CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL TE SURVEY AGENCY		ID: LWJ3 Facility ID: 00164	
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245242 2.STATE VENDOR OR MEDICAID NO. (L2) 159540700		3. NAME AND AD (L3) AUGUSTAN. (L4) 1007 EAST 1-(L5) MINNEAPO	A HEALTH CA 4TH STREET		TER OF MINNEAPOLIS (L6) 55404	4. TYPE OF ACT 1. Initial 3. Termination 5. Validation	PION: 7 (L8) 2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OWNERSI (L9)	HIP	7. PROVIDER/SUF	PPLIER CATEGOR	RY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey Af	9. Other ter Complaint	
6. DATE OF SURVEY 07/18/2019 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR END	DING DATE: (L35)	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 25: 13.Total Certified Beds 25:	5 (L18) 5 (L17)	Complianc1. A B. Not in Con	nce With equirements to Based On: Acceptable POC	am	And/Or Approved Waivers Of Th2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNI5. Life Safety Code		Services Limit Director Room Size	
14. LTC CERTIFIED BED BREAKDOWN	10 CNF		and/or Applied Wair	vers:	* Code: A 15. FACILITY MEETS	(L12) (L15)		
18 SNF 18/19 SNF 255 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L13)		
16. STATE SURVEY AGENCY REMARKS (IF An increase in the number of certified SN accordance with Minn. Stat. 144A.071, St they will have zero (0) beds on layaway.	F/NF beds falls. Ibd. 4b., as a	rom 255 beds to 286	beds, effective A	August 1, 20				
17. SURVEYOR SIGNATURE Eva Loch, Unit Supervis	sor	Date :	08/13/2019		18. STATE SURVEY AGENCY. Douglas Larson, Enf		Date:	
				(L19)				
DETERMINATION OF ELIGIBILITY		20. COM	IPLIANCE WITH C		21. 1. Statement of Final	ncial Solvency (HCFA-2		
OF PARTICIPATION 01/01/1982 (L24)	TC AGREEM BEGINNING [L41]	DATE	4. LTC AGREEMI ENDING DATI (L25)		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursem 03-Risk of Involuntary Termination	05-Fail	(L30) UNTARY to Meet Health/Safety to Meet Agreement	
A 27)	. Suspension	VE SANCTIONS n of Admissions: pension Date:	(L44) (L45)		04-Other Reason for Withdrawal	OTHEF 07-Prov 00-Acti	rider Status Change	
28. TERMINATION DATE:	29	. INTERMEDIARY/C	CARRIER NO.		30. REMARKS			

(L31)

(L33)

DETERMINATION APPROVAL

32. DETERMINATION OF APPROVAL DATE

07/23/2019

31. RO RECEIPT OF CMS-1539

(L28)

(L32)



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245242

August 13, 2019

Administrator Augustana Health Care Center Of Minneapolis 1007 East 14th Street Minneapolis, MN 55404

Dear Administrator:

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 July 16, 2019 the above facility is certified for:

255 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 255 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K 0521.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare and Medicaid Program.

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/or Medicaid provider agreement may be subject to non-renewal or termination.

Augustana Health Care Center Of Minneapolis August 13, 2019 Page 2

Please contact me if you have any questions.

Sincerely,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

DOWNES LADSON

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 13, 2019

Administrator Augustana Health Care Center Of Minneapolis 1007 East 14th Street Minneapolis, MN 55404

RE: Project Number S5242030, H5242119C, H5242121C, H5242122C

Dear Administrator:

On July 18, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under K 0521 at the time of the June 6, 2019 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Towers Stapson

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL E SURVEY AGENCY		ID: LWJ3 Facility ID: 00164
MEDICARE/MEDICAID PROVIDER NO. (L1) 245242 2.STATE VENDOR OR MEDICAID NO. (L2) 159540700 5. EFFECTIVE DATE CHANGE OF OWNERSH	(L3) (L4) (L5)) AUGUSTANA) 1007 EAST 14) MINNEAPOI	TH STREET	RE CENT	(L6) 55404	4. TYPE OF AC 1. Initial 3. Termination 5. Validation 7. On-Site Visit	2. Recertification 4. CHOW 6. Complaint
(L9)	01 1	Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey	After Complaint
6. DATE OF SURVEY 06/06/2019 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	_ (L10) 03 S	SNF/NF/Dual SNF/NF/Distinct SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR EN	NDING DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 250 13. Total Certified Beds 250	(L18)	A. In Complian Program Re Compliance1. A B. Not in Com	S CERTIFIED AS: ce With equirements e Based On: cceptable POC pliance with Progra nd/or Applied Waix	am	And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF 5. Life Safety Code	6. Scope 7. Medic	of Services Limit al Director Room Size
14. LTC CERTIFIED BED BREAKDOWN		Requirements a	nd/of Applied warv	reis.	* Code: B * 15. FACILITY MEETS	(L12)	
18 SNF 18/19 SNF 250	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
An increase in the number of certified SNI	7. SURVEYOR SIGNATURE Date: 18. STATE SURVEY AGENCY APPROVAL Date:						
PART I	I - TO BE CO	MPLETED I	BY HCFA RE	GIONAI	OFFICE OR SINGLE ST	ATE AGENCY	(L20
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible	(L21)		PLIANCE WITH C HTS ACT:	CIVIL	Statement of Finar Ownership/Contro Both of the Above	l Interest Disclosure S	
22. ORIGINAL DATE 23. LT	C AGREEMENT	24	. LTC AGREEM	ENT	26. TERMINATION ACTION:		(L30)
OF PARTICIPATION B 01/01/1982	EGINNING DATE	E	ENDING DATE	3	VOLUNTARY 00 01-Merger, Closure	05-Fa	DLUNTARY il to Meet Health/Safety
(L24)	.41)		(L25)		02-Dissatisfaction W/ Reimburseme	***	il to Meet Agreement
(I 27)	LTERNATIVE SA Suspension of Ad Rescind Suspension	dmissions:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	<u>OTH.</u>	ovider Status Change
28. TERMINATION DATE:	29 IN	ΓERMEDIARY/C.	(L45) ARRIER NO.		30. REMARKS		

(L31)

(L33)

DETERMINATION APPROVAL

03001

32. DETERMINATION OF APPROVAL DATE

(L28)

(L32)

31. RO RECEIPT OF CMS-1539



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 27, 2019

Administrator Augustana Health Care Center Of Minneapolis 1007 East 14th Street Minneapolis, MN 55404

RE: Project Number S5242030, H5242119C, H5242120C, H5242121C, H5242122C

Dear Administrator:

On June 6, 2019, 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. In addition, at the time of the June 6, 2019 standard survey, the Minnesota Department of Health completed an investigation of complaint numbers H5242119C, H5242120C, and H5242122C that were substantiated.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the June 6, 2019 standard survey, the Minnesota Department of Health completed an investigation of complaint number H5242121C that was found to be unsubstantiated.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is July 16, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

Augustana Health Care Center Of Minneapolis June 27, 2019 Page 2

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));
- Civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792

Phone: (651) 201-3792 Fax: (651) 215-9697

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department

Augustana Health Care Center Of Minneapolis June 27, 2019 Page 3

of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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 September 6, 2019 (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).

In addition, if substantial compliance with the regulations is not verified by December 6, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900 Augustana Health Care Center Of Minneapolis June 27, 2019 Page 4

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html.

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. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012

Fax: (651) 215-0525

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Downes Stapson

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

PRINTED: 07/16/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245242	B. WING			С
NAME OF F	PROVIDER OR SUPPLIER	243242	B. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE	06/	06/2019
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
F 000	Requirements was 6/6/19 during a rece		F 00	00		
	completed at your f Department of Hea NOT in compliance CFR Part 483, Sub Long Term Care Fa Additionally, comple	a standard survey was acility by the Minnesota lth. The facility was found with the requirements of 42 part B, and Requirements for acilities. aints were investigated on 42120C, H5242122C,				
	H5242121C, H5242 H5242120C was su issued. H5242122C was su was issued at F609 H5242121C was ur deficiency issued at	2119C. ubstantiated with no deficiency ubstantiated and a deficiency nsubstantiated with a				
	as your allegation on Department's accept enrolled in ePOC, year the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required first page of the CMS-2567 ic submission of the POC will tion of compliance.				
	on-site revisit of you	acceptable electronic POC, an ur facility will be conducted to				
ABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

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

Electronically Signed

07/03/2019

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY PLETED
		245242	B. WING _			C 06/2019
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
ALICHET	ANA UEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET		
AUGUST	ANA REALIR CARE	CENTER OF MINNEAPOLIS		MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000 F 558 SS=D	validate that substa regulations has be your verification. Reasonable Accor	antial compliance with the en attained in accordance with	F 00 F 55			7/16/19
	S483.10(e)(3) The services in the faci accommodation of preferences excependanger the healt other residents. This REQUIREME by: Based on observareview, the facility accessible for 2 of were capable of us. Findings include: R20's quarterly Mir 3/5/19, indicated Rand R20 needed etransfers. On 6/5/19, at 10:00 her recliner calling walked into the roclight approximately the bottom of a flow bed. R20 was interknow where her caget out of her chair juice.	right to reside and receive lity with reasonable resident needs and t when to do so would the or safety of the resident or NT is not met as evidenced tion, interview and document failed to ensure call lights were 2 residents (R20, R174) who		Augustana Health Care Center of Minneapolis' Plan of correction is a credible assertion of substantial compliance with the Federal and S requirement of Nursing facilities an skilled nursing facilities participatin Federal Medicare or State Medical Assistance programs. Please note nothing set forth in this document is or should be construed to be an admission by Augustana Health Ca Center of Minneapolis, or the validi accuracy of any of the deficiencies by the Minnesota Department of Herelative to the survey, certification, enforcement effort at issue. Further please note that nay and all document transmitted or otherwise provided & Augustana Health Care Center of Minneapolis, in relation to the plan correction, as well as any and all or communications in writing or otherwor on the behalf of Augustana Health	tate id/or g in the that s to be are ity or cited ealth and er inents by of ther wise by	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION		E SURVEY PLETED
		245242	B. WING			1	D 6/2019
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	, 00/0	30,2010
					007 EAST 14TH STREET		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			MINNEAPOLIS, MN 55404		
0(4) ID	CLIMMADV CT	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	VI.	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 558	Continued From pa	age 2	F 5	558			
	walked into R20's r	oom and verified R20's call			Center of Minneapolis, at law and/o	or in	
		A-K stated she must have			equity, all of which are not waived a		
		call light on R20's recliner			of which are reserved and retained		
		each it. NA-K stated R20 was			and on behalf of Augustana Health		
	able to use her call	light, has used her call light			Center of Minneapolis.		
		t was supposed to be in the					
		-K handed the call light to R20			F558		
		ne call light button a couple of			It is the policy of the Augustana He		
	times and activated	d it.			Care Center to provide services with		
	0 0/5/40				reasonable accommodation of resi		
		a.m. licensed practical nurse			needs and preferences including en		
		e expected residents' call lights			call lights are accessible for resider	าเร	
		for the residents who can use			capable or using the call light. Corrective Action:		
		d R20 had the ability to use her call light should have been			Immediate re-education of NAR's w	vho	
		she was sitting in her recliner.			incorrectly place call lights for the 2		
					identified residents		
	R174's call light wa	s observed on the floor			Identification of Other Residents:		
		ottom of a grab bar on 6/3/19,			Facility wide call light placement au	dit was	
		asked where his call light was			completed for all beds on 7-2-19		
		d not find it and needed to			Measures Put In Place:		
		per. R174 stated he needed			Mandatory education for all Nursing		
		as the only way he could reach			was conducted in regards to facility		
		gistered nurse (RN)-A entered			practice in regards to call light place	ement	
		rmed R174 could not reach his			and response.		
		as hanging and stated he was ng over to reach down the side			7-15-19 Monitoring Mechanisms:		
		g out of bed on his own. RN-A			Call light audits were conducted on	all	
		had previously requested to			units at various times to ensure sta		
		pinned to his shirt or gown and			of practice for call light placement a		
	he was capable of				response was being followed July 1		
		S			2019	- 7	
	R174's care plan d	ated 11/20/18, included:			Call lights audits will continue 1 tim	е	
		rmance with bathing due to			monthly on all units for the next 90		
	multiple fractures,	range of motion limitations.			QAPI committee will review call ligh		
					audits for maintaining facility standa		
		ote dated 5/29/19, at 1:56 p.m.			call light placement and response f	or the	
	included R174 was call light effectively	alert and oriented and used			next 90 days on or before: 7-31-19		

AND PLAN OF CO	RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	COMF	SURVEY PLETED
		245242	B. WING		06/0)6/2019
	DER OR SUPPLIER	CENTER OF MINNEAPOLIS	_	STREET ADDRESS, CITY, STATE, ZIP C 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	•	70/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
Clin a.m all r before using the content of the cont	a. her expectation resident's call light ore leaving the ring his call light. It director of nurse and her expectation in reach for all five facility's call light of the resident room. Section of the resident room. Section of the resident room of the resident room of the resident has the mote and facilities ough support of limited to the right of the resident has the mote and facilities ough support of limited to the right of the resident has the mote and facilities ough support of limited to the right of the right of the resident has the support of limited to the right of the right of the resident has the support of limited to the right of the right of the right of the resident has the support of limited to the right of t	CM)-A stated on 6/6/19, at 8:29 in would be for staff to ensure this were in the proper place from and R174 was capable of sing stated on 6/6/19, at 10:48 in would be for call lights to be facility residents. In the policy dated 12/31/18, ce call light so it would be esident at all times when in the call light to stay within the ent. In (3)(8) In the policy dated 12/31/18, ce call light so it would be esident at all times when in the call light to stay within the ent. In (3)(8) In the policy dated 12/31/18, ce call light so it would be esident at all times when in the call light to stay within the ent. In (3)(8) In (4)(8) In (5)(8) In (6)(8) In (7)(8) In (7)(8) In (8)(8) In (8)(8)	F 56	8-31-19 9-30-19 Responsible Person/s Administrator Director of Nursing or their of Assistant Administrator/Qualimprovement Director 7-16-19	lity	7/16/19

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	ľ	(3) DATE SURVEY COMPLETED
		245242	B. WING		C 06/06/2019
	PROVIDER OR SUPPLIER	E CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	00/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES :Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION DATE
F 561	community activiting facility. §483.10(f)(8) The participate in other religious, and comminterfere with the refacility. This REQUIREMED by: Based on observative, the facility bathing preference of bathing for 2 of who were reviewe. Findings include: R104 stated on 6/3 by staff he would gince his admission showers. R104 stated the function of the would like did not like to take because he could further stated the function what his bathing padmission and he could but was a litt having showers.	he community and participate in es both inside and outside the resident has a right to activities, including social, munity activities that do not ights of other residents in the ENT is not met as evidenced ation, interview and document failed to determine resident es or provide documented proof 7 residents (R104 and R174)	F 56	,	ent eeded ucted in the ences with
	a skin check with I R104's admission dated 4/10/19, ind improvement with	no areas of concern noted. care area assessment (CAA) icated R104 required activities of daily living (ADL's) skilled therapy and to refer to		Mandatory education for all nursing s will be conducted on observing reside bathing preferences. Monitoring Mechanism: 10% random audits for bathing preferences being documented and	

			DATE SURVEY COMPLETED			
		0.450.40				С
		245242	B. WING _		•	06/06/2019
NAME OF	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP (CODE	
ALIGHE	TANA UEALTU CADI	E CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET		
AUGUS	IANA IILALIII VANI	CENTER OF MINNEAPOLIS		MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 561	R104's care plan of had impaired self related to weakne asthma. The care extensive assist or resident to participal regarding bathing R104's progress of R104's progress of R104 being reashower in subsequence of R104 being reashower in subsequence of R104 lacked docupreferences or bath R104 was observent of	dated 4/15/19, indicated R104 performance with bathing ss, depression with anxiety, and plan included approaches of fone person and encourage pate as able but no information preferences. Notes were reviewed from with 4/5/19, the only ng reference which indicated he There was no documentation pproached or receiving another uent progress notes. Medical record (EMR) and tration record (TAR) for May, 75/19, at 1:40 p.m. revealed mentation of bathing thing having been completed. Med in his room on 6/5/19, at 3:49 stringy appearing and was clothes as the day before with em. (NA)-F stated on 6/5/19, at 3:32 art all resident's showers and ditell the registered nurse (RN) sal. NA-F also stated she was referred showers during the day	F 56	,	he QAPI g preference ndard of care pefore:	

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	COM	E SURVEY IPLETED
		245242	B. WING			06/2019
	PROVIDER OR SUPPLIER	E CENTER OF MINNEAPOLIS	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	, 50	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 561	documented week a resident refused approached shorth should be given as refusal or the next R174 stated on 6/3 direct care staff for would not get then would not even ge was real hot in his did not get his sho smelly. R174 stated on 6/4 assistant (NA) can would not get a sh his bath day. R174 out today and he for disappointed he would not get a sh his bath day. R174 out today and he for disappointed he would not get a sh his bath day. R174 stated R17 April on 4/9/19, an no documented bath ad impaired self promultiple fracture limitations. The catotal assist with one ensure comfort dubathing preferences. R174 stated on 6/8 approached the states.	showers and refusals were not ally as they should have been. If a shower they should be y after and the shower and one is soon as possible after the day. 3/19, at 9:42 a.m. he asked if two showers a week but in regularly and sometimes to one a week. R174 stated it room sometimes and when he wer or bath he felt sticky and 4/19, at 6:37 p.m. the nursing the by his room and told him he ower tonight because it was not a further stated it had been hot left sweaty and sticky and was ould not get a shower tonight. FAR review on 6/5/19, at 1:30 and athing preferences. Stated 11/20/18, indicated R174 performance with bathing due as and range of motion (ROM) are plan included approaches of the to two persons as needed to ring task but did not include	F 561			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	, COV	E SURVEY IPLETED
		245242	B. WING _			C /06/2019
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	00	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 561	for saying this was him a shower. R174 asked about his bar conferences and he many or when he was RN-G stated on 6/6 not assessed for bar admission and it was she was not aware could see there was him being bathed was the patient was satischedule. Bathing paddressed at care of plans updated with The Facility's Bathing dated 12/5/18, incluinterviewed at the titheir bathing prefere	not his shower day and gave 4 also stated he would not be thing preferences at care e had not been asked how would like showers. 6/19, at 8:29 a.m. R174 was athing preferences upon as missed. RN-G also stated he had missed showers but is missing documentation of weekly. Sing (DON) stated on 6/6/19, all be for staff to review all newly admitted residents I regularly after that to ensure sfied with their bathing preferences should also be conferences and the care	F 56	31		
F 580 SS=D	Notify of Changes (CFR(s): 483.10(g)(§483.10(g)(14) Not (i) A facility must imconsult with the resconsistent with his representative(s) w (A) An accident invo	ification of Changes. Imediately inform the resident; ident's physician; and notify, or her authority, the resident	F 58	30		7/16/19

