to include the monitoring for potential infection and bleeding of current CVC site.	F 309	• **F309** **Resident #42 has had her dialysis CVC site assessed for infection and bleeding and has had no negative effects from this practice.** **All residents receiving dialysis services have the potential to be affected by this practice.** **Nursing staff have been educated on need for CVC dialysis site monitoring and notification to medical team with changes.** **Nurse managers have reviewed all residents receiving dialysis services to ensure the treatment record reflects site management and monitoring** **DON/designee will complete weekly audits and results to be reviewed at QAA for three months to ensure adherence to policy.** **Deficient practice to be corrected by 1/13/2015.**	1/13/15

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F 309	Continued From page 9 During observations on 12/03/14, at 2:00 p.m. R42 was sitting in her wheelchair in her room and was watching television. R42 stated she went to a dialysis clinic three times per week to receive life sustaining treatment. When asked regarding her dialysis site, R24 pointed to her right upper chest and said, "here is the catheter". The site had a dressing on it. When asked how frequently the staff monitored her site for infection and bleeding, R24 stated, "the nurses don't look at it or do anything to it." During record review on 12/03/14, the dialysis plan of care, dated 10/19/14, revealed R24 went to dialysis three times per week due to End Stage Renal Disease (ESRD). The interventions included monitor lab, check vital signs, remove pressure dressing after dialysis per order and if bleeding occurs from the site apply pressure, if bleeding continues transport R24 to the emergency room. check for bruit/thrill (to monitor a graft or fistula's patency) every shift, do not draw blood or take blood pressure in the arm with graft. Although a hand written undated note under the social service's plan of care indicated R24's sublcavian dressing changes occurred at the dialysis site, there was no documentation whether the nursing staff monitored and recorded R42's CVC site integrity during each shift to limit/prevent infections, bleeding concerns and potential of dislodging of CVC catheters. On 12/04/12, at 10:00 a.m. Registered Nurse (RN)-C indicated R42 did not have a fistula or graft and the only site R42 had was the subclavian site for dialysis. After reviewing R42's current dialysis plan of care, RN-C stated, the dialysis plan of care needed revision to remove	F 309		

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F 309	Continued From page 10 graft care and add CVC care and monitoring. RN-C reviewed the medication and treatment records to see if the nursing staff was documenting CVC monitoring on these records and found there was no documentation regarding the CVC site monitoring. RN-C stated he would add the CVC site monitoring to the treatment records for nurses to document and update R42's medical care team if there were any changes in her CVC site.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide assistance to 2 of 3 residents (R80, R27) reviewed for activities of daily living that required assistance to participate with bathing. Findings include: R80's most recent Minimum Data Set, dated 9/18/14, collection revealed no concerns with memory/recall ability or cognitive skills for daily decision making. R80's care area assessment and minimum data set [MDS], dated 9/18/14 assessed R80 to need supervision by staff while bathing, noting, "He requires assist with setting up bathing utensils and is able to bathe himself after utensils are set	F 311	• **F311** **Resident #80 and resident #27 have been provided assistance to participate with bathing.** **Both residents have been interviewed and asked to provide their preferences related to shower schedule.** **All residents are at risk of needing assistance with ADL participation.** **Nursing staff educated on encouraging residents to participate in ADLs.** **Nursing staff educated on giving showers per resident preferences, schedule or PRN need. Education includes documenting on showers routinely as well as documenting refusals of care, notifying nurse and offering a shower again if prior refusal.** **Weekly audits by DON/designee to assure that showers are being completed and opportunity given for resident participation.** **Audits will be reviewed at QAA for three months to ensure adherence to policy.** **Deficient practice to be corrected by 1/13/2015**	1/13/15

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F 311	Continued From page 11 up." During interview, on 12/1/14 at 3:38 p.m. R80 was asked how many times a week R80 took a bath or shower?" R80 responded, "If I don't get in on Monday, I don't get it for that week, even if I really want it. I got one today because I really bitched." R80 added that he had not been bathed last week at all. R80 reported he was told it was due to staffing issues. R80's care plan related to "Self Care Deficit related to: dx [diagnosis] of progressive weakness", last revised on 9/23/14, directed staff "Provide assist and supervision with shower." R80's November treatment record directed staff "Bath/Shower once a week with skin check by nurse. Nurse to verify." A review of the November and December 2014 resident body audit forms, untitled bathing forms and November treatment record revealed R80 received showers on 11/3/14, 11/17/14 and 12/1/14 for the time period of 11/1/14 through 12/3/14. A review of Interdisciplinary Notes for 11/1/14 through 12/3/14 did not reflect R80 declined bathing at any point. On 12/3/14 at 8:00 a.m. the nurse manager for second floor, [RN]-B reported a body audit sheet should be completed to reflect if resident was bathed or refused. At 9:25 a.m. RN-B reported staff should offer a shower weekly on the scheduled day. If a resident chose not to have a shower at that time, the resident should be re-approached and offered different choices.	F 311		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 12 RN-B confirmed there was no evidence of showers being given, outside of 11/3/14,11/17/14 and 12/1/14. RN-B could not explain the circumstances surrounding R80 not receiving a shower each week. Although on 12/4/14 at 8:15 a.m. the director of nursing [DON] reported an aide [NA]-C had been called and reported she showered R80 on 11/10/14, the DON confirmed this was not reflected in R80's medical record. R27 was interviewed on 12/1/14 at 6:09 p.m. and was asked how often R27 took a bath or shower?" R27 responded that ideally she would shower every night but decided to go along with just one because the waiting is "horrible". A review of R27's care area assessment and Minimum Data Set (MDS), dated 8/14/14, revealed R27 required physical help by staff in part of bathing. The care area assessment further noted "Triggered because she required assist with cares. She does have a diagnosis of Parkinson's and she does become more stiff at times. She is alert and oriented and able to communicate her needs to the staff. She has had no change in the amount of assistance needed with cares though based on her diagnosis it is possible that she will have a change/deterioration in the amount of assistance need as her disease progresses." The MDS, dated 8/14/14, revealed R27 was cognitively intact. A review of R27's care plan titled "Self Care Deficit related to: weakness, Parkinson's and	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. BUILDING _____ B. WING _____	12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CHATEAU HEALTH CARE CENTER	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 13 dementia", last revised 9/25/11 directed staff "Assist with bathing" A review of R27's November and December medication administration record directed staff to ensure R27 used a prescription shampoo (Selenium Sulfate Lotion 2.5%) with showers once weekly. A review of the November and December treatment and medication administration records, body audits and untitled bath forms for 11/1/14 through 12/3/14 revealed R27 received a shower on 11/7/14, 11/14/14 and 11/28/14. No form was provided that reflected a refusal of shower. A review of interdisciplinary notes for 11/1/4 through 12/3/14 revealed R27 did not decline a shower. During interview on 12/4/14 at 8:25 a.m. R27 reported sometimes she was not showered at least once each week and had missed a weekly shower recently. R27 was told she would have to skip the shower due to not having staff to assist her. On 12/4/14 at 9:41 a.m. the director of nursing (DON) confirmed she had provided all evidence of R27's bathing for November and December. At 12:09 p.m. the DON reported the nursing assistant should know to shower R27 because of the shower schedule. The nurse should ensure the shower was completed. If the shower was not completed due to a refusal the nurse should attempt an intervention to ensure the resident showered and if unsuccessful offer alternatives. The nursing staff on the next shift should be made aware of missed showers in order to try an alternate time. The nurse manager should be aware of missed showers.	F 311		

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	245028	A. BUILDING _____ B. WING _____	12/04/2014

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HIGHLAND CHATEAU HEALTH CARE CENTER	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116

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F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This.REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 431	• **F431** **Residents #79, #124, #141 had medications replaced at the time surveyor notified facility.** **All residents are at risk for receiving medication that has not been dated with date opened and expiration date.** **Nurses have been educated on proper dating and expiration of eye drops and insulin.** **DON/designee to audit weekly to ensure proper dating and expiration of eye drops and insulin as per policy.** **Audits will be reviewed at QAA for three months to ensure adherence to this policy.** **Deficient practice to be corrected by 1/13/2015.**	1/13/15

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F 431	Continued From page 15 review, the facility failed to ensure medications were stored and labeled properly for 3 of 5 residents (R79, R124, R141) whose medications were observed for medication storage. Findings include: During observations of multiple medication storage areas throughout the facility, medications for R79, R124 and R141, which included insulin and eye drops, lacked dates to indicate when they were opened, or when the medications were expired. The medication storage area of first floor east was reviewed on 12/3/14, at 8:05 p.m. with licensed practical nurse (LPN)-C: R79's insulin vial, Novolog (medication for diabetes) was opened, undated and potentially expired. At 8:08 a.m. LPN-C verified the medication was opened and undated. LPN-C stated the insulin was delivered on 10/25/14 and would give it to the nurse manager to be destroyed. During the medication storage tour on 12/11/14, at 8:16 a.m. with director of nursing (DON), in the first floor east, multiple medication bottles and vials were observed to be opened and undated: R124's Novolog insulin and Novolin vials (medication for diabetes) were opened, undated and had been used. R141's Travatan (medication for ocular hypertension) eye drop bottle was opened, undated and used. Review of R124's and R141's medication administration record (MAR) for 11/14, and 12/14, revealed the improperly labeled insulin vials and	F 431		