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		MPLETED
		245242	B. WING		06	C 5/06/2019
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 580	mental, or psychos deterioration in heastatus in either life-clinical complicatio (C) A need to alter a need to discontint treatment due to accommence a new (D) A decision to tresident from the fights of the figh	ion; ange in the resident's physical, accial status (that is, a alth, mental, or psychosocial otheratening conditions or ns); treatment significantly (that is, are an existing form of diverse consequences, or to form of treatment); or ansfer or discharge the accility as specified in accility as specified in southfication under paragraph (g) on, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the stalso promptly notify the sident representative, if any, or roommate assignment 3.10(e)(6); or sident rights under Federal or tions as specified in paragraph on. st record and periodically is (mailing and email) and	F 5	80		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245242	B. WING _		l	C 06/2019
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CO		00/2013
10 000	TO VIDER OR GOLT EIER	•		1007 EAST 14TH STREET	.52	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	Continued From page	age 9	F 58	80		
		ween its different locations				
	under §483.15(c)(9					
		NT is not met as evidenced				
		w and document review, the		F580		
		tify the primary care provider		It is the policy of Augustana I	lealth Care	
		elopment of a facility acquired		Center to notify the physician	of change of	
		cer for 1 of 1 resident (R9)		condition		
	reviewed for press	ure ulcer.		Corrective Action:		
				Immediate re-education of N		
	Findings include:			failed to notify physician of checondition.	lange of	
	R0's quarterly Mini	imum Data Set (MDS) dated		Identified Resident's current	wound status	
		R9 had intact cognition and did		was reviewed and physician		
		iring the reference period. The		of current Pressure Ulcer sta		
		required extensive assistance		by wound nurse.		
		and total dependence for		Identification of Other Reside	ents:	
		e MDS indicated R9 was at risk		All residents with identified P	ressure	
		and had a pressure reducing		Ulcers on 6-6-19 were audite	d to ensure	
	device for his chair	r and bed.		proper notification of physicia	ın.	
				Measures Put in Place:		
		er Care Area Assessment		Mandatory Education of Nurs		
		icated R9 was at risk for skin		facility policy and procedure		
	preakdown and na	d a history of pressure ulcers.		of care for timely notification		
	PO's Skin Pick/ W/	ound Care Plan edited 6/5/19,		condition to physician will be 7-15-19	conducted	
		at risk for skin impairment and		Monitoring Mechanisms:		
		fer R9 to lay in bed with 30		Audits of all residents with Pr	essure	
		cument refusals, air mattress,		Ulcers to ensure proper notif		
		completed 5/30/19, wound		changes to physician will be		
		djust position in wheelchair		monthly for the next 90 days.		
		ear shorts, turn and reposition		The QAPI committee will rev		
	every 2-3 hours ar	nd pressure relieving wheelchair		notifications to physician for o	compliance	
	cushion.	-		with facility policy and proced	ures for the	
				next 90 days on or before:		
		es (PN), skin observations and		7-31-19		
		tration record (TAR) were		8-31-19		
		/19, through 6/5/19, and		9-30-19		
	indicated the follow	ving:		Responsible Person/s		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMI	ATE SURVEY DMPLETED	
		245242	B. WING				C 0 6/2019	
	PROVIDER OR SUPPLIE	E CENTER OF MINNEAPOLIS	,	10	REET ADDRESS, CITY, STATE, ZIP CODE 107 EAST 14TH STREET INNEAPOLIS, MN 55404	1 00.		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 580	-The skin observa "has a new press area," however la measurements, ir notification or treaThe TAR dated a evidence of woun -The TAR dated a indicated wound a injury which start 5/8/19. A subseque lower right side of -The PN dated 5/ pressure injury of updated on 5/7/19 R9's medical recomplysician notificate noted on 4/29/19. R9 was interviewed stated he had a s RN-C was interviewed and confirmed R9 4/29/19, indicated stated the wound wound was completed to see the mexplained she updated she	ation dated 4/29/19, indicated ure sore in back and coccyx cked evidence of assessment, interventions, provider atments; 4/1/19, through 4/30/19, lacked id care treatments; 5/1/19, through 5/31/19, care to right buttock pressure date 5/6/19, discontinue date uent order included wound care if sacrum start date 5/7/19; 7/19, identified R9 had a new of the right sacrum provider 9.	F 5	580	Clinical Managers Director of Nursing or Designee Assistant Administrator/Director of Improvement 7-16-19	Quality		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING CO	(X3) DATE SURVEY COMPLETED	
	C	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	/06/2019	
AUGUSTANA LISALTU CARE CENTER OF MININEAROLIS		
AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS MINNEAPOLIS, MN 55404		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 580 Continued From page 11 of the wound. Patient representative from primary physician's clinic was interviewed via telephone on 6/6/19, at 10:18 a.m. and stated R9's physician was first notified of the pressure ulcer on 5/7/19. The director of nursing was interviewed on 6/6/19, at 11:38 a.m. and stated it was her expectation for the nurse who first finds the wound to update the primary physician. The facility policy Skin Integrity dated 8/6/18, indicated the provider would be notified upon discovery of any new skin alteration. F 609 Reporting of Alleged Violations SS=D CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation involve abuse or result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through	7/16/19	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		(3) DATE SURVEY COMPLETED
		245242	B. WING		C 06/06/2019
	PROVIDER OR SUPPLIEF	E CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	30.30.20.10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION TE DATE
F 609	investigations to the designated repression accordance with Survey Agency, wincident, and if the appropriate correct This REQUIREME by: Based on observative, the facility Administrator and allegation of abust and an allegation residents (R167) in Findings include: R368's Admission dated 5/9/19, indicting facility on 5/9/19, a R368's face sheet Other (Other)-A hallowed on camput Campus Incident Other-A was loud asked to quiet down Other-A was intox and was verbally a toward registered indicated this was happened with Other.	fort the results of all the administrator or his or her entative and to other officials in state law, including to the State within 5 working days of the alleged violation is verified entire action must be taken. ENT is not met as evidenced action, interview and document failed to report to the to the State Agency (SA) and for 1 of 4 residents (R368) of mistreatment for 1 of 4 eviewed. Minimum Data Set (MDS) eated R368 was admitted to the and R368's cognition was intact. Indicated R368's Significant and trespassed and was not	F 609	F609 It is the policy of the Augustana Healt Care Center to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, and misappropriation of resident property reported immediately Corrective Action: Identified resident #368 was interview by Social Worker on 6-5-19 ensuring felt safe and felt the facility had handl the incident with boyfriend to her satisfaction ACP services were offere and accepted by resident. Social Services completed Abuse Assessment on 7-1-19 resident has recurrent concerns in regards to abuse or present. identified resident's #368 daughter was interviewed on 6-28-19 inquiring if she had any other concerns and to ensure feels the facility has put measures in place that are appropriate for her daughter Identified Resident #167 was interviewed Identified Resident #167 was Identif	g are ved she ed no past as e e she
	Member-A) stated	2 a.m. R368's daughter (Family a couple of days ago Other-A the facility and started arguing		and VA report filed on 6-5-19 Identification of Other Residents: Review of all security reports involving	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	L COMBI	
			A. BUILDII	NG		c
		245242	B. WING_			06/2019
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CO	•	00.2010
				1007 EAST 14TH STREET		
AUGUST	ANA HEALTH CARE	ECENTER OF MINNEAPOLIS		MINNEAPOLIS, MN 55404		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE PROPRIATE	COMPLETION DATE
F 609	Continued From p	age 13	F 60	09		
	with R368. FM-A s	stated she had concerns with		visitors with trespass notice a	nd/or visiting	
	Other-A that he ha	nd put his hands on her mother		restrictions was completed to	ensure all	
	and verbally abuse	es her. FM-A stated she had		required Vulnerable Adult rep	orting had	
		e a couple of weeks ago in May		been completed		
		ant Other-A visiting her mother		7-1-19		
		ses her mother and had		Review of all VA reports comp		
		er out of her wheelchair (w/c)		6-6-19 to ensure immediate re		
	while out at the pa	rk.		the administrator and a comp		
	On 6/6/10 at 1:41	p.m. RN-A stated one night		investigation including appropresidents and staff was condu		
		ner-A arguing loudly with R368		7-12-19	iciea.	
		ne was too loud and to lower his		Measures Put in Place		
		d Other-A had been a little bit		Facility Abuse assessment wa	as expanded	
		o loud in responding to her and		to add questions on abuse tha		
		N-A stated she had told		"Is there anyone you do not fe		
	Other-A if this con	tinued he would not be able to		around, Is there anyone that y	ou do not	
		stated this had happened in		want to visit here, and if yes p	lease	
		this was not the first		indicate who should not visit.		
		er-A arguing loudly and stated it		Mandatory education for all N		
		e of nights before that incident		all IDT team members, secur		
	with another nurse			the facility management team conducted on appropriate VA		
		A telling her in May that Other-A er mother and that she did not		immediate notification to adm		
		ner mother. RN-A stated the		and complete investigation of		
		ecurity were both present at the		incidences.	an .	
		she had not notified the		7-15-19		
		g (DON) or the Administrator of		Monitoring Mechanisms:		
	FM-A's allegation	as the supervisors and security		Security reports and documer		
		sent when FM-A had told her		verbally abusive or behavioral		
		she had documented about this		involving visitors and resident		
		s notes. RN-A stated FM-A had		reviewed to ensure facility pro		
		Other-A dumping her mother		Vulnerable Adult reporting and	1	
		that FM-A had told her Other-A		investigation were followed.	w audita of	
		r too fast in the w/c, and had s w/c forward and tried tripping		The QAPI committee will review security reports and document		
		she had not documented in the		or behavioral incidences for the		
		out Other-A regarding R368		days to ensure compliance wi		
		ad she told the DON or the		protocols for Vulnerable Adult		
	Administrator.			and investigation were follower		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDING	PLE CONSTRUCTION G	COM	(X3) DATE SURVEY COMPLETED	
		245242	B. WING			C / 06/2019
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	<u> </u>	00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 609	indicated that FM-A is very disrespectfu [R368] and agreed allowed to visit [R3 NOC supervisor ar [personnel]." Review of R368's revidence the allegareported to the SA On 6/6/19, at 3:13 (LSW)-A stated alleto be reported to the administrator "imm LSW stated he had on Tuesday 5/28/1 said the issue of cointerference with sounaware of any cointerference with sounaware of any cointerference with sounaware of any cointerference with sounaware of the allegation of verbal the w/c. DON state notified her of the away and stated shotified of any district she would have was find out if abuse haw the would have was find out if abuse haw witnessed. DON state witnessed. DON state witnessed.	ote dated 5/25/19, by RN-A A "acknowledged that [Other-A] all and verbally abusive to [Other-A] should not be 68] anymore in front of PM and ad security personal medical record lacked ation of verbal abuse was or Administrator. p.m. Licensed Social Worker egations of verbal abuse were are DON and to the ediately, as soon as possible". If been notified of the incident 9, at a morning meeting. He oncern was with Other-A with ecurity. LSW-A stated he was neerns between Other-A and ken with R368 on 5/31/19, and	F 609	before: 7-31-19 8-31-19 9-30-19 Responsible Person/s Administrator Director of Nursing or Designee Assistant Administrator/Quality Improvement Director 7-16-19		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION ING	COMP C 06/0 P CODE CORRECTION ON SHOULD BE HE APPROPRIATE	E SURVEY PLETED	
		245242	B. WING				C 06/2019
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP C 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD	BE	(X5) COMPLETION DATE
F 609	R167's cognition was two staff physical as On 6/3/19, at 12:44 assistant (NA)-G has was the first time shad the facility. R167 stated she had did not feel safe wit R167 stated NA-G proceeded anyway once asked NA-G to by NA-G, "No, I am to leave your room your room". R167 s vulnerable at the tin loudly so help would just stared, looking R167 stated the number of the inciden on 6/4/19, at 5:48 ptold him NA-G had hoyer lift and NA-G "freaking her out" a stated he had notificated was good at letting on 6/4/19 at 15 the fireaking her out" a stated he had notificated was good at letting on 6/4/19 at 15 the fireaking her out a stated he had notificated was good at letting on 6/4/19 at 15 the fireaking her out a stated he had notificated him. NA-H stated was good at letting on 6/4/19 at 15 the fireaking her out a stated he had notificated him. NA-H stated was good at letting on 6/4/19 at 15 the fireaking her out a stated he fireaking her out a stated her had notificated her had n	DS dated 5/7/19, indicated as intact and R167 needed esistance with transfer. p.m. R167 stated nursing ad verbally abused her and it he had ever felt vulnerable at lated NA-G had argued with sten to her when she told her her alone with the hoyer lift. Indicated to listen to her and R167 stated she more than to leave her room and was told not your slave, I do not have and I am not going to leave tated she felt helpless and the and started screaming out down at R167 stated NA-G down at R167, "grinning." It is on duty told NA-G to leave the had told the nurse no she did to left the room. R167 stated NA-G working with her again ractical nurse (LPN)-B also the late of the had just smiled at her not was really frightened. NA-Hed the nurse what R167 had the R167 was very alert and	F6	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		,	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245242	B. WING				C 06/2019
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP OF 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	CODE		00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E APPROPF	BE	(X5) COMPLETION DATE
F 609	interviewed R167 or considered the inci-had felt safe. DON 6/7/19, that she had abuse". DON stated argued with R167, transferred R167 at was an unsafe tran of mistreatment in Adult) policy dated Inappropriate treatment in the Adult) policy dated Inappropriate treatment was alone without a section of 6/5/19, at 9:01 and that she was head reported her about having is and that she was head reported her again and had was visibly upset alone of 6/6/19, at 4:23 pall allegations of abwere to be reported text, telephone or in needed to be reported to be reported to be reported the allegation of verification of verification of the Administrator and Smistreatment would within 24 hours to the street in the allegation of the Administrator and Smistreatment would within 24 hours to the street in the str	n 5/29/19, and R167 had not dent as abuse at the time, and stated R167 told LPN-B on d now felt it was "verbal d NA-G should have not and should have not lone with the hoyer lift as this sfer. DON stated the definition the facility VA (Vulnerable 11/21/18, read "Mistreatment: ment" of a resident. DON a resident with a hoyer lift cond staff was not appropriate. a.m. LPN-B stated the wound to her what R167 had said to sues with NA-G's cares for her urting when NA-G was trying in bed alone. LPN-B stated did not want NA-G working with said she was very mad and	F6	09			

T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		(X3) DATE SURVEY COMPLETED		
	245242	B. WING		C 06/06/2019		
			1007 EAST 14TH STREET	39/39/2010		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION		
abuse, protected a mistreatment woul Investigate/Preven CFR(s): 483.12(c)(s) \$483.12(c) In response lect, exploitation must: §483.12(c)(2) Have violations are thore \$483.12(c)(3) Preveneglect, exploitation investigation is in proceeding to the designated represeduction of the survey Agency, with incident, and if the appropriate correct This REQUIREME by: Based on observative allegation of verbal	and all allegations of abuse and d be investigated. t/Correct Alleged Violation (2)-(4) onse to allegations of abuse, in, or mistreatment, the facility evidence that all alleged oughly investigated. The evidence that all alleged oughly investigate and the evidence of the evid		F610 It is the policy of the Augustana Hea	7/16/19		
allegation of mistre (R69) reviewed for Findings include: R368's Admission dated 5/9/19, indic facility on 5/9/19, a	eatment for 1 of 4 residents abuse. Minimum Data Set (MDS) ated R368 was admitted to the and R368's cognition was intact.		exploitation or mistreatment, includi injuries of unknown source, and misappropriation of resident propert reported immediately. Corrective Action: Identified resident #368 was intervie by Social Worker on 6-5-19 ensurin felt safe and felt the facility had han	ty are ewed g she		
	PROVIDER OR SUPPLIER TANA HEALTH CARE SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From pa abuse, protected a mistreatment woul Investigate/Preven CFR(s): 483.12(c)(f) §483.12(c)(f) In resp neglect, exploitation must: §483.12(c)(f) Have violations are thore §483.12(c)(f) Prev neglect, exploitation investigation is in pa §483.12(c)(f) Rep investigatio	PROVIDER OR SUPPLIER TANA HEALTH CARE CENTER OF MINNEAPOLIS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 abuse, protected and all allegations of abuse and mistreatment would be investigated. Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigation to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to investigate an allegation of verbal abuse for 1 of 4 residents (R368) and failed to thoroughly investigate an allegation of mistreatment for 1 of 4 residents (R368) reviewed for abuse.	PROVIDER OR SUPPLIER TANA HEALTH CARE CENTER OF MINNEAPOLIS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 abuse, protected and all allegations of abuse and mistreatment would be investigated. Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to investigate an allegation of verbal abuse for 1 of 4 residents (R368) and failed to thoroughly investigate an allegation of verbal abuse for 1 of 4 residents (R369) reviewed for abuse. Findings include: R368's Admission Minimum Data Set (MDS) dated 5/9/19, indicated R368 was admitted to the facility on 5/9/19, and R368's cognition was intact.	PROVIDER OR SUPPLIER 245242 PROVIDER OR SUPPLIER TANA HEALTH CARE CENTER OF MINNEAPOLIS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 abuse, protected and all allegations of abuse and mistreatment would be investigated. Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) \$483.12(c) (1) Prevent further potential abuse, neglect, exploitation, or mistreatment, the facility must: \$483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. \$483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility on failed to invostigate an allegation of werbal abuse for 1 of 4 residents (R368) and failed to thoroughly investigate an allegation of mistreatment for 1 of 4 residents (R368) previewed for abuse. F610 It is the policy of the Augustana Heacare Care Center to ensure all alleged violation is rolly onlying abuse, neglect, exploitation or mistreatment, including injuries of unknown source, and misappropriation of resident proper reported immediately. Corrective Action: Identified resident #368 was intervied by Social Worker on 6-5-19 ensuring the facility on 5/9/19, and R368's cognition was intact.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245242	B. WING	_		06/0	6/2019
AUGUSTANA HI		CENTER OF MINNEAPOLIS		10	TREET ADDRESS, CITY, STATE, ZIP CODE 007 EAST 14TH STREET IINNEAPOLIS, MN 55404		
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
Other allower Camp Other asked Other and w toward indica happe Secur On 6/6 Members and vertical that slass he dumpo while of the control of	sed on campus Jus Incident R A was loud in to quiet dow A was intoxic as verbally and d registered r ted this was tened with Oth ity Officer to 36/19, at 10:52 per-A) stated ome back to 368. FM-A si A that he have be night nurse ne did not wa verbally abuse a repally abuse a her mothe out at the par 3/19, at 1:41 ad heard Oth ad told him he RN-A stated spropriate. RN -A if this cont 368. RN-A si RN-A stated to propriate. RN -A if this cont 368. RN-A si RN-A stated to propriate. RN -A if this cont 368. RN-A si RN-A stated to propriate RN -A if this cont 368. RN-A si RN-A stated to propriate RN -A if this cont 368. RN-A si RN-A stated to propriate RN -A if this cont 368. RN-A si RN-A stated to propriate RN -A if this cont 368. RN-A si RN-A stated to propriate RN -A if this cont 368. RN-A si RN-A stated to propriate RN -A if this cont 368. RN-A si RN-A stated to propriate RN -A if this cont 368. RN-A si RN-A stated to propriate RN -A if this cont 368. RN-A si RN-A stated to propriate RN -A if this cont 368. RN-A si RN-A stated to propriate RN -A if this cont 368. RN-A si RN-A stated to propriate RN -A if this cont 368. RN-A si RN-A stated to propriate RN -A if this cont 368. RN-A si RN-A stated to propriate RN -A if this cont 368. RN-A si RN-A stated to propriate RN -A if this cont 368. RN-A si RN-	d trespassed and was not is. Report dated 5/25/19, indicated a side R368's room and was an. The report also indicated cated, had alcohol with him, aggressive and disruptive and the second time this had a ser-A and RN-A had asked and er-A and RN-A had asked and couple of days ago Other-A and a started arguing at the facility and started arguing at the facility and started arguing and put his hands on her mother is her. FM-A stated she had a couple of weeks ago in May and Other-A visiting her mother sees her mother and had arout of her wheelchair (w/c)	F6	510	satisfaction ACP services were offer and accepted by resident. Social Services completed Abuse Assessment on 7-1-19 resident has current concerns in regards to abust or present. Identified resident #368 daughter with interviewed on 6-28-19 inquiring if shad any other concerns and to ensifeels facility has put measures in plath that are appropriate for her daughter lidentified resident #167 was interviewed on 6-5-19 Identification of Other Residents: Review of all security reports involvisitors with trespass notice or visiting restrictions was completed to ensure required Vulnerable Adult reporting been completed 7-1-19 Review of all VA reports completed 6-6-19 to ensure immediate reporting the administrator and a complete investigation including appropriate residents and staff was conducted. 7-12-19 Measures Put in Place: Facility Abuse assessment was expected and questions on abuse that including the reporting in the place investigation for all Nursing all IDT team members, security staffacility management team will be educated on appropriate Vulnerable reporting, immediate notification to administrator and complete investigation investigation and complete investigation an	s no se past vas she ure she ace er. ewed ring re all has since ng to canded ude: fe o not g Staff, ff and e Adult the	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/16/2019 FORM APPROVED