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F 431	Continued From page 16 eye drop bottle had been used to administer the medications to R124 and R141. During interview on 12/3/14 at 8:18 a.m. the director of nursing (DON) verified the medications needed to be labeled and stored properly. DON added that opened medications should be dated when opened and staff were supposed to date medication bottles when opened, check for expired medications and re-order them from the pharmacy. DON further indicated that new insulin vials would be ordered for R79 and R124, and a new eye drop bottle for R141. The facility's undated, Injectable medications storage and usage policy directed, "Insulin and other multidose injections should have the date of first use written on the vial. Insulin vials not refrigerated after opened should be discarded per manufacturer's recommendations."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	• **F441** **Nursing assistant "A" has been educated on proper hand washing procedures, including use of hand sanitizer.** **All residents who use the standing lift are at risk of breach of infection control by lack of hand washing between toileting and clothing assistance when up in the standing lift.** **Nursing staff educated on proper hand hygiene when using the lift, including option for hand sanitizer.** **Audits will be completed weekly by DON/designee to assure adherence to policy. Audits to be reviewed at QAA for three months to ensure adherence to this policy.** **Deficient practice to be corrected by 1/13/15.**	

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F 441	Continued From page 17 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene was conducted after personal care for 1 of 2 (R81) residents reviewed in the sample. Findings include: Review of R81's quarterly Minimum Data Set (MDS) dated 9/10/14, indcated R81 had no memory or cognitive problems and required extensive assistance with most ADL's. R81 was observed on 12/3/14, at 7:30 a.m., during morning cares. Nursing Assistant (NA)-A, entered R81's room to complete morning cares.	F 441		

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F 441	Continued From page 18 At 7:39 a.m., NA-B entered the room and assisted NA-A to transfer R81 from the bed onto the toilet with the EZ Stand. NA-B then left the room. NA-A washed her hands with soap and water in the bathroom and applied gloves. After toileting was completed, NA-A stood R81 using the EZ Stand and cleansed the perineal area using a disposable wipe. NA-A disposed of the wipe; disposed of the gloves; applied new gloves; and washed R81's buttock area. NA-A discarded the wipe and the gloves, and applied new gloves without completing hand hygiene. NA-A transferred R81 to the bedroom holding the EZ Stand handles, applied a clean incontinent product, and pulled up R81's pants. NA-A discarded her gloves and lowered R81 into the wheelchair touching the EZ Stand controls and wheelchair handles. NA-A then completed hand hygiene by washing hands with soap and water in the bathroom. On 12/3/14, at 12:55 p.m., NA-A confirmed that she had not washed her hands after R81's personal cares. NA-A stated, she typically does it that way as R81 has expressed she does not like to be in the EZ Stand for too long and it takes longer to wash hands with soap and water. On 12/3/14, at approximately 1:15 p.m., the Director of Nursing (DON) verified staff should hand wash their hands after personal cares. The DON added, maybe it would benefit the facility to provide hand sanitizer to decrease the time it takes to perform hand hygiene. The Perineal Care Policy dated 4/1/08, directed staff to remove gloves and wash hands after	F 441		

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F 441	Continued From page 19 cares and before applying new gloves. The Hand Washing Policy dated 4/1/08, states: "Sanitizer gels and liquids should be used when soap is not available. They should not be the primary cleansing agent."	F 441		

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

F50 38025

PRINTED: 12/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/04/2014

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Highland Chateau Healthcare Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	• **K050** **Fire drill practice has been updated to include varying times throughout all three shifts.** **Audits will be reviewed at QAA for three months to ensure adherence to this policy.** **Deficient practice to be corrected by 1/13/2015** POC ok 1-8-15 RECEIVED JAN - 8 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	01/08/15

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

G J Hennen | executive director | 01/08/15

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.

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Highland Chateau Healthcare Center is a 2-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1963 and was determined to be of Type II(222) construction. In 1970, an addition was constructed to the south side of the building that was determined to be of Type II(222) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fire sprinkler protected throughout. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor and resident rooms, that is monitored for automatic fire department notification. The facility has a licensed capacity of 64 beds and had a census of 58 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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	245028	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/04/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CHATEAU HEALTH CARE CENTER	**2319 WEST SEVENTH STREET SAINT PAUL, MN 55116**

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K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and interview,, it was determined that the facility failed to conduct fire drills in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Findings include: On facility tour between 09:00 AM and 01:00 PM on 12/04/2014, based on review of available documentation it was reveled that: Fire drills are not varied throughout the shift on all shifts: Day shift - 3 of 4 drills were conducted during the 9:00 to 10:00 hr. Evening shift - 3 of 4 drills were conducted during the 2:30 to 3:00 hr. Night shift - 3 of 4 drills were conducted during the 10:00 to 11:00 hr. This deficient practice was verified by Plant Operations Supervisor (JD).	K 050		