CENTE	49 FOR MEDICARE	& MEDICAID SERVICES			OMB M	<i>J.</i> 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		245242	B. WING		0(C 6/ 06/2019
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET		
				MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 610	want him visiting he supervisors and se time. RN-A stated so Director of Nursing FM-A's allegation a had also been present this. RN-A stated so in R368's progress not told her about to out of the w/c, but to pushes her mother tipped her mother's her. RN-A stated so progress notes about and her w/c nor had administrator. R368's progress not indicated that FM-A is very disrespectfur [R368] and agreed allowed to visit [R368] and agreed allowed to visit [R368] and agreed allowed to the same personnel]." Review of R368's no evidence the allegate reported to the SA investigated with Rand other residents. On 6/6/19, at 3:13 progress on the same personnel to the same personnel t	er mother. RN-A stated the curity were both present at the she had not notified the (DON) or the Administrator of is the supervisors and security ent when FM-A had told her he had documented about this notes. RN-A stated FM-A had other-A dumping her mother hat FM-A had told her Other-A too fast in the w/c, and had w/c forward and tried tripping he had not documented in the out Other-A regarding R368 d she told the DON or the other dated 5/25/19, by RN-A a "acknowledged that [Other-A] and verbally abusive to [Other-A] should not be security personal decical record lacked ation of verbal abuse was or Administrator; nor was 368, FM-A, staff interviews in the state of verbal abuse were egations of verbal abuse were	F6	of all incidences. 7-15-19 Monitoring Mechanisms: Security reports and docun verbally abusive or behavior involving visitors and reside reviewed to ensure facility Vulnerable Adult reporting investigation were followed The QAPI committee will resecurity reports and docum or behavioral incidence for days to ensure compliance protocols for Vulnerable Ad and investigation were followed to ensure compliance protocols for Vulnerable Ad and investigation were followed and investigation were followed before: 7-31-19 8-31-19 9-30-19 Responsible Person/s Administrator Director of Nursing or Desi Assistant Administrator/Qu Improvement Director 7-16-19	oral incidences ent will be protocols for and d. eview audits of nented abusive the next 90 e with facility dult reporting owed on or	

interference with security. LSW-A stated he was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C			
		245242	B. WING_		06	/ 06/2019		
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CO 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	•	1 33/33/2313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 610	R368 and had spokshe had not mention on 6/6/19, at 3:46 placen notified of the allegation of verbal the w/c. DON state notified her of the allegation of the away and stated shoutified of any disruif she would have be have told the nurse then to interview R3 she would have was find out if abuse haw witnessed. DON stand had just learner reported to SA. On 6/6/19, at 4:23 pall allegations of abwere to be reported text, telephone or in needed to be reported the allegation of versions and had not result to the state of the	cerns between Other-A and ten with R368 on 5/31/19, and ned it. D.m. DON stated she had not incident with Other-A, nor the abuse, nor the incident with ed the supervisor should have allegation of verbal abuse right the would have wanted to be aption on the floor. DON stated to ask Other-A to leave, and ask Other-A to leave, and ask and FM-A. DON stated need questions to be asked to doccurred or had been ated she had not known of this dof it "today" and had not be.m. the Administrator stated the including verbal abuse asked to the mediately to him, either by a person at the office, and the had not been notified of the reported it to the SA. Vulnerable Adult dated allegations of abuse would be bely, within two hours to the SA, and allegations of abuse and all allegations of abuse and all allegations of abuse and	F 6:					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTI NG	ON	•	
		245242	B. WING				C 06/2019
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS 1007 EAST 14TH MINNEAPOLIS		1 00.	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOUL EFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 610	identified R69 had in extensive staff assist total dependence for R69's Face Sheet of had diagnoses which depression, anxiety R69 was interviewed stated back in Februassistant (NA)-I who room anymore. R69 defensive, rude and bed during pericare was rough when shape pushed him an explaining what she NA-I had been on horoviding cares lauf foreign language. From her cell phone to touched his genital stated he felt humil molested. R69 indicated the clinical manage him since. Registered nurse (I6/3/19, at 12:22 p.n. made aware of R69 report had been made and instrator assistants of R69 report had been made aware of R69 report had been made and NA-J were alleged allegation of alleged allegation of R69 registered nurse (I6/4/19, at 7:04 p.m. NA-I and NA-J were alleged allegation of R69 registered allegation registered allegation registered allegation registered allegation registe	ontact cognition and required stance with bed mobility and or toileting needs. dated 6/6/19, indicated R69 ch included convulsions,	F6	10			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245242	B. WING_		C 06/06/2019	
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	00.00.20.10	
(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 CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION	
F 610	explained she did n information would he the investigation. The facility investigation reviewed and include NA-I and NA-J. How	straight forward. The DON ot see how any additional ave altered the outcome of ative file dated 5/6/19, was led an interview from R69, vever, the file lacked evidence	F 6	10		
F 677 SS=D	regarding the allege and also lacked evisupervision or monitor of the facility policy V [Minnesota] dated 1 of alleged abuse an promptly and thorouncluded that the invinterviews of any poincident and other reperpetrator provided ADL Care Provided CFR(s): 483.24(a)(2) A resistance of the facility of th	ulnerable adult-MN 1/21/18, indicated all reports ad mistreatment shall be ughly investigated. The policy vestigation would include betential witnesses to the esidents to whom the alleged d care or services. for Dependent Residents 2) ident who is unable to carry	F 6	77	7/16/19	
	out activities of daily services to maintain personal and oral h This REQUIREMEN by: Based on observat review the facility fa assistance for 2 of reviewed for activities	y living receives the necessary a good nutrition, grooming, and		F677 It is the policy of the Augustana He Care Center to provide the needed and services for residents who are to carry out activities of daily living Corrective Action: Nursing Assistants involved in iden incidences were immediately re-ed	care unable tified	

245242 B. WING	
LTULTL D. WING 06/06/	6/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	<u>"2010</u>
1007 EAST 14TH STREET	
AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS MINNEAPOLIS, MN 55404	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R187's quarterly Minimum Data Set dated 5/11/19, indicated R187 was cognitively intact and required extensive staff assist with ADL which included toilet use. R187's ADL Care Area Assessment dated 8/14/18, indicated R187 required assistance with ADL due to weakness. R187's Elimination Care Plan edited 5/17/19, identified R187 had some bowel control and directed staff to assist with use of the bedpan for bowel movement (BM) when requested. R187's Face Sheet dated 6/6/19, indicated R187 had diagnoses which included absence of left leg above the knee and peripheral vascular disease. R187 was interviewed on 6/3/19, at 8.47 a.m. and stated he had to "scream and yell nobody would help me" earlier this morning. R187 explained he had requested to be put onto the bed pan while it was still dark outside and later found out "the person forgot me, I waited a long time I was yelling and screaming still on the bed pan." R187 indicated he had pressed his call light multiple times for help off of the bedpan and when the staff would answer his light they would leave his room and turn his call light off without providing assistance to get off of the bedpan and when the staff would answer his light they would leave his room and turn his call light off without providing sasistance to get off of the bedpan and when the staff would answer his light they would leave his room and turn his call light off without providing sasistance to get off of the bedpan and when the staff would answer his light they would leave his room and turn his call light off without providing sasistance to get off of the bedpan and when the staff would answer his light they would leave his room and turn his call light off without providing sasistance to get off of the bedpan and when the staff would answer his load of the provided to the pure of the provided to th	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245242	B. WING				C 06/2019
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP O 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	CODE	00/	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD	BE	(X5) COMPLETION DATE
F 677	versus 1:9 when 4 verified R187 had to the needs of other arrived to his room R187 in bed seated on his buttocks. Nawhen R187 was as further stated the other R187 would neutilizing the bed parextra wipes" due to buttocks. NA-D stated the extra wipes due to buttocks. NA-D stated at 6:30 a.m NA-E was interview stated she would ty overnight shift with 4:45 a.m. to 5:15 a.m. made aware that R bedpan on 6/3/19, at 8:15 a.m. made aware that R bedpan on 6/3/19, at appened. RN-F extaff to communica resident was using The director of nurs 6/6/19, at 11:40 a.m. expectation for resicommunicated durid A facility policy regaresident was requered. R9's quarterly Minir	f 1:12 (one NA to 12 residents) NAs were present. NA-D o wait for assistance due to resident and when she had around 7:15 a.m. she found d on the bedpan with dry BM A-D explained she was unsure sisted onto the bedpan and vernight shift did not report to ed assist as he was currently n. NA-D stated she had to "use the BM dried onto R187's ted the overnight shift typically ved on 6/5/19, at 6:13 a.m. and rpically assist R187 during the his toileting needs between .m rse (RN)-F was interviewed on and stated she had been 187 had been left on the and was looking into what had explained it was her expectation te between shifts when a	F 6	77			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245242	B. WING		06/06/	2019	
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	1 33/33/2313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE CC	(X5) DMPLETION DATE	
F 677	not reject cares do MDS indicated R9 toileting. R9's Urinary Incordated 6/10/18, indicated 6/10/18, indicated for and needs. R9's Elimination Condentified R9 was directed staff to of and after meals, at ocheck and charcares, night round R9 was interviewed stated the overning so they leave him "that's how I got the evening hour whe would say "we are resulted in having multiple times. On 6/5/19, at 6:21 observation from R9's cares were of the stated R9 to the	aring the reference period. The had total dependence for had total dependence for a hitinence Care Area Assessment icated R9 was incontinent of ed total assist with toileting hit are Plan edited 3/7/19, incontinent of bladder and fer urinal upon arising, before to bedtime and night rounds and age with morning and bedtime is and every 2 hours as needed. In his wet "diaper" all night his sore." R9 stated during the in you ask for help everybody is short, we are short which to wait to be changed or helped a.m. during a continuous 6:21 a.m. through 9:00 a.m. bserved. At 6:21 a.m. R9 was	F 677	,			
	mattress sleeping At 8:09 a.m. R9 us time his appointm (RN)-F notified R9 however R9 was r or check and char assistant (NA) ent breakfast and left urinal use and/ or	need on his back on top of an air and his head of bed elevated. Seed the call light to ask what ent was today; registered nurse of his appointment time, not offered to use of urinal and/nge. At 8:20 a.m. nursing ered room to assist R9 with R9's room at 8:47 a.m No check and change were offered t 9:00 a.m. NA-B and NA-C					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245242	B. WING _			C /06/2019	
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		30.2010	
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	SHOULD BE CO		
F 677	Continued From page 26		F 67	77			
		emove R9's brief. NA- B ontinent brief was wet with					
	stated per their NA checked and chang needed. NA-A state	yed on 6/6/19, at 8:43 a.m. and group sheet R9 was to be ged every 2 hours and as ed R9 was typically toileted en at around 11:00 a.m. and 0 p.m					
		ved on 6/6/19, at 8:48 a.m. and e checked and changed every eded.					
	6/6/19, at 11:40 a.n	sing was interviewed on n. and stated it was her t residents per their care plan.					
F 686 SS=D	resident was reque Treatment/Svcs to	arding ADL for a dependent sted but not provided. Prevent/Heal Pressure Ulcer 1)(i)(ii)	F 68	66		7/16/19	
	resident, the facility (i) A resident receive professional standar pressure ulcers and ulcers unless the in demonstrates that to (ii) A resident with professional standard with professional standard	sure ulcers. prehensive assessment of a remust ensure that- res care, consistent with ards of practice, to prevent d does not develop pressure adividual's clinical condition they were unavoidable; and pressure ulcers receives at and services, consistent andards of practice, to revent infection and prevent					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	` '	E SURVEY PLETED
			A. BUILDING	3	,	
		245242	B. WING) 06/2019
NAME OF F	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.0	0.2010
				1007 EAST 14TH STREET		
AUGUST	ANA HEALTH CAR	E CENTER OF MINNEAPOLIS		MINNEAPOLIS, MN 55404		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL)		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	'RIATE	DATE
F 686	Continued From p	page 27	F 686	6		
	This REQUIREM	ENT is not met as evidenced				
	by:					
		ation, interview and document		F686		
		failed to develop and		It is the policy of the Augustana He		
		entions to promote healing of a		Care Center to provide the treatme		
		acrum pressure ulcer for 1 of 1		services to prevent/heal Pressure	Ulcers.	
	resident (R9) revie	ewed for pressure ulcer.		Corrective Action:	l -t-ff	
	Findings include:			Re-education of identified licensed person on facility policy per dressil		
	Findings include.			changes was completed	ig	
	R0 was interviewe	ed on 6/4/19, at 12:30 p.m. and		Identification of Other Residents:		
		ore on his bottom. R9 explained		All residents with Pressure Ulcers	on	
		t have not had enough help so		7-1-19 were audited to ensure wor		
		his wet "diaper" all night "that's		including dressing changes was be		
		e." R9 stated during the evening		completed per orders.		
	hour when you as	k for help everybody would say		7-15-19		
	"we are short, we	are short" which resulted in		Measures Put in Place:		
	having to wait to b	be changed or helped multiple		Mandatory education for all Nursin		
	times.			on Prevention of Pressure Ulcers,		
				following facility skin policy per pre		
		l a.m. during a continuous		ulcer/wound care standards of pra	ctice	
		6:21 a.m. through 9:00 a.m.		7-15-19		
		observed. At 6:21 a.m. R9 was ng in bed on his back on top of		Monitoring Mechanisms: 20% random audits of residents re	acaiving	
		oing and his head of bed		wound care to ensure compliance		
		a.m. R9 pushed call light to ask		facility standard of practice for woo		
		ointment was today. R9 was		will be conducted monthly for he n	ext 90	
		1 a.m. and stated his dressing		days.	5/11 0 0	
		cer had not been changed and		The QAPI committee will review a	udits for	
		. R9 stated he thought his		compliance with facility standard o	f	
		e changed daily. At 9:00 a.m.		practice for pressure ulcer prevent	ion and	
		(NA)-B and NA-C were		wound care on or before:		
		ting pericares. R9 was observed		7-31-19		
		sheets, one pillow under right		8-31-19		
		as and a towel under his lower		9-30-19		
		area; NA-B verified the items		Responsible Person/s		
	were supposed to	be under R9 while in bed.		Wound Care Nurse		
	On 6/5/40 -+ 0.40) a ma DN C and DN D		Director of Nursing or Designee		
	∣ ∪n ₀/ɔ/19, at 9:19	a.m. RN-C and RN-D were		Assistant Administrator/Quality		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245242	B. WING				C 06/2019
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		10	REET ADDRESS, CITY, STATE, ZIP CODE 107 EAST 14TH STREET INNEAPOLIS, MN 55404	1 00/1	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	observed turning R confirmed R9's dre wound was dated 6 sacrum wound which in length by 1.4 cm (dead tissue) in the 0.4 cm. RN-C state noted when the drestated there was mon the dressing that RN-C was interview and verified the wollast week's measur 1.3 cm and only hat and now had mode watery fluid and pushe would consider contact the provide explained R9's drest due to the Santyl (mplaced in the wound nurse on 6/4/19, did per orders and doc "nurse got too busy expectation if the next shift would have change. RN-C verified one incontinent pad bottom area. RN-C not have had extra only have had one incontinent pad but R9's skin observation had a pressure ulcanurse first assessmy was unable to find would not be supported to the same and th	9 onto his left side. RN-C ssing that covered his sacrum /3/19. RN-C measured R9's ch was 1.8 centimeters (CM) width and noted 100% slough wound bed and visual depth d there was a mild malodor ssing was removed. RN-C oderate serous exudate noted	F6	86	Improvement Director 7-16-19		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION ING		` ´сом	E SURVEY PLETED
		245242	B. WING				C 06/2019
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP OF 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	CODE	, 00/	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD E APPROPF	BE	(X5) COMPLETION DATE
F 686	RN-E was interview stated they were no ulcer until 5/6/19. R notified a resident have to see them wexplained she updated and obtained treath of the wound. R9's quarterly Mining 3/2/19, identified R9 not reject cares dur MDS indicated R9 with bed mobility art toileting needs. The for pressure ulcers device for his chair R9's Pressure Ulcedated 6/10/18, indicated R9 was a directed staff to offed degree wedge, door pressure mapping of care per orders, ad every hour, glideweevery 2-3 hours and cushion. R9's skin observational administration recounting the skin observation in the skin observation.	red on 6/5/19, at 9:51 a.m. and at aware R9's sacrum pressure N-E stated once they were ad a new open area they within 24 hours. RN-E atted R9's physician on 5/7/19, ment orders after assessment and intact cognition and did ing the reference period. The required extensive assistance and total dependence for a MDS indicated R9 was at risk and had a pressure reducing and bed. The Care Area Assessment atted R9 was at risk for skin and a history of pressure ulcers. The Care Plan edited 6/5/19, at risk for skin impairment and the R9 to lay in bed with 30 aument refusals, air mattress, completed 5/30/19, wound just position in wheelchair ar shorts, turn and reposition at pressure relieving wheelchair ar shorts, turn and reposition and pressure relieving wheelchair	F 6	86			

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	` '	E SURVEY PLETED
		245242	B. WING _		1	C 06/2019
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	1 00/	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	provider notification - The TAR dated 4/ evidence of wound - The TAR dated 5/ indicated wound ca injury which start da 5/8/19. A subseque lower right side of s however indicated " workload" on 5/15/1 - The TAR dated 6/1 wound care lower ri indicated "not comp 6/4/19. The director of nurs 6/6/19, at 11:38 a.m expectation for the wound to utilize the implement a treatm the wound nurse so assessed that day o stated it was her ex dressing changes p The facility policy S indicated a new wor appropriate treatme the electronic medic indicated to docume measurements in the	erventions and treatment, or 1/19, through 4/30/19, lacked care treatments; 1/19, through 5/31/19, re to right buttock pressure ate 5/6/19, discontinue date nt order included wound care acrum start date 5/7/19, not completed due to 9; 1/19, through 6/5/19, indicated ght side of sacrum, however eleted due to workload" on and stated it was her nurse who first finds the standing house orders and ent then they should update of the wound can be thoroughly or the next. The DON further pectation to complete	F 68	36		
F 689 SS=D	Free of Accident Ha		F 68	39		7/16/19
	§483.25(d) Acciden	t5.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		(X3) DATE SURVEY COMPLETED
		245242	B. WING		C 06/06/2019
	PROVIDER OR SUPPLIEF	E CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 689	as free of accident §483.25(d)(2)Eact supervision and a accidents. This REQUIREME by: Based on observer review, the facility assess and compevaluation for safe (R130) reviewed for Findings Include: R130's diagnosis behavioral disturb altered mental state dependence on supervision and seems of the seems	ensure that - e resident environment remains t hazards as is possible; and in resident receives adequate essistance devices to prevent ENT is not met as evidenced eation, interview and document failed to comprehensively lete ongoing monitoring and e smoking for 1 of 3 residents or smoking. included dementia without ances, vascular dementia, tus, nicotine dependence and upplemental oxygen. nimum Data Set (MDS) dated R130 was a smoker. A Care (CAA) related to smoking was	F 689	F689 It is the policy of the Augustana Hea Care Center that each resident rece adequate supervision and assistant devices to prevent accidents. Corrective Action: Identified resident was re-assessed smoking safety on 6-4-19 Resident Smoking Policy and Proce was reviewed and updated on 6-14-Resident re-assessed to ensure cor safe smoking practice on 7-3-19 Identification of Other residents: Smoking assessments for all reside who smoke were audited for accura resident's current smoking status All Care sheets were audited and up if needed to reflect resident's current smoking status and any needed safe interventions. 7-15-19 Measures Put in Place: Employee Communication was distred Re: Importance of safe smoking for residents Mandatory education was conducted the Therapeutic Activities staff on faresident smoking policy, and proper	for edure 19 ntinued ints icy to codated it ety ributed d for icility
		an, edited 6/4/19, identified oserved smoking in		assessment methods, content and procedures.	