Certified Mail # 7010 1670 0000 8044 4547

December 18, 2014

Ms. Erin Shvetzoff Hennessey, Administrator
Highland Chateau Health Care Center
2319 West Seventh Street
Saint Paul, Minnesota 55116

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5028025

Dear Ms. Shvetzoff Hennessey:

The above facility was surveyed on December 1, 2014 through December 4, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: susanne.reuss@state.mn.us
Telephone: (651) 201-3793
Fax: (651) 201-3790

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe

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

Enclosure(s)
cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00494	A. BUILDING: _____ B. WING _____	12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On December 1st through the 4th, 2014 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Health Regulation Division; Licensing and Certification	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00494	A. BUILDING: _____ B. WING _____	12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CHATEAU HEALTH CARE CENTER	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116

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2 000	Continued From page 1 Program; Minnesota Department of Health; P.O. Box 64900, St. Paul, Minnesota 55164-0900.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the	2 555		

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2 555	Continued From page 2 attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to review and revise the plan of care related to central venous catheter (CVC) hemodialysis site for 1 of 1 resident (R42) care plan reviewed. Findings include: R42's care plan related to hemodialysis treatment was not revised to include the monitoring for potential infection and bleeding of current CVC site. During observations on 12/03/14, at 2:00 p.m. R42 was sitting in her wheelchair in her room and was watching television. R42 stated she went to a dialysis clinic three times per week to receive life sustaining treatment. When asked regarding her dialysis site, R24 pointed to her right upper chest stating, "here is the catheter". The site had a dressing on it. When asked how frequently the staff monitored her site for infection and bleeding, R24 stated, "the nurses don't look at it or do anything to it." During record review on 12/03/14, the dialysis plan of care, dated 10/19/14, revealed R24 went to dialysis three times per week due to End Stage Renal Disease (ESRD). The interventions included monitor lab, check vital signs, remove	2 555		

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2 555	Continued From page 3 pressure dressing after dialysis per order and if bleeding occurs from the site apply pressure, if bleeding continues transport R24 to the emergency room. check for bruit/thrill (to monitor a graft or fistula's patency) every shift, do not draw blood or take blood pressure in the arm with graft. Although a hand written undated note under the social service's plan of care indicated R24's sublcavian dressing changes occurred at the dialysis site, there was no documentation whether the nursing staff monitored and recorded R42's CVC site integrity during each shift to limit/prevent infections, bleeding concerns and potential of dislodging of CVC catheters. On 12/04/12, at 10:00 a.m. Registered Nurse (RN)-C indicated R42 did not have a fistula or graft and the only site R42 had was the subclavian site for dialysis. After reviewing R42's current dialysis plan of care, RN-C stated, the dialysis plan of care needed revision to remove graft care and add CVC care and monitoring. RN-C reviewed the medication and treatment records to see if the nursing staff was documenting CVC monitoring on these records and found there was no documentation regarding the CVC site monitoring. RN-C stated he would add the CVC site monitoring to the treatment records for nurses to document and update R42's medical care team if there were any changes in her CVC site. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents plan of care revised in a timely manner; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality	2 555		

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2 555	Continued From page 4 Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 555		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 3 residents reviewed for activities of daily living, R80 and R27 were bathed according to their plan of care. Findings include: R80's most recent Minimum Data Set, dated 9/18/14, collection revealed no concerns with memory/recall ability or cognitive skills for daily decision making. R80's care plan related to Self Care Deficit, last revised 9/23/14, directed staff to provide assist and supervision with shower. R80's November treatment record directed staff, "Bath/Shower once a week with skin check by nurse. Nurse to verify." Interview with R80 on 12/1/14 at 3:38 p.m., R80 was asked a question regarding bathing and	2 565		

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2 565	Continued From page 5 responded, "If I don't get in on Monday, I don't get it for that week, even if I really want it." R80 explained that he had not been bathed last week and was supposed to be bathed one time a week. A review of the November and December 2014 resident body audit forms, untitled bathing forms and November treatment record revealed R80 received showers on 11/3/14, 11/17/14 and 12/1/14 for the time period of 11/1/14 through 12/3/14. A review of Interdisciplinary Notes for 11/1/14 through 12/3/14 did not reflect R80 declined bathing at any point. On 12/3/14 at 8:00 a.m. the nurse manager for second floor, [RN]-B reported a body audit sheet should be completed to reflect if resident was bathed or refused. At 9:25 a.m. RN-B reported staff should offer a shower weekly on the scheduled day. If a resident chose not to have a shower at that time, the resident should be re-approached and offered different choices. RN-B confirmed there was no evidence of showers being given, outside of 11/3/14,11/17/14 and 12/1/14. RN-B could not explain the circumstances surrounding R80 not receiving a shower each week. Although, on 12/4/14 at 8:15 a.m., the director of nursing [DON] reported an aide [NA]-C had been called and reported she showered R80 on 11/10/14, the DON confirmed this was not reflected in R80's medical record. R27's MDS, dated 8/14/14, was reviewed and revealed R27 was cognitively intact. A review of	2 565		

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2 565	Continued From page 6 R27's care plan titled "Self Care Deficit related to: weakness, Parkinson's and dementia", last revised 9/25/11, directed staff "Assist with bathing" A review of R27's November and December medication administration record directed staff to ensure R27 used a prescription shampoo (Selenium Sulfate Lotion 2.5%) with showers once weekly. During interview on 12/1/14 at 6:09 p.m., R27 was asked about her shower/bathing schedule. R27 responded that ideally she would like a shower every night, but decided to go along with just once a week because she does'nt like waiting. During interview on 12/4/14 at 8:25 a.m. R27 reported that sometimes she was noteven showered weekly and had missed a weekly shower recently. R27 explained that she was told the shower would need to be skipped because there wasn't enough staff to assist her. A review of the November and December treatment and medication administration records, body audits and untitled bath forms for 11/1/14 through 12/3/14 revealed R27 received a shower on 11/7/14, 11/14/14 and 11/28/14. No form was provided that reflected a refusal of shower. A review of interdisciplinary notes for 11/1/4 through 12/3/14 revealed R27 did not decline a shower. On 12/4/14 at 9:41 a.m. the director of nursing [DON] confirmed she had provided all records of R27's bathing for November and December. At	2 565		

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2 565	Continued From page 7 12:09 p.m. the DON reported the nursing assistant should know to shower R27 because of the shower schedule. The nurse should ensure the shower was completed. If the shower was not completed due to a refusal the nurse should attempt an intervention to ensure the resident showered and if unsuccessful offer alternatives. The nursing staff on the next shift should be made aware of missed showers in order to try an alternate time. The nurse manager should be aware of missed showers. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents' plan of care is followed to provide proper care; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		

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2 830	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to review and revise the plan of care related to central venous catheter (CVC) hemodialysis site for 1 of 1 resident (R42) to provide necessary care and services. Findings include: R42's care plan related to hemodialysis treatment was not revised to include the monitoring for potential infection and bleeding of current CVC site. During observations on 12/03/14, at 2:00 p.m. R42 was sitting in her wheelchair in her room and was watching television. R42 stated she went to a dialysis clinic three times per week to receive life sustaining treatment. When asked regarding her dialysis site, R24 pointed to her right upper chest and said, "here is the catheter". The site had a dressing on it. When asked how frequently the staff monitored her site for infection and bleeding, R24 stated, "the nurses don't look at it or do anything to it." During record review on 12/03/14, the dialysis plan of care, dated 10/19/14, revealed R24 went to dialysis three times per week due to End Stage Renal Disease (ESRD). The interventions included monitor lab, check vital signs, remove pressure dressing after dialysis per order and if bleeding occurs from the site apply pressure, if bleeding continues transport R24 to the emergency room. check for bruit/thrill (to monitor	2 830		

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2 830	Continued From page 9 a graft or fistula's patency) every shift, do not draw blood or take blood pressure in the arm with graft. Although a hand written undated note under the social service's plan of care indicated R24's sublcavian dressing changes occurred at the dialysis site, there was no documentation whether the nursing staff monitored and recorded R42's CVC site integrity during each shift to limit/prevent infections, bleeding concerns and potential of dislodging of CVC catheters. On 12/04/12, at 10:00 a.m. Registered Nurse (RN)-C indicated R42 did not have a fistula or graft and the only site R42 had was the subclavian site for dialysis. After reviewing R42's current dialysis plan of care, RN-C stated, the dialysis plan of care needed revision to remove graft care and add CVC care and monitoring. RN-C reviewed the medication and treatment records to see if the nursing staff was documenting CVC monitoring on these records and found there was no documentation regarding the CVC site monitoring. RN-C stated he would add the CVC site monitoring to the treatment records for nurses to document and update R42's medical care team if there were any changes in her CVC site. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents receive proper nursing care and treatment regarding dialysis catheter; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee.	2 830		

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2 830	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide assistance to 2 of 3 residents (R80, R27) reviewed for activities of daily living that required assistance to participate with bathing. Findings include: R80's most recent Minimum Data Set, dated 9/18/14, collection revealed no concerns with memory/recall ability or cognitive skills for daily	2 915		