PRINTED: 07/16/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
			A. BUILD	ING _			
		245242	B. WING			06/0	06/2019
	PROVIDER OR SUPPLIER TANA HEALTH CARE	CENTER OF MINNEAPOLIS		10	REET ADDRESS, CITY, STATE, ZIP CODE 107 EAST 14TH STREET INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	non-designated are clothing due to move Resident is able to smoking apron. A common of 6/5/19, identified R decisions and was consequences of dimpaired cognition. R130 had a history awareness especial consequences of since R130 was observed p.m. When asked, cigarettes and was manage her smoking R130 untied a plass wheelchair next to land exposed four dipacks of cigarettes cigarettes. Registered nurse (Fo/4/19, at 1:27 p.m. either in the smoking designated smoking building. RN-I furthed deemed to be safe have any safety prestated R130 kept her and staff did no or monitor her smoon on 6/4/19, at 1:31 pase to smoke and her room. RN-H fur recreation (TR) depression of the signated smoke and her room. RN-H fur recreation (TR) depression of the safe have and her room. RN-H fur recreation (TR) depression of the safe have and her room. RN-H fur recreation (TR) depression of the safe have and her room. RN-H fur recreation (TR) depression of the safe have and her room. RN-H fur recreation (TR) depression of the safe have and her room. RN-H fur recreation (TR) depression of the safe have and her room. RN-H fur recreation (TR) depression of the safe have and her room. RN-H fur recreation (TR) depression of the safe have and her room.	eas (2016). Burn hole found in vement when smoking. smoke independently with a cognition care plan, revised 130 made poor healthcare unable to foresee ecisions with moderately. The Care plan also noted of lacking personal safety ally related to smoking and moking in undesignated areas. It is the company of the company o	F6	689	Mandatory education for all Nursing on resident smoking policies and procedures. 7-15-19 Monitoring Mechanism: Random audits will be conducted 3 weekly for the next 90 days, of the designated facility smoking areas to ensure that interventions for identify residents related to smoking are in and to ensure other residents who are continuing to practice safe smobehaviors. QAPI committee will review audits ensure compliance with facility poliprocedures related to smoking safe assessment for residents for the next days on or before: 7-31-19 8-31-19 9-30-19 Responsible Person/s Therapeutic Activity Director or Desassistant Administrator/Quality Improvement Director 7-16-19	s times o ied place smoke oking to cy and ety and ext 90	

who smoked. RN-H stated TR would alert nursing

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	COM	E SURVEY IPLETED
		245242	B. WING _			C 06/2019
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	smoking assessments were needed. At 1:45 p.r four disposable light cigarettes and two her room RN-H stasmoker" and was massessment that in smoke without safe R130 was observed a.m. R130's smok wheelchair which was reasted to her. A smodesigned to be wor intended for individing protective shield frocigarettes) was followheelchair. A bag R130's wheelchair. A bag R130's wheelchair or near the smokin residents were smooth to receptionist (Rat 7:47 a.m. and stable to visualize the camera from the retorn monitor if a residents wear an apron whill had never address.	bellems found during a ent. RN-H stated smoking done quarterly and as m. RN-H verified R130 had aters, two opened packs of unopened packs of cigarettes ated R130 was a "safe to aware of a smoking dicated R130 was not safe to ety precautions in place. If in her bed on 6/5/19, at 6:18 ing supplies were in her was placed next to her bed. At so observed smoking a lit ing in a chair in the designated om. R130's wheelchair was king apron (an over-garment in while smoking tobacco uals who smoke and require a some hot ashes and dropped died over the back of R130's of smoking materials was on seat. Staff was not present in groom. A total of four oking in the room. I-A) was interviewed on 6/5/19, ated although the she was esmoking room by video eception area, she was unable lent was wearing a smoking explained she did not know is were identified as needing to be smoking because the staff ed it with her. R-A was ity monitored residents'	F 68	9		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	\ , ,	TE SURVEY MPLETED
		245242	B. WING _		06	C 5 /06/2019
	PROVIDER OR SUPPLIEF	E CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP (1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 689	On 6/5/19, at 7:52 facility smoking ro smoking apron. At was given a smok she kept it on the At 8:21 a.m. was designated smokin apron in place. As noted on the aproduced on the aproduced on the aproduced on 6/6/19, a was in charge of assessments, the staff or implement a resident was four smoking, a smoking, a smoking it on all day." monitor this practical policy in place. RN-H was intervied stated R130 was at to need an apronous RN-H did not receive therefore did not promoted RN-H further states system in place to apron applied where the procession and the director of number 10:20 a.m. that if sin place for a residuced the facility stated the facility stat	a.m. R130 was observed in the om. R130 was wearing a 8:02 a.m. R130 stated she ing apron "yesterday", which back of her wheelchair. continued to smoke in the ng room. R130 had a smoking hes from R130's cigarette were	F 68	9		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION 3	COM	E SURVEY IPLETED
		245242	B. WING			C 06/2019
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	1 00/	00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	concluded, "A good	ge 35 first step would be to monitor ies. We need to take a look at	F 68	9		
	noted R130 had bu was able to smoke smoking apron, Th "encourage" R130 th nursing assistant (N not identify R130 was	note (PN), dated 6/5/19, rn holes in her clothing but independently when wearing a e PN directed staff to to "use it." The current IA) care sheet, undated, did as a smoker or direct staff to e of a smoking apron.				
F 725 SS=E	plan policy, dated 1 smokes will be assepractices and would require smoking material. The policy also assessed to be unsinterventions may buse of a smoking a holders or ash trays rationed smoking mursing station. The monitoring these in	Staff	F 72	5		7/16/19
	the appropriate con provide nursing and resident safety and practicable physica well-being of each r resident assessmen	nt Staff. ve sufficient nursing staff with nepetencies and skills sets to a related services to assure attain or maintain the highest and mental, and psychosocial resident, as determined by the sand individual plans of care a number, acuity and				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		ATE SURVEY OMPLETED
		245242	B. WING _		C 6/ 06/2019
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	0,00,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From padiagnoses of the far accordance with that §483.70(e). §483.35(a)(1) The by sufficient numb types of personnel nursing care to all resident care plans (i) Except when was this section, licens (ii) Other nursing plimited to nurse aid §483.35(a)(2) Exceparagraph (e) of the designate a license nurse on each tour This REQUIREME by: Based on observative review, the facility was available to massistance of 1 of activities of daily livesident and 3 of 3 reviewed for medicaddition, the facility	age 36 acility's resident population in the facility assessment required facility must provide services ers of each of the following on a 24-hour basis to provide residents in accordance with acility assessment required on a 24-hour basis to provide residents in accordance with acility accordance with acility and personnel, including but not des. The personnel including	F 72	F725 It is the policy of the Augustana Health Care Center of Minneapolis to ensure sufficient staff are available to meet resident needs. Corrective Action: Nursing Assistants and Licensed staff employee involved in identified incidence	
	residents (R9) reviews findings include: R187 was interviews tated he had to "shelp me" earlier the had requested to be was still dark outsi	ohysician orders for 1 of 1 ewed for pressure ulcer. wed on 6/3/19, at 8:47 a.m. and acream and yell nobody would is morning. R187 explained he be put onto the bed pan while it de and later found out "the I waited a long time I was		were all re-educated per facility protocols for meeting resident needs in a timely manner. Identification of Other Residents Residents identified as dependent in toileting were audited for compliance with facility standard for toileting All residents with Pressure Ulcers on 7-1-19 were audited to ensure wound ca including dressing changes is being completed per orders	1

PRINTED: 07/16/2019 FORM APPROVED OMB NO. 0938-0391

CLIVIL	13 I OIT WILDICAIL	A MEDICAID SERVICES			<u> </u>	VID INO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
						(5
		245242	B. WING			l	06/2019
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ALICHET	ANA UEAL TU CADE	CENTED OF MINNEADOUG		1	007 EAST 14TH STREET		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		N	MINNEAPOLIS, MN 55404		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
IAO			17.0		DEFICIENCY)		
F 725	Continued From pa	ge 37	F7	725			
	yelling and screami	ng still on the bed pan." R187			Medication administration audits we	ere	
	indicated he had pr	essed his call light multiple			completed to identify residents with		
		the bedpan and when the			medication preferences or demons		
		his light they would leave his			clinical need for time sensitive med	ication	
		all light off without providing			administration.		
		Ipan. R187 identified he was			7-15-19		
		'over one hour" and had fallen			Measures Put in Place		
		o waiting so long. R187 stated			Facility continues to staff significan		
		t time this had happened and to nursing staff, however he			above the state minimum requirem Facility is developing different staffi		
		re just short of help."			protocols around shift change and	i ig	
	Would be told We a	ire just short of help.			employee breaks, and continues to	look at	
	Nursing Assistant (NA)-D was interviewed on			best practice for medication		
		n. and confirmed four east unit			administration and meeting the nee	ds or	
		ue to only 3 NA today with a			residents in a timely manner.		
		1:9 when 4 NA were present.			Mandatory education for all Nursing	g staff	
		had to wait for assistance			was conducted on facility staffing		
		other resident and when she			protocols and Medication Administr	ation	
		oom around 7:15 a.m. she			7-15-19		
		seated on the bedpan with dry			Monitoring Mechanisms:	au irina	
		. NA-D explained she was was assisted onto the bedpan			10% random audits of residents rectoileting assistance will be conducted		
		he overnight shift did not			monthly on all units for compliance		
		would need assist as he was			facility standard of care for the next		
		e bed pan. NA-D stated she			days.		
		ipes" due to the BM dried onto			20% random audits of all residents		
		A-D stated the overnight shift			receiving wound care to ensure		
	typically left at 6:30	a.m.			compliance with facility standard or		
					practice for wound care will be con-	ducted	
		ed on 6/3/19, at 7:55 a.m. and			monthly for the next 90 days		
		een receiving his Sinemet			10% random audits of timely medic		
		ologist orders. R89 stated the			administration will be conducted mo	onthly	
		resulted in neck and shoulder			on all units for the next 90 days.	dita far	
	spasms. R80's Physician Or	der Report dated 5/6/19,			The QAPI committee will review au compliance with facility standard of		
		uded Sinemet to be			for toileting assistance , pressure u		
		0 a.m., 9:00 a.m., 12:00 p.m.,			reduction and timely medication	1001	
		and 8:00 p.m. for Parkinson			administration on or before:		
	יייק ססיס, ביייק ביייק ביייק	= 2.22 p2. / armineeri					

disease.

7-31-19

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	СОМ	E SURVEY PLETED
		245242	B. WING			06/2019
	PLAN OF CORRECTION 245242 ME OF PROVIDER OR SUPPLIER JGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS K4) ID REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	1 00/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 725	R89's medication a was reviewed 3/1/revealed the follow -3/1/19, through 3/not receive his Sin "resident unavailablate due to "helping administered late of time the medicatio "drug/ item unavail-4/1/19, through 4/not receive his Sin unavailable," three "helping with cares late," 11 times administered due t-5/1/19, through 5/not receive his Sin unavailable," admi "helping with cares times administered late of 1/19, through 6/administered late of 1/19, through 6/4 when a medication hour after the scheprompt her to indicadministered late. was "short" staffed opposed to 4 NA's facility for the TMA TMA-A stated this when administering medications to be verified in R89's M	administration record (MAR) 19, through 6/5/19, and ving: 31/19, MAR indicated R89 did emet five times due to ole," four times administered g with cares," 18 times due to "charted late" and one n was not administered due to lable;" 30/19, MAR indicated R89 did emet once due to "resident etimes administered late due to s," nine times "administered medication was not to "drug/ item unavailable;" 31/19, MAR indicated R89 did emet once due to "charted medication was not to "drug/ item unavailable;" 31/19, MAR indicated R89 did emet once due to "resident nistered late once due to s," twice "administered late," 10 d late due to "charted late;" 5/19, MAR indicated R89 once due to "charted late." ation aide (TMA)-A was /19, at 6:08 p.m. and explained n was administered beyond one eduled time the MAR would cate a reason it was TMA-A indicated when the unit with 3 nursing assistants (NA) it was the expectation of the	F 725	8-31-19 9-30-19 Responsible Person/s Administrator Director of Nursing or Designee Assistant Administrator/Quality Improvement Director 7-16-19		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED C		
		245242	B. WING _		06	/06/2019	
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	•	100/2010	
(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 CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 725	and she needed to R89's Sinemet was beyond the schedu R133 On 6/5/19, at 10:42 administration pass following medicatio citalopram (antidep (anticoagulant), me pressure), and mul R133's Physician C through 6/5/19, incl medications to be a aspirin, metoprolol, report indicated cita administered daily a R81 On 6/5/19, at 10:50 administration pass following medication diltiazem (treats allergies), fluoremedicatione (diuretic (treats acid reflux), spironolactone (diu acetaminophen (and R81's Physician Or through 6/5/19, incl medications to be a omeprazole, tums, acetaminophen, dil furosemide, spironolactone, dil furosemide, spironolact	help with resident cares so administered over an hour led time. 2 a.m. during a medication sobservation for R133; the ns were administered aspirin, pressant), eliquis stoprolol (treats high blood tivitamin. 2 a.m. during a medication sobservation for R8100 a.m. multivitamin and eliquis. The alopram was to be at 7:30 a.m. 3 a.m. during a medication sobservation for R81; the ns were administered ph blood pressure), Flonase acoxetine (anti-depressant), c), metoprolol, omeprazole Qvar inhaler (treats asthma), retic), tums (anti-acid) and halgesic). 3 der Report dated 6/1/19, and ded the following administered at 8:00 a.m. fluoxetine, Flonase,	F 72	25			

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245242	B. WING_		06	C / 06/2019	
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	•	100/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 725	administered late a administered no la to one nurse not considered medito administered medito administered five addition outlined in red which had not been administered late. R9 R9 was interviewed stated he had a so the overnight shift they leave him in how I got this sore hour when you ask "we are short, we are short, and the short are short as a short and the short are short as a short and the short are short as a	and should have been ter than 9:00 a.m. however due oming in TMA-B was pulled to cations so she got a late start. He work list for the unit and nal resident's names were ch indicated their medications nistered and would be d on 6/4/19, at 12:30 p.m. and re on his bottom. R9 explained have not had enough help so is wet "diaper" all night "that's "R9 stated during the evening of for help everybody would say are short" which resulted in the changed or helped multiple obsequent interview on 6/5/19, ated his dressing to his not been changed and he stated he thought his dressing I daily. a.m. registered nurse (RN)-C served turning R9 onto his left and R9's dressing that covered	F 7:	25			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		MPLETED
		245242	B. WING _		06	C 5 /06/2019
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		10012013
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 725	5/1/19, through 6/5 following: - The TAR dated 5 indicated wound castart date 5/7/19, homeomber who documble to completed was unavailable formed the transport of the TAR dated 6/6 wound care lower indicated "not come 6/4/19. Staff mem regarding not come 6/4/19, was unavailable formed the transport of transport of the transport of the transport of the transport of transport of the transport of the transport of the transport of transport of the transport of the transport of the transport of transport of the transport of the transport of the transport of transport of the transport of the transport of transport of the transport of transport of the transport of	ord (TAR) was reviewed from 1/19, and indicated the 1/1/19, through 5/31/19, are lower right side of sacrum owever indicated "not workload" on 5/15/19. Staff mented on TAR regarding edue to workload on 5/15/19, or interview. 1/19, through 6/5/19, indicated right side of sacrum, however pleted due to workload" on ber who documented on TAR pleted due to workload on	F 72	5		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG	СОМ	E SURVEY PLETED
		245242	B. WING_		1	C 06/2019
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	1 00.	00/2010
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725 F 755 SS=D	by running shorter saide to be split betw NAs per unit. The director of nurs 6/6/19, at 11:42 a.n 1:8 to a 1:10 for NA was based on total reviewed the facility staffing ratios that was ease of the reside care were one licen 1:9. The DON indict to meet that staff le Pharmacy Srvcs/Pr CFR(s): 483.45(a)(s) §483.45 Pharmacy The facility must prodrugs and biological them under an agres §483.70(g). The fapersonnel to admin permits, but only una licensed nurse. §483.45(a) Procedu pharmaceutical ser that assure the accedispensing, and adbiologicals) to meet §483.45(b) Service must employ or obtipharmacist who-	shifts or utilization of a bath ween two units instead of 4 sing (DON) was interviewed on an and stated they try to run a set to resident ratio and this census in house. The DON assessment and verified were determined to meet the ents who resided in long term ased staff, one TMA and NAs stated they do the best they can evel. Tocedures/Pharmacist/Records b)(1)-(3) Services Ovide routine and emergency als to its residents, or obtain element described in cility may permit unlicensed ister drugs if State law ender the general supervision of the ures. A facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and at the needs of each resident. Consultation. The facility tain the services of a licensed	F 7:			7/16/19
		ides consultation on all ision of pharmacy services in				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG	СОМ	E SURVEY PLETED
		245242	B. WING			C 06/2019
	AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 755 Continued From page 43 the facility. §483.45(b)(2) Establishes a system of records receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are order and that an account of all controlled drug is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure Sinemet (Parkinson medication) was administered as prescribed by the physician for 1 of 1 resident (R89) reviewed who had complaints of untimely medication administration. In addition, the facility failed to ensure dispensed to meet the needs of 2 of 2 residents (R133, R81) reviewed for medication administration. Findings include: R89's quarterly Minimum Data Set dated 4/13/identified R89 had intact cognition and diagnos which included Parkinson disease. R89 was interviewed on 6/3/19, at 7:55 a.m. an stated he had not been receiving his Sinemet timely per his neurologist orders. R89 stated the late administration resulted in neck and should.			STREET ADDRESS, CITY, STATE, ZIP CO 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	•	
PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 755	the facility. §483.45(b)(2) Est receipt and dispossufficient detail to reconciliation; and §483.45(b)(3) Deforder and that an is maintained and This REQUIREMI by: Based on observeriew the facility (Parkinson medic prescribed by the (R89) reviewed we medication adminifialed to ensure meet the needs or reviewed for med Findings include: R89's quarterly Midentified R89 had which included Parkinson medication adminifialed to ensure meet the needs or reviewed for med Findings include: R89's quarterly Midentified R89 had which included Parkinson medication administration spasms. R89's Physician C through 6/6/19, in administered at 6	ablishes a system of records of sition of all controlled drugs in enable an accurate dremines that drug records are in account of all controlled drugs periodically reconciled. ENT is not met as evidenced ation, interview and document failed to ensure Sinemet ation) was administered as physician for 1 of 1 resident ho had complaints of untimely instration. In addition, the facility nedications were dispensed to f 2 of 2 residents (R133, R81) ication administration. inimum Data Set dated 4/13/19, d intact cognition and diagnosis arkinson disease. wed on 6/3/19, at 7:55 a.m. and been receiving his Sinemet rologist orders. R89 stated the	F 7	F755 It is the policy of Augustana It Center to provide pharmaceus including procedures that assaccurate acquiring, receiving and administering of all drugs biologicals to meet the needs resident. Corrective Action: Employees involved in the identification administration instre-educated Identification of Other Resides Medication administration aus completed to identify resident medication preferences or declinical need for time sensitive administration. 7-15-19 Measures Put in Place All TMA's completed a read and education specific to timely medication. Mandatory education for all News conducted on the import timely medication administration.	atical services sure the dispensing, so and so of each stances were ents: dit was to with emonstrated e medication and sign nedication stance of tion and	