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2 915	Continued From page 11 decision making. R80's care area assessment and minimum data set [MDS], dated 9/18/14 assessed R80 to need supervision by staff while bathing, noting, "He requires assist with setting up bathing utensils and is able to bathe himself after utensils are set up." During interview, on 12/1/14 at 3:38 p.m. R80 was asked how many times a week R80 took a bath or shower?" R80 responded, "If I don't get in on Monday, I don't get it for that week, even if I really want it. I got one today because I really bitched." R80 added that he had not been bathed last week at all. R80 reported he was told it was due to staffing issues. R80's care plan related to "Self Care Deficit related to: dx [diagnosis] of progressive weakness", last revised on 9/23/14, directed staff "Provide assist and supervision with shower." R80's November treatment record directed staff "Bath/Shower once a week with skin check by nurse. Nurse to verify." A review of the November and December 2014 resident body audit forms, untitled bathing forms and November treatment record revealed R80 received showers on 11/3/14, 11/17/14 and 12/1/14 for the time period of 11/1/14 through 12/3/14. A review of Interdisciplinary Notes for 11/1/14 through 12/3/14 did not reflect R80 declined bathing at any point. On 12/3/14 at 8:00 a.m. the nurse manager for second floor, [RN]-B reported a body audit sheet	2 915		

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2 915	Continued From page 12 should be completed to reflect if resident was bathed or refused. At 9:25 a.m. RN-B reported staff should offer a shower weekly on the scheduled day. If a resident chose not to have a shower at that time, the resident should be re-approached and offered different choices. RN-B confirmed there was no evidence of showers being given, outside of 11/3/14,11/17/14 and 12/1/14. RN-B could not explain the circumstances surrounding R80 not receiving a shower each week. Although on 12/4/14 at 8:15 a.m. the director of nursing [DON] reported an aide [NA]-C had been called and reported she showered R80 on 11/10/14, the DON confirmed this was not reflected in R80's medical record. R27 was interviewed on 12/1/14 at 6:09 p.m. and was asked how often R27 took a bath or shower?" R27 responded that ideally she would shower every night but decided to go along with just one because the waiting is "horrible". A review of R27's care area assessment and Minimum Data Set (MDS), dated 8/14/14, revealed R27 required physical help by staff in part of bathing. The care area assessment further noted "Triggered because she required assist with cares. She does have a diagnosis of Parkinson's and she does become more stiff at times. She is alert and oriented and able to communicate her needs to the staff. She has had no change in the amount of assistance needed with cares though based on her diagnosis it is possible that she will have a change/deterioration in the amount of assistance need as her disease	2 915		

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2 915	Continued From page 13 progresses." The MDS, dated 8/14/14, revealed R27 was cognitively intact. A review of R27's care plan titled "Self Care Deficit related to: weakness, Parkinson's and dementia", last revised 9/25/11 directed staff "Assist with bathing" A review of R27's November and December medication administration record directed staff to ensure R27 used a prescription shampoo (Selenium Sulfate Lotion 2.5%) with showers once weekly. A review of the November and December treatment and medication administration records, body audits and untitled bath forms for 11/1/14 through 12/3/14 revealed R27 received a shower on 11/7/14, 11/14/14 and 11/28/14. No form was provided that reflected a refusal of shower. A review of interdisciplinary notes for 11/1/4 through 12/3/14 revealed R27 did not decline a shower. During interview on 12/4/14 at 8:25 a.m. R27 reported sometimes she was not showered at least once each week and had missed a weekly shower recently. R27 was told she would have to skip the shower due to not having staff to assist her. On 12/4/14 at 9:41 a.m. the director of nursing (DON) confirmed she had provided all evidence of R27's bathing for November and December. At 12:09 p.m. the DON reported the nursing assistant should know to shower R27 because of the shower schedule. The nurse should ensure the shower was completed. If the shower was not completed due to a refusal the nurse should attempt an intervention to ensure the resident showered and if unsuccessful offer alternatives.	2 915		

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2 915	Continued From page 14 The nursing staff on the next shift should be made aware of missed showers in order to try an alternate time. The nurse manager should be aware of missed showers. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents activities of daily living is based on their comprehensive resident assessments; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 915		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as	21390		

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21390	Continued From page 15 defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene was conducted after personal care for 1 of 2 (R81) residents reviewed in the sample. Findings include: Review of R81's quarterly Minimum Data Set (MDS) dated 9/10/14, indcated R81 had no memory or cognitive problems and required extensive assistance with most ADL's. R81 was observed on 12/3/14, at 7:30 a.m., during morning cares. Nursing Assistant (NA)-A, entered R81's room to complete morning cares. At 7:39 a.m., NA-B entered the room and assisted NA-A to transfer R81 from the bed onto the toilet with the EZ Stand. NA-B then left the room. NA-A washed her hands with soap and water in the bathroom and applied gloves. After toileting was completed, NA-A stood R81 using the EZ	21390		

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21390	Continued From page 16 Stand and cleansed the perineal area using a disposable wipe. NA-A disposed of the wipe; disposed of the gloves; applied new gloves; and washed R81's buttock area. NA-A discarded the wipe and the gloves, and applied new gloves without completing hand hygiene. NA-A transferred R81 to the bedroom holding the EZ Stand handles, applied a clean incontinent product, and pulled up R81's pants. NA-A discarded her gloves and lowered R81 into the wheelchair touching the EZ Stand controls and wheelchair handles. NA-A then completed hand hygiene by washing hands with soap and water in the bathroom. On 12/3/14, at 12:55 p.m., NA-A confirmed that she had not washed her hands after R81's personal cares. NA-A stated, she typically does it that way as R81 has expressed she does not like to be in the EZ Stand for too long and it takes longer to wash hands with soap and water. On 12/3/14, at approximately 1:15 p.m., the Director of Nursing (DON) verified staff should hand wash their hands after personal cares. The DON added, maybe it would benefit the facility to provide hand sanitizer to decrease the time it takes to perform hand hygiene. The Perineal Care Policy dated 4/1/08, directed staff to remove gloves and wash hands after cares and before applying new gloves. The Hand Washing Policy dated 4/1/08, states: "Sanitizer gels and liquids should be used when soap is not available. They should not be the primary cleansing agent."	21390		

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21390	Continued From page 17 A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that infection control policy and procedures are developed and implemented; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced	21426		

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21426	Continued From page 18 by: Based on interview and document review, the facility failed to ensure a tuberculosis (TB) risk assessment was completed, using current Centers for Disease Control and Prevention (CDC) guidelines, for 3 of 5 employees reviewed (E-A, E-B and E-C) for TB and 2 of 5 residents reviewed, (R43 and R67). This had the potential to impact all residents residing at the facility. Findings include: The facility failed to ensure the facility TB risk assessment used the most current guidelines from the CDC in determining risk level. A review of the TB Risk Assessment Worksheet-Attachment A, dated 5/13/14 revealed the facility was low risk. The form referred to the document, Guidelines for Preventing the Transmission of Myobacterium tuberculosis in Health-Care Facilities, 1994. During interview on 12/04/2014 11:46 a.m. the director of nursing (DON) reported she was not aware she was using outdated guidelines. DON was not aware she should be using either the Guidelines for Preventing the Transmission of Myobacterium tuberculosis in Health-Care Facilities, 2005; Appendix B: Tuberculosis (TB) risk assessment worksheet from the Centers for Disease Control and Prevention (CDC) or, Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by the Minnesota Department of Health (MDH). The facility failed to ensure 3 of 5 newly hired employees reviewed were appropriately screened for TB.	21426		

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21426	Continued From page 19 A review of a new employee file for (E)-A revealed E-A had a history of a positive tuberculin skin test (TST) per clinic exam record, dated 10/24/13. However, E-A did not have a chest x-ray completed and on file with the facility. A review of employee file for (E)-C revealed no TB symptom screening was completed prior to start of employment. A review of employee file for (E)-B revealed no TB symptom screening was completed prior to start of employment. Both E-B's and E-C's TB screening form, dated 8/4/14, directed staff "If you had a positive tuberculin skin test or history of tuberculosis, complete the following sections. If you develop any of the following symptoms, report to the Infection Control Nurse as soon as possible." The facility failed to ensure 2 out of 5 newly admitted residents reviewed were appropriately screened for TB. A review of R43's medical record revealed R43 was admitted on 9/7/14. A TB symptom screening was not completed. A review of R67's medical record revealed R67 was admitted on 9/12/14. A TB symptom screen and 2 step TST was not initiated or completed. During interview on 12/04/2014 11:46 a.m. the DON confirmed findings. The Tuberculosis Control Plan policy, undated, directed staff "Every healthcare setting should conduct initial and ongoing evaluations of the risk for transmission of TB, regardless of whether or not patients/residents with suspected or confirmed TB are expected to be encountered at	21426		

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21426	Continued From page 20 the setting. The TB risk assessment determines the types of administrative, environmental, and respiratory-protection controls needed for a setting and serves as an ongoing evaluation of the quality of TB infection control and for the identification of needed improvements in infection control measures." The policy further directed staff "All residents will have a two-step TST upon admission and will be evaluated for symptoms of TB, including cough, fever, night sweats, weight loss, etc. If the TST is positive, a chest x-ray will be done and the attending physician and/or medical director will determine if further laboratory studies are indicated." The policy further directed staff "All employees will have an initial two-step TST on hire and a single step annual TST of indicated, or symptom review to determine risk of possible progression to active disease." The policy did not direct staff to complete an initial TB symptom screening and two step TST for all employees.	21426		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were stored and labeled properly for 3 of 5 residents (R79, R124, R141) whose medications were observed for medication storage. Findings include: During observations of multiple medication	21620		

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21620	Continued From page 21	21620		

storage areas throughout the facility, medications for R79, R124 and R141, which included insulin and eye drops, lacked dates to indicate when they were opened, or when the medications were expired.