PRINTED: 07/16/2019 FORM APPROVED OMB NO. 0938-0391

	to i oit medio ite	· · · · · · · · · · · · · · · · · · ·			<u> </u>	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0000 0001
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		E SURVEY PLETED
		245242	B. WING	i		1	0
		243242	D. WIIVO			06/	06/2019
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	TANA HEALTH CARE	CENTER OF MINNEAPOLIS			007 EAST 14TH STREET IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	R89's medication a was reviewed 3/1/1 revealed the followi-3/1/19, through 3/3 not receive his Sine "resident unavailab late due to "helping administered late d time the medicatior "drug/ item unavailab-4/1/19, through 4/3 not receive his Sine unavailable," three "helping with cares late," 11 times adm late" and twice the administered due to -5/1/19, through 5/3 not receive his Sine unavailable," admin "helping with cares times administered -6/1/19, through 6/3 administered late of the trained medication hour after the sche prompt her to indicadministered late. The twas "short" staffed opposed to 4 NA's facility for the TMA TMA-A stated this viewed 3/1/19.	dministration record (MAR) 9, through 6/5/19, and ing: 81/19, MAR indicated R89 did emet five times due to le," four times administered with cares," 18 times ue to "charted late" and one n was not administered due to able;" 80/19, MAR indicated R89 did emet once due to "resident times administered late due to "nine times "administered inistered late due to "charted medication was not o "drug/ item unavailable;" 81/19, MAR indicated R89 did emet once due to "resident histered late once due to "twice "administered late," 10 late due to "charted late;" 5/19, MAR indicated R89 nce due to "charted late." ution aide (TMA)-A was 19, at 6:08 p.m. and explained was administered beyond one duled time the MAR would	F 7	755	administration protocols 7-15-19 Monitoring Mechanism: 10% random audits will be conduct monthly for the next 90 days of medication records to ensure timel medication administration 10% random audits will be conduct monthly for the next 90 days of res will medication preferences or demonstrated clinical need for time sensitive medication administration ensure timely medication administration ensure timely medication administration audits for maintaining facility standards for timedication administration on or be 7-31-19 8-31-19 9-30-19 Responsible Person's Clinical Managers Director of Nursing or Designee Assistant Administrator/Quality Improvement Director 7-16-19	y red idents e i to ration. r	

verified in R89's MAR when documented "helping

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245242	B. WING _		06	C 5/06/2019	
	PROVIDER OR SUPPLIER	E CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	· · · · · · · · · · · · · · · · · · ·	70072010	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 755	Continued From p	age 45	F 75	55			
	and she needed to R89's Sinemet was beyond the scheduled and they do their best preferences for ac explained when the was likely due to the off that the medical RN-F further explaindicated the TMA administrations to light, causing the verified when a medical results of the terms of the term	rse (RN)-F was interviewed on in and explained it was the redications were administered me of one hour before and after ininistration time. RN-F stated to accommodate resident liministration times. RN-F e MAR indicated charted late it the person not being able to sign ation was administered timely. In a single helping with cares a stopped with medications assist a resident with their call TMA to get behind. RN-F edication was administered of the scheduled time it was					
	6/6/19, at 11:40 a. expectation for me according to the sideviation would be. The facility pharm telephone on 6/6/2 Sinemet should be minutes of schedules.	rsing was interviewed on m. and stated it was her ediations to be administered cheduled time and any e noted on the MAR. acist was interviewed via 19, at 2:07 p.m. and stated e administered within 15 alled administration time to avoid					
	revised ate 5/2019 be administered to	ms. ation Administration policy b, indicated medications would b residents as prescribed by the der and that medications would					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG			E SURVEY PLETED
		245242	B. WING				C 06/2019
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIF 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	, CODE	1 00/	00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE -REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 755	scheduled administindicated medication documented prompto R133 On 6/5/19, at 10:42 administration pass following medication citalopram (antidep (anticoagulant), medications appressure), and multiple medications to be a aspirin, metoprolol, report indicated cital administered daily at R81 On 6/5/19, at 10:50 administration pass following medication diltiazem (treats high (treats allergies), fluorsemide (diuretic (treats acid reflux), spironolactone (diuretic (treats) acid reflux).	e hour before or after tration time. The policy further on administration is to be only after administration. a.m. during a medication is observation for R133; the inside were administered: aspirin, ressant), eliquis otoprolol (treats high blood tivitamin. Order Report dated 6/1/19, uded the following administered at 8:00 a.m. multivitamin and eliquis. The alopram was to be at 7:30 a.m a.m. during a medication is observation for R81; the inside were administered: gh blood pressure), Flonase acoxetine (anti-depressant), co), metoprolol, omeprazole Qvar inhaler (treats asthma), retic), tums (anti-acid) and halgesic). der Report dated 6/1/19, uded the following administered at 8:00 a.m. fluoxetine, Flonase,	F 7	55			
	TMA-B was intervie	ewed on 6/5/19. at 10:54 a.m.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY PLETED
		245242	B. WING			C 06/ 2019
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	administered late a administered no lat to one nurse not condition administered medical TMA-B reviewed the verified five addition outlined in red which had not been administered late. RN-F was interviewed to confirmed medication one hour before and the scheduled administered late. The director of nurse 6/6/19, at 11:40 a. respectation for medical according to the scheduled time. The facility pharmatelephone on 6/6/19 was his expectation administered within scheduled time.	and R81's medications were and should have been ther than 9:00 a.m. however due oming in TMA-B was pulled to cations so she got a late start. He work list for the unit and nal resident's names were chindicated their medications mistered and would be used on 6/6/19, at 8:18 a.m. and stone should be administered and no later than one hour after ministration time. Sing was interviewed on mand stated it was her dications to be administered theduled time. Licist was interviewed via 9, at 2:07 p.m. and stated it in for medications to be in one hour before or after the stion Administration policy	F 75	5		
	be administered to primary care provid be administered on scheduled adminis	,Store/Prepare/Serve-Sanitary	F 812	2		7/16/19
	§483.60(i) Food sa The facility must -	fety requirements.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245242	B. WING _			C 06/2019
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 812 Continued From page 48 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable Statiand local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not proclude residents from consuming foods not procured by the facil §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to disposed expired foods in the walk in freezer, cooler, refrigerator, and on trays in the kitchen about to be served to residents residing in the facility. This had the potential to affect 209 of 217 residents eating of the kitchen. Finding includes: During initial tour of kitchen on 6/3/19, at 7:22 a.m. Dietary Assistant (DA) verified in the refrigerator turkey slices in a container with lid ajar, dated 5/21, a mayonnaise container opens not dated, and pork base opened and not dated.				STREET ADDRESS, CITY, STATE, ZIP CO 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	•	00/2010
PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	S483.60(i)(1) - Proapproved or consistate or local auth (i) This may include from local produce and local laws or (ii) This provision facilities from usin gardens, subject the safe growing and (iii) This provision from consuming for S483.60(i)(2) - Store serve food in acceptance from this REQUIREMED by: Based on observer review, the facility foods in the walk in and on trays in the	page 48 coure food from sources idered satisfactory by federal, orities. de food items obtained directly ers, subject to applicable State regulations. does not prohibit or preventing produce grown in facility to compliance with applicable food-handling practices. does not preclude residents toods not procured by the facility. The prepare, distribute and ordance with professional diservice safety. ENT is not met as evidenced eation, interview and document failed to disposed expired in freezer, cooler, refrigerator, exitchen about to be served to	F 8	F812 It is the policy of the Augusta Care Center to store, prepare and serve food in accordance	ina Health e, distribute e with	DATE
	potential to affect of the kitchen. Finding includes: During initial tour a.m. Dietary Assis refrigerator turkey ajar, dated 5/21, anot dated, and po DA stated the foothrown out after sthe refrigerator that thrown out seven	209 of 217 residents eating out of kitchen on 6/3/19, at 7:22 stant (DA) verified in the slices in a container with lid a mayonnaise container opened,		professional standards for fo safety. Corrective Action Food Service Director compl of all kitchen areas to ensure with proper storage and datir items. Identified tomato product was discontinued due to possible with dating, alternate product acquired Identification of Other Reside Food Service Director will be times weekly for he next 30 censure compliance with prop storage and dating for all kitches.	eted an audit e compliance ng of all food s confusion t will be ents auditing 2 days to per food	

PRINTED: 07/16/2019 FORM APPROVED OMB NO. 0938-0391

CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			OMB NO.	<u>. 0938-0391 </u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245242	B. WING _			C 06/2019
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Ē	
ALIQUIOT		05NT50 05 MINNEADOLIO		1007 EAST 14TH STREET		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 812	opened 11/14/18, 2 stated she was goin DA verified a bag of undated. DA tossed into the garbage and dated to know how verified in the walk and five juices with been placed in the stated shakes were on the 14th day after verified in the coolecups with the outsic "KEEP FROZEN". It cups were placed in would needed to be for 14 days after the On 6/3/19, at 7:57 a slices were good for Cook stated he did base was good for On 6/3/19, at 8:32 a up trays with food for trays that had six jut on them unlabeled cooler. Dietary aided the trays and labeled the juices and shake the garbage can. On 6/3/19, at 8:28 a slices were good for good for two to three toast when dated were good for good for two to three toast when dated were good for good for two to three toast when dated were good for good for two to three toast when dated were good for good for two to three toast when dated were good for good for two to three toast when dated were good for good for two to three toast when dated were good for good for two to three toast when dated were good for good for two to three toast when dated were good for good for two to three toast when dated were good for good for two to three toast when dated were good for good for two to three toast when dated were good for good for two to three toast when dated were good for good for two to three toast when dated were good for good for two to three toast when dated were good for good for two to three toast when dated were good for good for two to three toast when dated were good for good for two to three toast when dated were good for good for two to three toast when dated were good for good	rers not secured with dates 1/15/19, and 4/10/19. DA ng to dispose of the ice cream. If french toast, opened and If the bag of the french toast and stated it should have been long it had been opened. DA in cooler four mighty shakes out a label indicating when had cooler from the freezer. DA in to be labeled and disposed of er placing in the cooler. DA in a box of 28 tomato juice de of the box label indicating DA stated the tomato juice in the cooler 4/26/19, and is disposed as were only good awing. In the cooler 4/26/19, and is disposed as were only good awing. In the cooler 4/26/19, and is disposed as were only good awing. In the residents and verified inces and three mighty shakes and not dated when placed in in stated evening shift made up and the drinks. Dietary aide took ites off the trays and threw in In the cooler of the trays and threw in In the drinks. Dietary aide took ites off the trays and threw in In the cooler of	F8	and food items. Measures Put in Place All dietary employees were edu a read and sign document on p storage and dating 7-15-19 Monitoring Mechanisms: Unplanned audits of the kitche food storage and dating of food be conducted by QAPI commit members at random times and times monthly for the next 90 of The QAPI committee will revier ensure compliance with proper storage and dating per facility p standards of practice on or bef 7-31-19 8-31-19 9-30-19 Responsible Person/s Director of Food Service or De Assistant Administrator/Director Improvement 7-16-19	n for proper d items will tee days 4 lays. w audits to food policy and ore:	
		as good up to 12 months, and covers were on tight were				

good up to 12 months. Dietitian stated she would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245242	B. WING		C 06/06/2019	
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS	1	TREET ADDRESS, CITY, STATE, ZIP CODE 007 EAST 14TH STREET MINNEAPOLIS, MN 55404	7 33/33/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLÉTIO	N
F 812	Dietitian stated the juice were good for then needed to be	rer about the pork base. mighty shakes and tomato 14 days after thawing and	F 812			
	Infection Prevention CFR(s): 483.80(a)(§483.80 Infection C The facility must est infection prevention designed to provide comfortable environ	n & Control 1)(2)(4)(e)(f) Control stablish and maintain an n and control program e a safe, sanitary and nment and to help prevent the ransmission of communicable	F 880		7/16/19	
	program. The facility must es and control prograr a minimum, the foll §483.80(a)(1) A sylidentifying, reporting infections and compresidents, staff, volindividuals providing arrangement based conducted according accepted national states §483.80(a)(2) Writtle procedures for the but are not limited to (i) A system of surpossible communications.	stem for preventing, g, investigating, and controlling municable diseases for all unteers, visitors, and other g services under a contractual d upon the facility assessmenting to §483.70(e) and following standards; sen standards, policies, and program, which must include, to:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245242	B. WING			C / 06/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO. 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		100/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 880	communicable dis reported; (iii) Standard and it to be followed to p (iv)When and how resident; including (A) The type and of depending upon the involved, and (B) A requirement least restrictive pocircumstances. (v) The circumstant must prohibit emp disease or infected contact with reside contact with reside contact will transm (vi)The hand hygie by staff involved in §483.80(a)(4) A sylidentified under the corrective actions §483.80(e) Linens Personnel must have transport linens so infection. §483.80(f) Annual The facility will con IPCP and update in This REQUIREME by: Based on observations	ility; thom possible incidents of ease or infections should be transmission-based precautions revent spread of infections; risolation should be used for a but not limited to: duration of the isolation, ne infectious agent or organism that the isolation should be the ssible for the resident under the noces under which the facility loyees with a communicable diskin lesions from direct ents or their food, if direct nit the disease; and ene procedures to be followed or direct resident contact. Instantantal or recording incidents to facility's IPCP and the taken by the facility. In andle, store, process, and or as to prevent the spread of	F 88	F880 It is the policy of the Augustar	na Health		
		sident use glucometer between		Care Center to maintain an in			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245242	B. WING			·	0
		245242	D. WING			06/0	06/2019
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			007 EAST 14TH STREET		
				N	IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	observed for glucor Findings include: On 6/4/19, at 5:13 p (LPN)-A was observed from the glucor LPN-A was observed from the glucometer to obtain the blood sugar of LPN-A removed a scontainer and wrap wipe. LPN-A stated sanitizer and keep wipe for five minute Sani-hands were the Assistant director oby the surveyor on LPN-A had used the sanitizing wipes should be sanitized for the sanitized for th	orm. licensed practical nurse ved to use the glucometer to od and record the blood sugar ne procedure LPN-A removed a blue top container and neter in the wipe. At 5:21 p.m. and to remove the Sani-hands ar and proceed to use the nadrop of blood and record R23. Following the procedure Sani-Wipe from a blue top ped the glucometer in the he was to use the wipes with the glucometer wrapped in the as. LPN-A verified the PDI are correct wipes to use. If nursing (ADON) was notified 6/4/19, at 5:39 p.m. that the Sani-hands wipes to cleanse ween residents. ADON verified correct wipes and identified build have been used. Ilean-disinfect glucometer icated the glucometer was to	F8	380	prevention and control program desto provide a safe, sanitary and comfortable environment to help pre the development and transmission communicable diseases and infection Corrective Action: Employee involved in the identified incident was immediately re-educated 6-4-19 Identification of Other Residents ADON immediately checked all glucometer carts to ensure proper sanitizing product was being used a place on all carts. Measures Put in Place: Mandatory education for all Nursing will be conducted on proper sanitizing product for disinfecting glucometers related infection control procedures 7-15-19 Monitoring Mechanisms: Infection Control Nurse will inspect glucometer carts 2 times weekly for next 30 days and then 1 time week the next 60 days to ensure complia with use of proper sanitizing product Infection Control Nurse will do 10% random audits of nurses to ensure infection control procedures are befollowed in regards to cleaning of glucometers will be conducted monthe next 90 days. The QAPI committee will review au compliance with facility infection coprocedures related to cleaning and glucometers on or before: 7-31-19 8-31-19 9-30-19	event of cons. tion on and graffing s and s. the ly for nce ct. proper ing athly for dits for ntrol	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	TE SURVEY MPLETED
		245242	B. WING		06	C 5/ 06/2019
NAME OF F	PROVIDER OR SUPPLIEF	₹		STREET ADDRESS, CITY, STATE, ZIP		700/2010
AUGUST	ANA HEALTH CARE	E CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET		
A00001	ANA IILALIII VAIL	SERVICE OF MINIMEA SEIS		MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 880	Continued From p	page 53	F 8		gnee	

PRINTED: 07/11/2019 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 B. WING 245242 06/05/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1007 EAST 14TH STREET **AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS** MINNEAPOLIS, MN 55404 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 000 INITIAL COMMENTS K 000 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. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on August 21, 2018. At the time of this survey. Augustana Health Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

07/03/2019

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.

PRINTED: 07/11/2019 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245242 B. WING 06/05/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET **AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS** MINNEAPOLIS, MN 55404 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 Continued From page 1 K 000 **DEFICIENCIES (K TAGS) TO:** HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@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. Augustana Health Care Center of Minneapolis is a 6-story building with a full basement that was constructed at 3 different times. The original building was constructed in 1945 and was determined to be of Type II(222) construction. In 1968, an addition was constructed to the South side of the building that was determined to be of Type II(222) construction. In 1974, an addition was constructed to the West 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.

Facility ID: 00164

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245242	B. WING		06/	05/2019	
	PROVIDER OR SUPPLIER TANA HEALTH CARE	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZI 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
K 521	automatic fire sprin complete fire alarm in the corridors and that are monitored notification. The facility has a community census of 217 at time. The requirement a NOT MET as evided HVAC CFR(s): NFPA 101. HVAC Heating, ventilation	protected throughout by an alkler systems and has a an system with smoke detection dispaces open to the corridor, for automatic fire department apacity of 250 beds and had a me of the survey. It 42 CFR, Subpart 483.70(a) is enced by: In, and air conditioning shall dishall be installed in emanufacturer's		521		7/16/19	
	by: Based on observa the facility has faile and ventilation in a Safety Code 101 2 and NFPA 90A 19.3 could effect 250 of Findings include:	NT is not met as evidenced tions and staff interview, that ed to install the facility's heating ccordance with the NFPA Life 012 edition section 19.5.2.1 5.2.2. This deficient practice 250 residents.		See Attached waiver and documents for K521	d supporting		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245242	B. WING		06	/05/2019	
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS				STREET ADDRESS, CITY, STATE, ZIP CO 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
-	Continued From partit was observed and the Director of Main located throughout are being used as a	age 3 d confirmed by interview, with ntenance that the corridors the main building of the facility an exhaust air plenum.	K 5	DEFICIENCY)			

PART III - RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)

JUSTIFICATION

K400

K 521 SS=F

The building heating, ventilation and air conditioning equipment (HVAC) does not comply with LSC (00) Section 9.2, and NFPA 90A, 1999 Ed., because the corridors are being used as a plenum

Surveyor (Signature)	Title	Office	Date
outveyor (orginaturo)	TILLO	Office	Date
Fire Authority Official (Signature)	Title	Office	Date
_ · · · · · · · · · · · · · · · · · · ·	Titlo	Office	Date
Then I I what 12424			
1 Mm & J want 12424			
./ //			

PART III - RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)

JUSTIFICATION

K400

K 521 SS=F

The building heating, ventilation and air conditioning equipment (HVAC) does not comply with LSC (00) Section 9.2, and NFPA 90A, 1999 Ed., because the corridors are being used as a plenum

Surveyor (Signature)	Title	Office	Date
Fire Authority Official (Signature)	Title	Office	Date
The & of while 12424			

PART III - RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)

JUSTIFICATION

K400

K 521 SS=F

The building heating, ventilation and air conditioning equipment (HVAC) does not comply with LSC (00) Section 9.2, and NFPA 90A, 1999 Ed., because the corridors are being used as a plenum

Surveyor (Signature)	Title	Office	Date
Curveyor (Cignaturo)	Title	Office	Date
Fire Authority Official (Signature)	Title	Office	Date
The I salf 12424			

PART III - RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)

JUSTIFICATION

K400

K 521 SS=F

The building heating, ventilation and air conditioning equipment (HVAC) does not comply with LSC (00) Section 9.2, and NFPA 90A, 1999 Ed., because the corridors are being used as a plenum

Surveyor (Signature)	Title	Office	Date
our veyor (orginature)	TILLE	Office	Date
Fire Authority Official (Signature)	Title	Office	Date
	TILLO	Office	Date
Then I I what 12424			
1 1 mm of 1 12424			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 27, 2019

Administrator Augustana Health Care Center Of Minneapolis 1007 East 14th Street Minneapolis, MN 55404

Re: State Nursing Home Licensing Orders - Project Number S5242030, H5242119C, H5242120C, H5242121C, H5242122C

Dear Administrator:

The above facility was surveyed on June 3, 2019 through June 6, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number S5242030, H5242119C, H5242120C, H5242121C, and H5242122C. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

Augustana Health Care Center Of Minneapolis June 27, 2019 Page 2

order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us

Phone: (651) 201-3792 Fax: (651) 215-9697

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,

Jovens Stapson

Douglas Larson, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Augustana Health Care Center Of Minneapolis June 27, 2019 Page 3

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

PRINTED: 07/16/2019 FORM APPROVED

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _____ С B. WING _ 00164 06/06/2019

	001	64	B. WING		06/06/2019
	PROVIDER OR SUPPLIER	DE MINI 1007 EAS	DRESS, CITY, S T 14TH STRI OLIS, MN 59		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF (EACH DEFICIENCY MUST BE P REGULATORY OR LSC IDENTIFY	DEFICIENCIES RECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 000	Initial Comments *****ATTENTION***	***	2 000		
	In accordance with Minnesot 144A.10, this correction orde pursuant to a survey. If, upo found that the deficiency or dherein are not corrected, a fin not corrected shall be assess with a schedule of fines prom the Minnesota Department or	a Statute, section r has been issued n reinspection, it is eficiencies cited ne for each violation sed in accordance nulgated by rule of			
	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 of that may result from non-comorders provided that a writter the Department within 15 day notice of assessment for non-	npliance with these request is made to s of receipt of a			
	INITIAL COMMENTS: You have agreed to participa receipt of State licensure ord the Minnesota Department of Informational Bulletin 14-01, http://www.health.state.mn.us obul.htm. State licensing orde 2567, under the Minnesota D	ers consistent with f Health available at s/divs/fpc/profinfo/inf ers are delineated on			