The medication storage area of first floor east was reviewed on 12/3/14, at 8:05 p.m. with licensed practical nurse (LPN)-C:
R79's insulin vial, Novolog (medication for diabetes) was opened, undated and potentially expired. At 8:08 a.m. LPN-C verified the medication was opened and undated. LPN-C stated the insulin was delivered on 10/25/14 and would give it to the nurse manager to be destroyed.

During the medication storage tour on 12/11/14, at 8:16 a.m. with director of nursing (DON), in the first floor east, multiple medication bottles and vials were observed to be opened and undated:
R124's Novolog insulin and Novolin vials (medication for diabetes) were opened, undated and had been used.
R141's Travatan (medication for ocular hypertension) eye drop bottle was opened, undated and used.

Review of R124's and R141's medication administration record (MAR) for 11/14, and 12/14, revealed the improperly labeled insulin vials and eye drop bottle had been used to administer the medications to R124 and R141.

During interview on 12/3/14 at 8:18 a.m. the director of nursing (DON) verified the medications needed to be labeled and stored properly. DON added that opened medications should be dated when opened and staff were supposed to date medication bottles when opened, check for

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21620	Continued From page 22 expired medications and re-order them from the pharmacy. DON further indicated that new insulin vials would be ordered for R79 and R124, and a new eye drop bottle for R141. The facility's undated, Injectable medications storage and usage policy directed, "Insulin and other multidose injections should have the date of first use written on the vial. Insulin vials not refrigerated after opened should be discarded per manufacturer's recommendations." A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that all medications are labeled and stored properly; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R27),	21805		

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21805	Continued From page 23 reviewed for dignified treatment, was treated in a way that maintained dignity with activities of daily living. Findings include: R27's most recent Minimum Data Set (MDS), dated 8/14/14, revealed R27 was cognitively intact and required physical assistance of one staff for transfers, toileting and dressing. On 12/1/14 at 6:13 p.m. R27 reported; did not feel staff treated her with dignity and respect because of having to wait so long for help. R27 added having to wait a half hour to get help from staff to get off the toilet. R27 added she waited a long time for help in being transferred into bed, dressed and undressed. When asked how that made her feel, R27 responded "Like I'm not even here, like their playing games with a human being. I'm human but I don't get treated like human. I just get treated like a wall flower or something." R27's care plan for impaired mobility related to weakness and Parkinson's, last revised 6/9/14, directed staff to provide assistance of one staff for transfers and ambulation. The fall prevention care plan, last revised 11/19/14 directed staff to have two staff assist with getting up in the morning. The self care deficit care plan, last revised 9/25/11, directed staff to provide assistance of one staff for dressing. On 12/2/14 at 3:25 p.m. a nursing assistant on R27's unit, (NA)-E, reported residents waited a long time for call lights to get answered when only	21805		

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21805	Continued From page 24 three nursing assistants were on second floor. NA-E explained if resident required assistance of 2 or 3 staff for cares, that did not leave a nursing assistant to help answer call lights. NA-E reported sometimes residents complained about having to wait for help. On 12/2/14 at 3:25 p.m. a nursing assistant, (NA)-D, on R27's unit reported residents frequently had to wait a long time for call lights to get answered, particularly when three nursing assistants were scheduled on the second floor, instead of four. NA-D added residents had many physical and mental issues and required timely assistance from staff. On 12/4/14 at 2:06 p.m. a nursing assistant working on R27's unit, (NA)-A, reported regularly residents have to wait a long time for help with using the toilet. R27 used to be able to sit on the toilet alone after transfer assistance, but recently she has not been allowed to be left in there alone. NA-A reported R27 usually would yell when she needed something but has also needed to wait for staff to help with cares. On 12/4/14 at 2:08 p.m. a nursing assistant working on R27's unit, (NA)-B, reported residents often needed to wait for help if only three nursing assistants worked on second floor. NA-B explained if nursing aides helped one resident onto the toilet and then another resident on the unit needed help, then the one on the toilet might need to wait for enough staff to be available for staff to return and finish helping them with toileting. A review of R27's call light log for 11/4/14 through 12/4/14 revealed the call light was activated for over twenty minutes before staff	21805		

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21805	Continued From page 25 arrived to help on five occasions. Three of those occasions indicated the call light was activated from the bathroom. Two indicated the call light was activated from the bedroom. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents receive dignified care; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21805		