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

07/03/19 **Electronically Signed**

STATE FORM 6899 If continuation sheet 1 of 58 LWJ311

TITLE

(X6) DATE

NAME OF PROVIDER OR SUPPLIER AUGUSTANA HEALTH CARE CENTER OF MINI STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		DED: I`´	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
AUGUSTANA HEALTH CARE CENTER OF MIN			00164	B. W	ING			_
minited a very finit votot			F CENTER OF MIN	1007 EAST 141	TH STRE	EET		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	PRÉFIX	(EACH DEFICIENCY	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FU	JLL PR	ID REFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF	OULD BE	(X5) COMPLETE DATE
licensing order statute(s) being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "Corrected" in the box available for text. You must then indicate on the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting your plan of correction to the Minnesota Department of Health. On 6/3/19 through 6/6/19, the Minnesota Department of Health. On 6/3/19 through 6/6/19, the Minnesota Department of Health, Licensure and Certification surveyors visited Augustana Health Care Center of Minneapolis and the following correction orders were issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Additionally, complaints were investigated on 6/3/19-6/6/19, H5242120C, H5242122C, H5242121C, H5242120C was substantiated no deficiencies issued. H5242122 C was substantiated and a deficiecny was issued at 1995. H5242121C was unsubstantiated with a deficiency issed at 2000. H5242119C was substantiated with a deficiency issed at 2000. H5242119C was substantiated on 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 found out of compliance is listed in		licensing order state electronically. Althous necessary for State the word "Corrected You must then indicallicensure process, and the the Minnesota Department of Heasurveyors visited Aurof Minneapolis and were issued. Pleasuration of correction the orders, and identify completed. Additionally, completed. H5242121C, H5242, H5242121C was sured. H5242121C was sured at 1995, H5242121C was urdeficiency issed at H5242119C was sured. Minnesota Department State Licensing federal software. Tassigned to Minneson Nursing Homes. The assigned tag in column entitled "ID"	atute(s) being submitted hough no plan of correction te Statutes/Rules, please ed" in the box available for dicate on the electronic Statutes will be corrected ubmitting your plan of concept that you have reviewed that you have r	to you ion is e enter for text. State inpletion d prior prection diffication Center in orders ronic these il be in on included in orders ciecny in the state of t	00			

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 2 of 58

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00164		B. WING)6/2019
	PROVIDER OR SUPPLIER			DRESS, CITY, S T 14TH STR	STATE, ZIP CODE EET	1 00.0	
AUGUS	TANA HEALTH CARE	CENTER OF MIN	MINNEAP	OLIS, MN 5	5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2		2 000			
	the correction order the findings, which statute after the sta as evidence by". findings are the "Si Correction " and the " PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA THERE IS NO RECEPLAN OF CORRECT	es the "To Comply" process. This column also in are in violation of the stement, "This Rule is Following the surveyuggested Method of the "Time Period for Control of	orrection OF THE N." THIS SONLY. BMIT A IONS OF				
2 265	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, an attending physician development of the have criteria which appropriate notifica	atus ust develop and imple aff decisions to consular an assistants, and no known, notify the rese or an interested fament's acute illness, se At a minimum, the d and the medical direct must be involved in se policies. The poli address at least the tion times for: involving the residen I has the potential for	ement ult urse sident's nily rious irector of or or an the cies must	2 265			7/16/19

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 3 of 58

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		00164		B. WING		_	C 06/06/2019	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 00.0	0.2010	
AUGUS	TANA HEALTH CARE	CENTER OF MIN		T 14TH STR OLIS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
2 265	B. a significant physical, mental, o example, a deterior psychosocial status conditions or clinica C. a need to altexample, a need to of treatment due to begin a new form or D. a decision to resident from the number of the sacral from the number of the sacral pressure ulcoreviewed for his chair	change in the resider psychosocial status ation in health, mentin either life-threated complications; ter treatment signification and exist adverse consequent for treatment; or transfer or dischargursing home; or dischargursing the primary care proportion of a facility are for 1 of 1 resident are ulcer.	s, for tal, or ning antly, for ing form ces, or to ge the nt deaths. denced w, the rovider acquired (R9)) dated and did riod. The ssistance for was at risk reducing ment for skin	2 265	Corrected			

Minnesota Department of Health STATE FORM

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00164	B. WING			C 06/2019	
	PROVIDER OR SUPPLIER	CENTER OF MIN 1007 EA	DDRESS, CITY, S ST 14TH STR POLIS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
2 265	R9's Skin Risk/ Wo indicated R9 was a directed staff to offe degree wedge docupressure mapping care per orders, ad every hour, glidewe every 2-3 hours and cushion.	und Care Plan edited 6/5/19, trisk for skin impairment and er R9 to lay in bed with 30 ument refusals, air mattress, completed 5/30/19, wound just position in wheelchair ear shorts, turn and reposition d pressure relieving wheelchairs (PN), skin observations and	2 265				
	reviewed from 4/1/indicated the follow -The skin observati "has a new pressur area," however lack measurements, into notification or treatr -The TAR dated 4/indicated wound -The TAR dated 5/indicated wound cainjury which start da 5/8/19. A subseque lower right side of s -The PN dated 5/7/	on dated 4/29/19, indicated the sore in back and coccyx sed evidence of assessment, the erventions, provider ments; 1/19, through 4/30/19, lacked					
	physician notification noted on 4/29/19.	d lacked evidence regarding on of the pressure ulceration					
	stated he had a sor RN-C was interview and confirmed R9's	l on 6/4/19, at 12:30 p.m. and e on his bottom. /ed on 6/5/19, at 9:38 a.m. s skin observation dated R9 had a pressure ulcer, RN-C					

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 5 of 58

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′	LE CONSTRUCTION		SURVEY PLETED
71110 1 127111	OF CONTRECTION	IDENTIFICATION NOWIDER.	A. BUILDING:	:		
		00164	B. WING			C 06/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MIN	ST 14TH STR POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 265	wound was completed find wound care if the physician was through 5/6/19, in FRN-E was interview stated they were not ulcer until 5/6/19. Reported a resident have to see them we explained she updated and obtained treatment of the wound. Patient representated clinic was interview 10:18 a.m. and state notified of the pressort find the wound to update the wound to up	urse first assessment the sted on 5/7/19, and was unable orders and/ or documentation a updated from 4/29/19, R9's medical record. Wed on 6/5/19, at 9:51 a.m. and the amount aware R9's sacrum pressure RN-E stated once they were nad a new open area they within 24 hours. RN-E ated R9's physician on 5/7/19, ment orders after assessment assessment wive from primary physician's red via telephone on 6/6/19, at ted R9's physician was first sure ulcer on 5/7/19. Sing was interviewed on and stated it was her nurse who first finds the re primary physician. Skin Integrity dated 8/6/18, der would be notified upon				
	TIME PERIOD FOR	R CORRECTION: Twenty-one				

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 6 of 58

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00164		B. WING		06/0	
		00104				1 06/0	6/2019
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MIN		T 14TH STR OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 6		2 265			
	(21) days						
2 430	MN Rule 4658.0210) Subp. 1 Room Assiç	gnments	2 430			7/16/19
	A nursing home me resident's preference	assignments and furni ust attempt to accomi ces on room assignm rnishings whenever p	modate a ients,				
	by: Based on observati review, the facility fa	ent is not met as evident, interview and doc ailed to ensure call lig 2 residents (R20, R17 ing the call light.	ument hts were		Corrected		
	Findings include:						
	3/5/19, indicated R2	imum Data Set (MDS 20's cognition was im _l ctensive assistance w	paired				
	her recliner calling of walked into the roor light approximately the bottom of a flow bed. R20 was intervented where her call	a.m. R20 was sitting out for toast and egg. m and observed R20' 20 feet from resident ver vase on a stand noviewed and stated shell light was and was un. R20 stated she want	Surveyor s call placed in ext to the e did not nable to				
	walked into R20's re light in the vase. NA forgotten to put the	a.m. nursing assistar oom and verified R20 A-K stated she must h call light on R20's rec ach it. NA-K stated R	's call lave cliner				

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 7 of 58

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BI	JILDING: _			,
		00164	B. W	ING		06/0	6/2019
NAME OF I	PROVIDER OR SUPPLIER	STR	EET ADDRESS	S, CITY, S	TATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MIN	7 EAST 141 INEAPOLIS				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PF	ID REFIX FAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 430	Continued From pa	 age 7	2 4	30			
	able to use her call and stated call light resident reach. NA- and she pressed th times and activated On 6/5/19, at 11:07 (LPN)-B stated she to be within reach	light, has used her call light was supposed to be in the K handed the call light to be call light button a coupled it. Ya.m. licensed practical new expected residents' call I for the residents who can	ne R20 e of urse ights use				
	them. LPN-B stated R20 had the ability to use her call light and R20's call light should have been within reach when she was sitting in her recliner. R174's call light was observed on the floor hanging from the bottom of a grab bar on 6/3/19, at 10:07 a.m. R174 asked where his call light was and stated he could not find it and needed to reach a staff member. R174 stated he needed the call light as it was the only way he could reach staff members. Registered nurse (RN)-A entered the room and confirmed R174 could not reach his call light where it was hanging and stated he was not capable of rolling over to reach down the side of the bed or getting out of bed on his own. RN-A further stated R174 had previously requested to have the call light pinned to his shirt or gown and he was capable of using it.						
	Impaired self-performultiple fractures, r	ated 11/20/18, included: rmance with bathing due trange of motion limitations of the dated 5/29/19, at 1:56	p.m.				
	call light effectively. Clinical manager (Ca.m. her expectationall resident's call light	alert and oriented and us CM)-A stated on 6/6/19, at on would be for staff to ens ghts were in the proper pla room and R174 was capa	t 8:29 sure ace				

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 8 of 58

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	COMPLETED			
		00164		B. WING		06/0)6/2019
		00104				06/0	16/2019
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MIN		T 14TH STRI OLIS, MN 5:			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY I SC IDENTIFYING INFORMA'	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 430	Continued From pa	ge 8		2 430			
	a.m. her expectatio within reach for all f The facility's call lig directed staff to place accessible to the reresident room. Second	ht policy dated 12/31/ ce call light so it woul sident at all times wh ure the call light to sta	hts to be 118, d be en in				
	access of the resident. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing or designee could review all resident room call light placement to ensure they accommodate resident needs and preferences. Facility staff could be educated accommodation of residents needs. The administrator or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.						
2 800	Staffing requirement Subpart 1. Staffing home must have or number of qualified registered nurses, I nursing assistants to residents at all nursing all buildings if more	requirements. A nur n duty at all times a su nursing personnel, i icensed practical nur o meet the needs of ses' stations, on all flo ore than one building ides relief duty, week	sing ufficient ncluding rses, and the ors, and	2 800			7/16/19
	This MN Requirements	ent is not met as evid	lenced				

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 9 of 58

PRINTED: 07/16/2019 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION :		(X3) DATE SURVEY COMPLETED	
		00164	B. WING			C 06/2019
	PROVIDER OR SUPPLIER	CENTER OF MIN 1007 EAS	DDRESS, CITY, ST 14TH STF POLIS, MN 4			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 800	Based on observation review, the facility facili	ge 9 on, interview and document ailed to ensure sufficient staff eet resident needs related to residents (R187) reviewed for ing (ADL) of the dependent residents (R89, R133, R81) ation administration. In failed to ensure wound care hysician orders for 1 of 1 ewed for pressure ulcer. yed on 6/3/19, at 8:47 a.m. and cream and yell nobody would a morning. R187 explained here put onto the bed pan while it le and later found out "the waited a long time I was ng still on the bed pan." R187 essed his call light multiple if the bedpan and when the his light they would leave his call light off without providing dpan. R187 identified he was dover one hour" and had fallen to waiting so long. R187 stated to time this had happened and to nursing staff, however he are just short of help." NA)-D was interviewed on and confirmed four east unit ue to only 3 NA today with a 1:9 when 4 NA were present. If had to wait for assistance of other resident and when she seated on the bedpan with dry. NA-D explained she was		Corrected		

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 10 of 58

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			B. WING		I	C
		00164	B. WING		06/	06/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
A.I.O.I.O.		1007 EAS	ST 14TH STR	EET		
AUGUS	TANA HEALTH CARE	MINNEAL MINNEAL	POLIS, MN 5	5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION TO THE	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
				DEFICIENCY)	
2 800	Continued From pa	ge 10	2 800			
	unsure when R187 and further stated the report to her R187 of currently utilizing the had to "use extra w	was assisted onto the bedpan he overnight shift did not would need assist as he was e bed pan. NA-D stated she ipes" due to the BM dried onto A-D stated the overnight shift				
	stated he had not b timely per his neuro late administration is spasms. R89's Physician Or through 6/6/19, incl administered at 6:0 3:00 p.m., 6:00 p.m.	ed on 6/3/19, at 7:55 a.m. and been receiving his Sinemet blogist orders. R89 stated the resulted in neck and shoulder der Report dated 5/6/19, uded Sinemet to be 0 a.m., 9:00 a.m., 12:00 p.m., a. and 8:00 p.m. for Parkinson				
	was reviewed 3/1/1 revealed the following -3/1/19, through 3/3 not receive his Sine resident unavailable late due to "helping administered late due to time the medication drug/ item unavailated -4/1/19, through 4/3 not receive his Sine unavailable," three helping with cares, late," 11 times administered due to -5/1/19, through 5/3 not receive his Sine sine unavailable.	81/19, MAR indicated R89 did emet five times due to le," four times administered with cares," 18 times ue to "charted late" and one was not administered due to able;" 80/19, MAR indicated R89 did emet once due to "resident times administered late due to " nine times "administered inistered late due to "charted				
	"helping with cares,	nistered late once due to ," twice "administered late," 10 late due to "charted late:"				

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 11 of 58

STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00164	B. WING		06/0	6/2019
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
AUGUS1	ANA HEALTH CARE	CENTER OF MIN	T 14TH STR OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	administered late of The trained medical interviewed on 6/4/when a medication hour after the scheprompt her to indicadministered late. Twas "short" staffed opposed to 4 NA's facility for the TMA TMA-A stated this when administering medications to be a verified in R89's Mawith cares" was time and she needed to R89's Sinemet was beyond the schedu R133 On 6/5/19, at 10:42 administration pass following medication citalopram (antidep (anticoagulant), medications to be a aspirin, metoprolol, report indicated cital administered daily a R81 On 6/5/19, at 10:50	of/19, MAR indicated R89 nce due to "charted late." ation aide (TMA)-A was 19, at 6:08 p.m. and explained was administered beyond one duled time the MAR would ate a reason it was TMA-A indicated when the unit with 3 nursing assistants (NA) it was the expectation of the to assist with resident cares. Would cause her to run behind medications causing administered late. TMA-A AR when documented "helping tes the unit only had 3 NAs help with resident cares so administered over an hour led time. It a.m. during a medication is observation for R133; the ns were administered aspirin, pressant), eliquis etoprolol (treats high blood tivitamin. Order Report dated 6/1/19, and the following administered at 8:00 a.m. multivitamin and eliquis. The alopram was to be at 7:30 a.m.	2 800	DEFICIENCY		
	administration pass	a.m. during a medication s observation for R81; the ns were administered				

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 12 of 58

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00164	B. WING			C 06/2019
	PROVIDER OR SUPPLIER	CENTER OF MIN 1007 EAS	DDRESS, CITY, S ST 14TH STR POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 800	diltiazem (treats hig (treats allergies), flufurosemide (diuretic (treats acid reflux), spironolactone (diu acetaminophen (an R81's Physician Or through 6/5/19, incl medications to be a omeprazole, tums, acetaminophen, dilfurosemide, spironolations to be a diversified R133 and verified R133 and veri	ph blood pressure), Flonase poxetine (anti-depressant), c), metoprolol, omeprazole Qvar inhaler (treats asthma), retic), tums (anti-acid) and algesic). der Report dated 6/1/19, uded the following administered at 8:00 a.m. fluoxetine, Flonase, tiazem, metoprolol, plactone, and Qvar inhaler. Ewed on 6/5/19, at 10:54 a.m. and R81's medications were not should have been er than 9:00 a.m. however due ming in TMA-B was pulled to eations so she got a late start. It is work list for the unit and nal resident's names were h indicated their medications instered and would be I on 6/4/19, at 12:30 p.m. and re on his bottom. R9 explained have not had enough help so s wet "diaper" all night "that's to rehanged or helped multiple properties of the properties of the changed or helped multiple properties of the properties of the sequent interview on 6/5/19, and the stated he thought his dressing to his not been changed and he stated he thought his dressing				

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 13 of 58

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00164	B. WING			C 06/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	·	
AUGUS1	ANA HEALTH CARE	CENTER OF MIN	T 14TH STRE			
0/0.15	CLIMMA DV CTA		POLIS, MN 55		ADDECTION	()/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 13	2 800			
	and RN-D were obs	a.m. registered nurse (RN)-C served turning R9 onto his left ed R9's dressing that covered was dated 6/3/19.				
	and verified the nur R9's dressing per o completed the "nurs it was her expectati	yed on 6/5/19, at 9:38 a.m. se on 6/4/19, did not change rders and documented not se got too busy." RN-C stated on if the nurse was too busy ould have completed the				
	5/1/19, through 6/5/following: - The TAR dated 5/indicated wound ca start date 5/7/19, he completed due to we member who docur unable to complete was unavailable for -The TAR dated 6/2 wound care lower riindicated "not comp 6/4/19. Staff member 1/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2	rd (TAR) was reviewed from 19, and indicated the 1/19, through 5/31/19, re lower right side of sacrum owever indicated "not rorkload" on 5/15/19. Staff mented on TAR regarding due to workload on 5/15/19, interview. 1/19, through 6/5/19, indicated 1/19, i				
	on 6/6/19, at 10:33 had 30 positions op nursing assistants. offering pick up bor recruitment efforts. long term care unit	ordinator (SC) was interviewed a.m. and stated the facility en between nurses and The SC stated they had been nuses and working on their The SC explained the 4 east with a census of 36 were to A, 4 NA's when fully staffed.				

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 14 of 58

NAME OF PROVIDER OR SUPPLIER AUGUSTANA HEALTH CARE CENTER OF MINI (X4) ID (EACH DEPROCENCY MIST BE PRECEDED BY FULL FEBRUARY STATEMENT OF DEPICIENCIES (EACH DEPROCENCY MIST BE PRECEDED BY FULL FEBRUARY OF CORRECTION FOR SHOULD BE (EACH DEPROCENCY MIST BE PRECEDED BY FULL FEBRUARY OF U.S. OBJECTION FOR SHOULD BE (EACH DEPROCENCY MIST BE PRECEDED BY FULL FEBRUARY OF U.S. OBJECTION FOR SHOULD BE (EACH DEPROCENCY MIST BE PRECEDED BY FULL FEBRUARY OF U.S. OBJECTION FOR SHOULD BE (EACH DEPROCENCY MIST BE PRECEDED BY FULL FEBRUARY OF U.S. OBJECTION FOR SHOULD BE (EACH DEPROCENCY OF U.S. OBJECTION FOR SHOULD BE (EACH DEPROCENCE OF U.S. OBJECTION FOR SHOULD BE (EACH DEPROC		NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HEALTH CARE CENTER OF MIN (X4) ID (EACH DEPTICENCY MIST BE PRECEDED BY FULL FREDULATION? OR LSO DENIFYING INFORMATION) 2 800 Continued From page 14 The SC reviewed the nurse staff schedule 5/4/19, through 6/5/19, and revealed during 17 shifts the 4 east unit had 1 nurse, 1 TMA and 3 NAs instead of 4. The SC explained when there was a check mark next to the staff name when they were verified as present for the shift and if their name was circled it meant the person was late and to check if there were here. The SC indicated when there was an orientee person listed on the schedule they were not allowed to be on their own so they would need to be with another NA when working on the floor. The SC further explained when census for the building was low it was the expectation to cut hours across the building either by running shorter shifts or utilization of a bath aide to be split between two units instead of 4. NAs per unit. The director of nursing (DON) was interviewed on 6/6/19, at 11:42 a.m. and stated they try to run a 1.8 to a 1:10 for NAs to resident ratio and this was based on total census in house. The DON reviewed the facility assessment and verified staffing ratios that were determined to meet the needs of the residents who resided in long term care were one licensed staff, one TMA and NAs 1:9. The DON indicated they do the best they can to meet that staff level. SUGGESTED METHOD FOR CORRECTION: The administrator, director of nursing or designee could develop and implement policies and procedures related to Sufficient Staffing. The quality assessment and assurance committee could perform random audits to ensure	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COIVIE	LEIED
AUGUSTANA HEALTH CARE CENTER OF MIN 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404 1007 EAST 14TH STREET MINNEAPOLIS 1007 EAST 14TH STREET MIN			00164	B. WING			_
MINEAPOLIS, MN 55404 MINEAPOLIS MN 55404 M	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 800 Continued From page 14 The SC reviewed the nurse staff schedule 5/4/19, through 6/5/19, and revealed during 17 shifts the 4 east unit had 1 nurse, 1 TMA and 3 NAs instead of 4. The SC explained when there was a check mark next to the staff name when they were verified as present for the shift and if their name was circled it meant the person was late and to check if there were here. The SC indicated when there was an orientee person listed on the schedule they were not allowed to be on their own so they would need to be with another NA when working on the floor. The SC further explained when census for the building was low it was the expectation to cut hours across the building either by running shorter shifts or utilization of a bath aide to be split between two units instead of 4 NAs per unit. The director of nursing (DON) was interviewed on 6/6/19, at 11:42 a.m. and stated they try to run a 1:8 to a 1:10 for NAs to resident ratio and this was based on total census in house. The DON reviewed the facility assessment and verified staffing ratios that were determined to meet the needs of the residents who resided in long term care were one licensed staff, one TMA and NAs 1:9. The DON indicated they do the best they can to meet that staff level. SUGGESTED METHOD FOR CORRECTION: The administrator, director of nursing or designee could develop and implement policies and procedures related to Sufficient Staffing. The quality assessment and assurance committee could perform random audits to ensure	AUGUST	ANA HEALTH CARE	CENTER OF MIN				
The SC reviewed the nurse staff schedule 5/4/19, through 6/5/19, and revealed during 17 shifts the 4 east unit had 1 nurse, 1 TMA and 3 NAs instead of 4. The SC explained when there was a check mark next to the staff name when they were verified as present for the shift and if their name was circled it meant the person was late and to check if there were here. The SC indicated when there was an orientee person listed on the schedule they were not allowed to be on their own so they would need to be with another NA when working on the floor. The SC further explained when census for the building was low it was the expectation to cut hours across the building either by running shorter shifts or utilization of a bath aide to be split between two units instead of 4 NAs per unit. The director of nursing (DON) was interviewed on 6/6/19, at 11:42 a.m. and stated they try to run a 1:8 to a 1:10 for NAs to resident ratio and this was based on total census in house. The DON reviewed the facility assessment and verified staffing ratios that were determined to meet the needs of the residents who resided in long term care were one licensed staff, one TMA and NAs 1:9. The DON indicated they do the best they can to meet that staff level. SUGGESTED METHOD FOR CORRECTION: The administrator, director of nursing or designee could develop and implement policies and procedures related to Sufficient Staffing. The quality assessment and assurance committee could perform random audits to ensure	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
TIME PERIOD FOR CORRECTION: Twenty (21) days.	2 800	The SC reviewed the through 6/5/19, and 4 east unit had 1 not instead of 4. The Scheck mark next to were verified as prename was circled it and to check if ther when there was an schedule they were so they would need working on the floowhen census for the expectation to cut he by running shorter saide to be split betw. NAs per unit. The director of nurse 6/6/19, at 11:42 a.m. 1:8 to a 1:10 for NA was based on total reviewed the facility staffing ratios that we needs of the reside care were one licer 1:9. The DON indicates the same that staff less SUGGESTED MET The administrator, could develop and procedures related quality assessment could perform rand compliance. TIME PERIOD FOR	ne nurse staff schedule 5/4/19, direvealed during 17 shifts the curse, 1 TMA and 3 NAs C explained when there was a the staff name when they esent for the shift and if their timeant the person was late the were here. The SC indicated orientee person listed on the end allowed to be on their own to be with another NA when the resulting was low it was the nours across the building either shifts or utilization of a bath ween two units instead of 4 sing (DON) was interviewed on the nours across the building either shifts or utilization of a bath ween two units instead of 4 sing (DON) was interviewed on the number of the sensus in house. The DON of the sensus in house. The DON of the sensus in house in long term and staff, one TMA and NAs the stated they do the best they can evel. THOD FOR CORRECTION: director of nursing or designee implement policies and to Sufficient Staffing. The tand assurance committee om audits to ensure				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE S COMPL				
		00164	B. WING		06/0	6/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	·	
AUGUST	ANA HEALTH CARE	CENTER OF MIN	ST 14TH STR POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 15	2 830			
2 830	Proper Nursing Car		2 830			7/16/19
	receive nursing carcustodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursiof bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.				
	by: Based on observati review, the facility fa assess and comple	ent is not met as evidenced on, interview and document ailed to comprehensively te ongoing monitoring and smoking for 1 of 3 residents r smoking.		Corrected		
	R130's diagnosis in behavioral disturbal altered mental statu dependence on sup R130's annual Mini 8/10/18, identified F	ncluded dementia without nces, vascular dementia, us, nicotine dependence and oplemental oxygen. mum Data Set (MDS) dated R130 was a smoker. A Care CAA) related to smoking was				
	A smoking assessn	nent, dated 2/14/19, noted				

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 16 of 58

PRINTED: 07/16/2019 FORM APPROVED

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00164		B. WING		I	C 06/2019
	PROVIDER OR SUPPLIER	CENTER OF MIN	007 EAS	DRESS, CITY, S T 14TH STRI OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	R130 had actual altincluded smoking ir smoking assessment R130 had impaired participate in the snassessment directer material and to kee nursing station. A smoking care pla R130 had been obston-designated are clothing due to move Resident is able to smoking apron. A compaired cognition. R130 had a history awareness especial consequences of simpaired cognition. R130 was observed p.m. When asked, cigarettes and was manage her smoking R130 untied a plass wheelchair next to land exposed four dipacks of cigarettes cigarettes. Registered nurse (F6/4/19, at 1:27 p.m. either in the smoking building. RN-I furthed deemed to be safe	teration in behavior which unsafe areas. Another of the dated 4/29/19, indicated the cognition and refused the staff set-up R130's supplied the served smoking material as (2016). Burn hole for the common the served smoking in the served smoki	reated to late of the late of the late of the late of the late of late of the late of	2 830			

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 17 of 58

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED	
		00164	B. WING			C 06/2019
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	STATE, ZIP CODE		00/2010
AUGUST	TANA HEALTH CARE	CENTER OF MIN 1007 EAS	ST 14TH STR	EET		
	TANA TIEAETTI GARE	MINNEAL	POLIS, MN 5	5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 17	2 830			
	her and staff did no or monitor her smol or monitor her smol on 6/4/19, at 1:31 pase to smoke and her room. RN-H fur recreation (TR) dep conducting smoking who smoked. RN-H with changes or prosmoking assessments were	c.m. a RN-H stated R130 was keep her smoking supplies in ther explained the therapeutic partment was in charge of g assessments for residents I stated TR would alert nursing oblems found during a ent. RN-H stated smoking done quarterly and as				
	four disposable ligh cigarettes and two her room RN-H sta smoker" and was n assessment that inc	n. RN-H verified R130 had ters, two opened packs of unopened packs of cigarettes ated R130 was a "safe ot aware of a smoking dicated R130 was not safe to try precautions in place.				
	a.m. R130's smoki wheelchair which w 7:42 a.m. R130 was cigarette while sittin facility smoking roo next to her. A smol designed to be worn intended for individual protective shield frocigarettes) was fold wheelchair. A bag R130's wheelchair.	d in her bed on 6/5/19, at 6:18 ng supplies were in her as placed next to her bed. At sobserved smoking a lit ing in a chair in the designated m. R130's wheelchair was king apron (an over-garment in while smoking tobacco uals who smoke and require a per hot ashes and dropped led over the back of R130's of smoking materials was on seat. Staff was not present in groom. A total of four oking in the room.				
	at 7:47 a.m. and sta	-A) was interviewed on 6/5/19, ated although the she was a smoking room by video				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00164	B. WING			C 06/2019
	PROVIDER OR SUPPLIER	CENTER OF MIN 1007 EA	DDRESS, CITY, S ST 14TH STRE POLIS, MN 55	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	camera from the re to monitor if a resid apron. R-A further of who what residents wear an apron while had never addressed unaware if the facility smoking habits on a construction of the facility smoking apron. At a was given a smoking apron. At a was given a smoking apron in place. As a noted on the apron. The director of the stated on 6/6/19, at was in charge of consideration of the stated on assessments, there is staff or implement of a resident was found smoking, a smoking kept it on all day." The monitor this practical a policy in place. RN-H was interview stated R130 was as to need an apron of RN-H did not receive therefore did not put the force of the stated R130 continuation applied when verified R130 continuation.	ception area, she was unable ent was wearing a smoking explained she did not know were identified as needing to e smoking because the staff ed it with her. R-A was ty monitored residents' a regular basis. a.m. R130 was observed in the m. R130 was wearing a 3:02 a.m. R130 stated she ag apron "yesterday", which ack of her wheelchair. ontinued to smoke in the g room. R130 had a smoking es from R130's cigarette were	e n			

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 19 of 58

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C			E CONSTRUCTION		SURVEY PLETED
741011114	or contraction	IDENTIFICATION NOMBE		A. BUILDING:			
		00164		B. WING		l l	C 06/2019
NAME OF	PROVIDER OR SUPPLIER	ST	TREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MIN		T 14TH STRI OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	nge 19		2 830			
	10:20 a.m. that if st in place for a reside be at risk while sme should be followed stated the facility st to ensure safety an concluded, "A good their smoking supp that." A nursing progress noted R130 had but was able to smoke smoking apron, Thencourage R130 nursing assistant (Inot identify R130 w	sing (DON) stated on 6/6 taff put smoking interventent who had been assest oking, these intervention by the staff. The DON food have a system in put compliance. The DON first step would be to make a line where the PN, dated 6/5/19 independently when we he PN directed staff to to "use it." The current NA) care sheet, undated as a smoker or direct state of a smoking apron.	ntions ssed to ns further place N nonitor look at but earing a				
	plan policy, dated 1 smokes will be ass practices and would require smoking marea. The policy alsassessed to be unsinterventions may buse of a smoking a holders or ash trays rationed smoking nursing station. The monitoring these in SUGGESTED MET The director of nursidevelop, review, an procedures to ensure the smoking of the state of the sta	gustana/Elim Affiliation, 2/5/19, stated a residen essed for safe smoking d indicate if cognitive fur aterials be kept in a sect so stated if a resident was afe in their smoking prape put in place which incopron, use of adaptive cigs, supervised smoking, anaterials and/or kept at the policy lacked direction terventions. THODS OF CORRECTION IN THO IN THE PROPERSION IN THO IN THE PROPERSION IN THE PR	nction ured as actices, cluded: garette and the for				

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 20 of 58

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLE				
		00164	B. WING		06/0) 6/2019
	PROVIDER OR SUPPLIER	CENTER OF MIN 1007 EAS	DRESS, CITY, S T 14TH STR OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	The DON or design systems to ensure report the results to committee for further	ge 20 lee could develop monitoring ongoing compliance and the quality assurance er recommendations. R CORRECTION: Twenty-one	2 830			
2 840	Proper Nursing Car Subp. 2. Criteria for proper care. The oradequate and proper management of the condition requires the must be given a condition of the condition	or determining adequate and criteria for determining	2 840			7/16/19

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 21 of 58

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION :		E SURVEY PLETED
		00164	B. WING			C 06/2019
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AUGUS1	TANA HEALTH CARE	CENTER OF MIN	ST 14TH STF POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 840	Clean linens or clot promptly each time Perineal care include the perineal area. It to keep the bed dry comfort. Special at skin to prevent irritatypes of protectors completely covered contact with the resultant clothing must be represident areas to president	hing must be provided the bed or clothing is soiled. des the washing and drying of Pads or diapers must be used and for the resident's tention must be given to the ation. Rubber, plastic, or other must be kept clean, be , and not come in direct ident. Soiled linen and moved immediately from revent odors.	2 840			
	by: Based on observati review the facility fa assistance for 2 of reviewed for activiti were unable to perf assistance.	on, interview and document liled to provide timely toileting 5 residents (R187, R9) es of daily living (ADL) who form ADL's and needed staff		Corrected		
	5/11/19, indicated F and required extens which included toile Assessment dated required assistance R187's Elimination identified R187 had directed staff to ass	nimum Data Set dated R187 was cognitively intact sive staff assist with ADL at use. R187's ADL Care Area 8/14/18, indicated R187 with ADL due to weakness. Care Plan edited 5/17/19, some bowel control and sist with use of the bedpan for BM) when requested.				
		dated 6/6/19, indicated R187 ch included absence of left leg				

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 22 of 58

PRINTED: 07/16/2019 FORM APPROVED

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
ANDILAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		00164	B. WING		06/0	6/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUS	TANA HEALTH CARE	CENTER OF MIN	T 14TH STR OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 840	above the knee and R187 was interview stated he had to "sub help me" earlier this had requested to be was still dark outside person forgot me, I yelling and screamindicated he had province for help off of staff would answer room and turn his consistance to get or identified he was lead hour" and had falle so long. R187 state this had happened nursing staff, howe just short of help." Nursing Assistant (6/3/19, at 12:04 p.m was "short today" doday with a ratio or versus 1:9 when 4 verified R187 had to the needs of other arrived to his room R187 in bed seated on his buttocks. NA when R187 was as further stated the one tillizing the bed parextra wipes" due to buttocks. NA-D stateft at 6:30 a.m	d peripheral vascular disease. Yed on 6/3/19, at 8:47 a.m. and cream and yell nobody would so morning. R187 explained here put onto the bed pan while it de and later found out "the waited a long time I was ing still on the bed pan." R187 ressed his call light multiple of the bedpan and when the his light they would leave his call light off without providing off of the bedpan. R187 reference of the bedpan "over one of the bedpan "over one of the bedpan "over one of the bedpan over one of the bedpan over the would be told "we are over he wou	2 840			

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 23 of 58

	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
	00164	B. WING			C 06/2019
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HEALTH CARE CEN	TER OF MIN 1007 EAS	DRESS, CITY, S T 14TH STRI OLIS, MN 59			
PREFIX (EACH DEFICIENCY MUST	ENT OF DEFICIENCIES IT BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
overnight shift with his to 4:45 a.m. to 5:15 a.m The Registered Nurse (I 6/6/19, at 8:15 a.m. and made aware that R187 I bedpan on 6/3/19, and v happened. RN-F explair staff to communicate be resident was using the bound of the director of nursing v 6/6/19, at 11:40 a.m. an expectation for residents communicated during sland A facility policy regarding resident was requested. R9's quarterly Minimum 3/2/19, identified R9 had not reject cares during the MDS indicated R9 had to toileting. R9's Urinary Incontinent dated 6/10/18, indicated bladder and needed total needs. R9's Elimination Care Pidentified R9 was incontined after meals, at bedt to check and change wit cares, night rounds and	RN)-F was interviewed on I stated she had been had been left on the was looking into what had ned it was her expectation etween shifts when a bedpan. was interviewed on a stated it was her stoileting needs to be hift to shift report. g ADL for a dependent but not provided. Data Set (MDS) dated do intact cognition and did the reference period. The total dependence for the companient of all assist with toileting. Plan edited 3/7/19, tinent of bladder and inal upon arising, before time and night rounds and	2 840			

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 24 of 58

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE	SURVEY PLETED		
		A. BUILDING:			C		
		00164		B. WING)6/2019
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MIN		T 14TH STR OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 840	stated the overnigh so they leave him in "that's how I got thin evening hour when would say "we are stresulted in having the multiple times. On 6/5/19, at 6:21 and observation from 6 R9's cares were observed lying in both mattress sleeping at 8:09 a.m. R9 us time his appointme (RN)-F notified R9 however R9 was not or check and changassistant (NA) enter breakfast and left Furinal use and/or of during this time. At were observed to reconfirmed R9's incoming the stated per their NA checked and changaneeded. NA-A stated before breakfast the then at around 1:0 RN-F was interview stated R9 was to be 2 hours and as need the confirmed R9 was to be 2 hours and as need the confirmed R9 was to be 2 hours and as need the confirmed R9 was to be 2 hours and as need the confirmed R9 was to be 2 hours and as need the confirmed R9 was to be 2 hours and as need the confirmed R9 was to be 2 hours and as need the confirmed R9 was to be 2 hours and as need the confirmed R9 was to be 2 hours and as need the confirmed R9 was to be 2 hours and as need the confirmed R9 was to be 2 hours and as need the confirmed R9 was to be 2 hours and as need the confirmed R9 was to be 2 hours and as need the confirmed R9 was to be 2 hours and as need the confirmed R9 was to be 2 hours and as need the confirmed R9 was to be 2 hours and as need the confirmed R9 was to be 2 hours and as need the confirmed R9 was to be 2 hours and as need R9 was to be 2 hours and as need R9 was to be 2 hours and as need R9 was to be 2 hours and as need R9 was to be 2 hours and as need R9 was to be 2 hours and as need R9 was to be 2 hours and as need R9 was to be 2 hours and as need R9 was to be 2 hours and 3 hours a	at shift never has enough his wet "diaper" all nows sore." R9 stated duryou ask for help ever short, we are short" wo wait to be changed on a.m. during a continuous a.m. during a continuous a.m. during a continuous a.m. through 9:00 a.m. through 9:00 aserved. At 6:21 a.m. feed on his back on top and his head of bed eled the call light to ask not was today; register of his appointment time of offered to use of urige. At 8:20 a.m. nursing ared room to assist R9 as and seed and change were as and change were as and seed on 6/6/19, at 8:43 aroup sheet R9 was toged every 2 hours and and R9 was typically to en at around 11:00 a.m. wed on 6/6/19, at 8:48 around and change and around and change as a sing was interviewed on as a sing was interviewed and a sing was interviewed as a sing was interv	ight ing the ybody hich or helped ous a.m. R9 was of an air evated. what ed nurse he, nal and/ng with No e offered NA-C B with a.m. and to be as leted m. and a.m. and ed every on	2 840			
		n. and stated it was he t residents per their ca					

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 25 of 58

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED	
744012744			A. BUILDING:			
		00164	B. WING		06/0)6/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MIN	T 14TH STR OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 840	Continued From pa	ge 25	2 840			
	resident was reque SUGGESTED MET The director of nurs review and revise p to ensuring incontir individual resident designee could devand develop a monare providing care a of care.	arding ADL for a dependent sted but not provided. THOD OF CORRECTION: sing (DON) or designee could policies and procedures related before care is provided for each. The director of nursing or relop a system to educate staff itoring system to ensure staff as directed by the written plan.				
2 900	, , ,	5 Subp. 3 Rehab - Pressure	2 900			7/16/19
	comprehensive res of nursing services development of a n provides that: A. a resident wh without pressure s pressure sores unle condition demonstr authenticates, that B. a resident w receives necessar promote healing, pi	sores. Based on the ident assessment, the director must coordinate the ursing care plan which o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and tho has pressure sores by treatment and services to revent infection, and prevent				
	new sores from dev	veloping.				

Minnesota Department of Health STATE FORM

PRINTED: 07/16/2019 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		.	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMP	SURVEY LETED	
	00164			B. WING		06/0	6/2019
AUGUSTANA HEALTH CARE CENTER OF MIN			7 EAST	RESS, CITY, S 14TH STR DLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	This MN Requirement by: Based on observation review, the facility frimplement intervent facility acquired sacresident (R9) review. Findings include: R9 was interviewed stated he had a sorthe overnight shift hey leave him in himow I got this sore. hour when you ask "we are short, we a having to wait to be times. On 6/5/19, at 6:21 a observation from 6: R9's cares were ob observed to be lying air mattress sleeping elevated. At 8:09 a what time his appointerviewed at 8:11 to his pressure ulce he wondered why. I dressing was to be nursing assistant (Nobserved completing to have two draw ship, incontinent pass back and bottom ar were supposed to the On 6/5/19, at 9:19 at 19.50 and 19.50 are sing was to be nursing assistant (Nobserved completing to have two draw ship, incontinent pass back and bottom ar were supposed to the On 6/5/19, at 9:19 at 19.50 are single was to be nursing assistant (Nobserved completing to have two draw ship, incontinent pass back and bottom ar were supposed to the On 6/5/19, at 9:19 at 19.50 are single was to be nursing assistant (Nobserved completing to have two draw ship, incontinent pass back and bottom ar were supposed to the On 6/5/19, at 9:19 at 19.50 are single was the passion of the passi	ge 26 ent is not met as evidence on, interview and docume ailed to develop and tions to promote healing of the crum pressure ulcer for 1 wed for pressure ulcer. I on 6/4/19, at 12:30 p.m. e on his bottom. R9 explainave not had enough helps wet "diaper" all night "the 'R9 stated during the everybody would be short" which resulted in changed or helped multiple a.m. during a continuous 21 a.m. through 9:00 a.m. served. At 6:21 a.m. R9 was a.m. and stated his dress or had not been changed are h	and ained o so nat's ening say naple o ask as sing and m. erved ght werns	2 900	Corrected		

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 27 of 58

PRINTED: 07/16/2019 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING	A. BUILDING:			
		00164	B. WING			C 06/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MIN	ST 14TH STR POLIS, MN 5			
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORREC	TION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	COMPLETE DATE
2 900	Continued From pa	ige 27	2 900			
2 900	confirmed R9's drewound was dated 6 sacrum wound which in length by 1.4 cm (dead tissue) in the 0.4 cm. RN-C state noted when the drestated there was mon the dressing that RN-C was interview and verified the wood stated th	ssing that covered his sacrum 5/3/19. RN-C measured R9's ch was 1.8 centimeters (CM) width and noted 100% slough wound bed and visual depthed there was a mild malodor essing was removed. RN-C oderate serous exudate noted that was removed. Wed on 6/5/19, at 9:38 a.m. und was slightly larger than				
	last week's measur 1.3 cm and only har and now had mode watery fluid and purshe would consider contact the provide explained R9's dresdue to the Santyl (nplaced in the wound nurse on 6/4/19, did per orders and doc "nurse got too busy expectation if the nurse shift would have change. RN-C veriff one incontinent pace bottom area. RN-C not have had extra only have had one incontinent pad but R9's skin observation had a pressure ulce nurse first assessm was unable to find val/29/19, through 5/4 RN-E was interview	rements which were 1.5 cm by d small amount of drainage trate with seropurulent (mix of s) drainage and odor which a decline and planned to r for new orders. RN-C ssing was to be changed daily nedication) that was to be d bed daily. RN-C verified the d not change R9's dressing umented not completed the r." RN-C stated it was her urse was too busy that the ve completed the dressing fied R9 had two draw sheets, d and two towels behind R9's indicated R9's air bed should draw sheet and one no towels. RN-C confirmed on dated 4/29/19, indicated Rer. RN-C stated the wound nent the wound on 5/7/19, and wound care orders from 6/19, in R9's medical record.	9			

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 28 of 58

AND DIAN OF CORRECTION . IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
00164		B. WING			C 06/2019		
AUGUSTANA HEALTH CARE CENTER OF MIN			007 EAS	DRESS, CITY, S T 14TH STR OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
	notified a resident hwere to see them wexplained she updated and obtained treatm of the wound. R9's quarterly Minimal	N-E stated once they ward a new open area the rithin 24 hours. RN-E ted R9's physician on 5 hent orders after assess and total dependence for equired extensive assist and had a pressure red and bed. The Care Area Assessment a	ated addid d. The stance s at risk ducing at and 30 tress, and air osition eelchair from sated cyx ment,	2 900			

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 29 of 58

PRINTED: 07/16/2019 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED	
7 I VID I LY II V	OF CONTROL OF THE CON	BENTH IOM HOWBER.	A. BUILDING:			
	00164		B. WING		06/0)6/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	TANA HEALTH CARE	CENTER OF MIN	T 14TH STR OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 900	evidence of wound - The TAR dated 5/ indicated wound cainjury which start data 5/8/19. A subseque lower right side of showever indicated workload" on 5/15/-The TAR dated 6/ wound care lower rindicated "not comp 6/4/19. The director of nurs 6/6/19, at 11:38 and expectation for the wound to utilize the implement a treatmenthe wound nurse so assessed that day stated it was her expectation for the wound ressing changes pure the electronic medicated a new wo appropriate treatmenthe electronic medicated to docum measurements in the and to complete a cassessment. SUGGESTED MET The director of nurs all residents at risk they are receiving the treatment/services from developing an pressure ulcers. The substantial residents at risk they are receiving the treatment/services from developing an pressure ulcers.	care treatments; (1/19, through 5/31/19, are to right buttock pressure ate 5/6/19, discontinue date ent order included wound care sacrum start date 5/7/19, "not completed due to 19; 1/19, through 6/5/19, indicated ight side of sacrum, however oleted due to workload" on sing (DON) was interviewed on an and stated it was her nurse who first finds the estanding house orders and nent then they should update of the wound can be thoroughly or the next. The DON further expectation to complete over orders. Skin Integrity dated 8/6/18, and should have had ent wound care initiated into cal record. The policy further ent the skin alteration and the electronic medical record comprehensive skin risk THOD OF CORRECTION: sing or designee, could review for pressure ulcers to assure	2 900			

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 30 of 58

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY DMPLETED	
		00164	B. WING		06/0)6/ 2019
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	1 0000	
AUGUST	AUGUSTANA HEALTH CARE CENTER OF MIN 1007 EA MINNEA					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 30	2 900			
		ensure appropriate care and nented; to reduce the risk for elopment.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21015	MN Rule 4658.0610 Requirements- Sar) Subp. 7 Dietary Staff nitary conditi	21015			7/16/19
	procedures and cor	conditions. Sanitary nditions must be maintained in dietary department at all				
	by: Based on observati review, the facility fa foods in the walk in and on trays in the l residents residing ir	ent is not met as evidenced on, interview and document ailed to disposed expired freezer, cooler, refrigerator, kitchen about to be served to a the facility. This had the 09 of 217 residents eating out		Corrected		
	Finding includes:					
	a.m. Dietary Assistate refrigerator turkey stagar, dated 5/21, a mot dated, and pork DA stated the foods thrown out after seven the refrigerator that thrown out seven dain the walk in freeze	kitchen on 6/3/19, at 7:22 ant (DA) verified in the slices in a container with lid mayonnaise container opened base opened and not dated. It is should all be dated and ven days. DA verified a sign or indicated foods should be ays after opening. DA verified ar three containers of mint ice ers not secured with dates				

Minnesota Department of Health

AND DI AN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		` '	E CONSTRUCTION		E SURVEY PLETED		
00164		B. WING			C 06/2019		
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ALIGUET	AUGUSTANA HEALTH CARE CENTER OF MIN 1007 EAS						
MINNEAF			MINNEAP	OLIS, MN 5	5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21015	Continued From pa	ge 31		21015			
	stated she was goir DA verified a bag of undated. DA tossed into the garbage and dated to know how verified in the walk and five juices with been placed in the stated shakes were on the 14th day after verified in the coole cups with the outsic "KEEP FROZEN". It cups were placed in the stated in the coole cups with the outsic "KEEP FROZEN".	/15/19, and 4/10/19. Ing to dispose of the ice of french toast, opened the bag of the french distated it should have long it had been open in cooler four mighty out a label indicating cooler from the freeze to be labeled and dister placing in the cooler a box of 28 tomato die of the box label incool on the cooler 4/26/19, are disposed as were or awing.	ce cream. d and h toast ve been ned. DA shakes when had er. DA sposed of er. DA juice licating juice and				
	slices were good fo	a.m. cook stated the t r seven days after op not know how long thafter opened.	ened.				
	up trays with food for trays that had six ju on them unlabeled cooler. Dietary aide the trays and labele	a.m dietary aide was or the residents and vices and three mighty and not dated when particled the drinks. Dietary es off the trays and the	verified y shakes placed in made up aide took				
	slices were good fo good for two to thre toast when dated w ice cream when the good up to 12 mont ask the manufactur	a.m. dietitian stated to r seven days, mayon e months after openeras as good up to 12 mo covers were on tight ths. Dietitian stated sl er about the pork bas mighty shakes and to	naise ed, french nths, and t were ne would se.				

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 32 of 58

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COMPLETED	
	00164		B. WING		06/0	C 0 6/2019
NAME OF I			l .	27ATE 7/D 00DE	1 00/0	70/2013
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MIN	T 14TH STR OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21015	Continued From pa	ge 32	21015			
	•	14 days after thawing and				
	Facility policy was r	equested, not made available.				
	The director of dieta development and in procedures to ensu implemented. The designee could the appropriate staff for procedures.	THOD OF CORRECTION: ary services or designee could implement policies and ire proper food storage is director of dietary services or in educate and monitor the ir adherence to the policies and CORRECTION: Twenty-one				
21390	MN Rule 4658.0800	O Subp. 4 A-I Infection Control	21390			7/16/19
	control program mu procedures which particles and a surveillance collection to identify residents; B. a system for control of outbreaks. C. isolation and reduce risk of trans. D. in-service exprevention and con E. a resident he immunization programmed in part 465 procedures of resident the prevention and F. the developmemployee health possible collection.	and procedures. The infection ast include policies and provide for the following: based on systematic data a nosocomial infections in a detection, investigation, and so of infectious diseases; disprecautions systems to mission of infectious agents; ducation in infection trol; ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		A. BUILDING:					
		00164		B. WING		06/0	6/2019
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUSTANA HEALTH CARE CENTER OF MIN				T 14TH STR OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCI Y MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	H. a system for products which affed disinfectants, antistic incontinence products. In methods for current standards of the s	8.0815; r reviewing antibiotic r review and evalua- ect infection control, eptics, gloves, and cts; and maintaining awaren of practice in infection ent is not met as evaluated failed to implement points of 2 residents (R91,	ess of on control. videnced ocument procedures er between R23) cal nurse ometer to plood sugar a removed r and to 5:21 p.m. ani-hands see the or conduct to person to the wipes with poped in the le PDI use.	21390	Corrected		
		6/4/19, at 5:39 p.m.	that				

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 34 of 58

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7.1. 20.25.1.10	·		
		00164	B. WING		06/0	6/2019
	PROVIDER OR SUPPLIER	CENTER OF MIN 1007 EA	ODRESS, CITY, ST 14TH STR POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	the glucometer between those were not the sanitizing wipes should be sanitized with sanitized wi	ween residents. ADON verified correct wipes and identified buld have been used. lean-disinfect glucometer icated the glucometer was to				
21525	Consultation A nursing home many services of a pharm Board of Pharmacy A. provides corprovision of pharmathome; B. establishes and disposition of a detail to enable and C. determines accurately maintain controlled drugs is a service.	nsultation on all aspects of the acy services in the nursing a system of records of receipt all controlled drugs in sufficient accurate reconciliation; and that drug records are led and that an account of all				7/16/19
		on, interview and document		Corrected		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00164	B. WING			C 06/2019
	PROVIDER OR SUPPLIER	CENTER OF MIN 1007 EA	DDRESS, CITY, S ST 14TH STRE POLIS, MN 55	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21525	review the facility farkinson medical prescribed by the p (R89) reviewed who medication administialled to ensure memeet the needs of 2 reviewed for medical. Findings include: R89's quarterly Minicentified R89 had in which included Park R89 was interviewed stated he had not be timely per his neurol late administration in spasms. R89's Physician Or through 6/6/19, included administered at 6:03:00 p.m., 6:00 p.m. disease. R89's medication a was reviewed 3/1/1 revealed the following -3/1/19, through 3/3 not receive his Sine "resident unavailablate due to "helping administered late due to "helping administered l	ailed to ensure Sinemet cion) was administered as hysician for 1 of 1 resident to had complaints of untimely stration. In addition, the facility dications were dispensed to 2 of 2 residents (R133, R81) ation administration. imum Data Set dated 4/13/19, ntact cognition and diagnosis kinson disease. ad on 6/3/19, at 7:55 a.m. and een receiving his Sinemet ologist orders. R89 stated the resulted in neck and shoulder der Report dated 5/6/19, uded Sinemet to be 0 a.m., 9:00 a.m., 12:00 p.m., a. and 8:00 p.m. for Parkinson dministration record (MAR) 9, through 6/5/19, and ng: B1/19, MAR indicated R89 did emet five times due to le," four times administered with cares," 18 times ue to "charted late" and one in was not administered due to				

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 36 of 58

Minnesota Department of Health

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	` ′	E CONSTRUCTION		SURVEY PLETED
74401 674	TO CONTRACTION	IDENTIFICATION NONDER.	A. BUILDING:			
		00164	B. WING		I	C 06/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUS	TANA HEALTH CARE	CENTER OF MIN	T 14TH STR			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21525	"helping with cares late," 11 times adm late" and twice the administered due to -5/1/19, through 5/3 not receive his Sine unavailable," admir "helping with cares times administered -6/1/19, through 6/3 administered late of the trained medical interviewed on 6/4/ when a medication hour after the sche prompt her to indicadministered late. Was "short" staffed opposed to 4 NA's facility for the TMA TMA-A stated this when administering medications to be a verified in R89's Mowith cares" was time and she needed to R89's Sinemet was beyond the scheduled admithed the time frame the scheduled admithed the the scheduled admithed the scheduled ad	"," nine times "administered inistered late due to "charted medication was not o "drug/ item unavailable;" 31/19, MAR indicated R89 did emet once due to "resident nistered late once due to," twice "administered late," 10 late due to "charted late;" 5/19, MAR indicated R89 ince due to "charted late." ation aide (TMA)-A was 19, at 6:08 p.m. and explained was administered beyond one duled time the MAR would ate a reason it was TMA-A indicated when the unit with 3 nursing assistants (NA) it was the expectation of the to assist with resident cares. Would cause her to run behind a medications causing administered late. TMA-A AR when documented "helping tes the unit only had 3 NAs help with resident cares so a administered over an hour	21525			

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 37 of 58

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00164	B. WING			C 06/2019
	PROVIDER OR SUPPLIER	CENTER OF MIN 1007 EA	DDRESS, CITY, S ST 14TH STRI POLIS, MN 5	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
21525	RN-F further explaindicated the TMA sadministrations to a light, causing the Tliverified when a med beyond one hour of considered administration for med according to the sold deviation would be according to the sold deviation would be the facility pharmatelephone on 6/6/18 Sinemet should be minutes of schedule Parkinson symptom. The facility Medicat revised ate 5/2019, be administered to primary care provide be administered on scheduled administindicated medication documented promp. R133 On 6/5/19, at 10:42 administration pass following medication citalopram (antidep (anticoagulant), me pressure), and multiple properties of the surface of the	ned helping with cares stopped with medications assist a resident with their call MA to get behind. RN-F dication was administered the scheduled time it was stered late. Sing was interviewed on an and stated it was her diations to be administered heduled time and any noted on the MAR. Cist was interviewed via 2, at 2:07 p.m. and stated administered within 15 and administration time to avoid the second second that medications would residents as prescribed by the er and that medications would be hour before or after ration time. The policy further nadministration is to be only after administration. a.m. during a medication observation for R133; the newere administered: aspirin ressant), eliquis toprolol (treats high blood				
	through 6/5/19, incl					

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 38 of 58

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
1		00164	B. WING		06/0	6/2019
	PROVIDER OR SUPPLIER	STREET AD CENTER OF MIN	DRESS, CITY, S		1 06/0	00/2019
(X4) ID PREFIX	SUMMARY STA	MINNEAP TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	OLIS, MN 5	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
21525			21525			
	aspirin, metoprolol, multivitamin and eliquis. The report indicated citalopram was to be administered daily at 7:30 a.m					
	administration pass following medication diltiazem (treats high (treats allergies), flufurosemide (diuretic (treats acid reflux), spironolactone (diu acetaminophen (and R81's Physician Or through 6/5/19, incl medications to be a	der Report dated 6/1/19, uded the following administered at 8:00 a.m. fluoxetine, Flonase,				
	furosemide, spirono TMA-B was intervie and verified R133 a administered late a administered no lat to one nurse not co administered medic TMA-B reviewed th verified five addition outlined in red which had not been administered late. RN-F was interview confirmed medicatione hour before an the scheduled administered administered late.	ewed on 6/5/19, at 10:54 a.m. and R81's medications were nd should have been er than 9:00 a.m. however due oming in TMA-B was pulled to cations so she got a late start. e work list for the unit and nal resident's names were the indicated their medications nistered and would be seed on 6/6/19, at 8:18 a.m. and ons should be administered d no later than one hour after				

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 39 of 58

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMP			
		00164	B. WING			C 06/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE	·	
AUGUST	ANA HEALTH CARE	CENTER OF MIN	AST 14TH STR APOLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21525	6/6/19, at 11:40 a.m expectation for med according to the solution of the solution of the solution according to the solution of the solution o	n. and stated it was her dications to be administered heduled time. cist was interviewed via 2, at 2:07 p.m. and stated it in for medications to be one hour before or after the one hour before or after the ion Administration policy indicated medications would residents as prescribed by the rand that medications would resident to time. THOD FOR CORRECTION: lirector of nursing or designed may be made to timely medication quality assessment and see could perform random	d ne Ild			
	TIME PERIOD FOR days.	R CORRECTION: Twenty (2	21)			
21830	MN St. Statute 144 Residents of HC Fa	.651 Subd. 10 Patients & ac.Bill of Rights	21830			7/16/19
	Subd. 10. Particip notification of family	pation in planning treatment; y members.				
	in the planning of the includes the opportunities with includes the opportunities with include the control of t	Il have the right to participate neir health care. This right unity to discuss treatment ar lividual caregivers, the est and participate in formal				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.		,	,
		00164	B. WING		06/0	6/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUS ¹	TANA HEALTH CARE	CENTER OF MIN	T 14TH STR			
	T	MINNEAP	OLIS, MN 5	5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21830	Continued From pa	ge 40	21830			
21830	care conferences, a family member or oboth. In the event the present, a family member or conferences. (b) If a resident with unconscious or concommunicate, the freshorts as required either a family member to planning by the reside an emergency that admitted to the facifamily member to planning, unless the to believe the reside directive to the consectified in writing member included in notifying a family member to planning, the facility efforts, consistent with practice, to determine executed an advances of the consection of th	and the right to include a other chosen representative or that the resident cannot be ember or other representative lent may be included in such who enters a facility is natose or is unable to facility shall make reasonable under paragraph (c) to notify other or a person designated in the resident has been lity. The facility shall allow the articipate in treatment the facility knows or has reason ent has an effective advance trary or knows the resident has that they do not want a family in treatment planning. After ember but prior to allowing a articipate in treatment or must make reasonable with reasonable medical ne if the resident has ce directive relative to the re decisions. For purposes of asonable efforts" include: the personal effects of the resident has a the resident has a the resident normally goes for the physician to whom the	21630			

6899

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY
7.1.12 . 2.1.1	0. 00.11.20.10.1		A. BUILDING:	·		
		00164	B. WING		06/0)6/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MIN	ST 14TH STR POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21830	whether the resider directive. If a facilit designated emerge member to participe accordance with the liable to resident for the notification of the emergency contact family member was patient's privacy rig (c) In making reafamily member or a designative of the facility shall attended the facility shall attended to the facility and the facility has been member or designated emerges service agency or lethat assists a facility subdivision is not list damages on the grather family member	oes for care, if known, at has executed an advance by notifies a family member or ency contact or allows a family ate in treatment planning in a paragraph, the facility is not a damages on the grounds that he family member or or the participation of the simproper or violated the hts. asonable efforts to notify a lesignated emergency contact, ampt to identify family gnated emergency contact by onal effects of the resident cords of the resident in the acility. If the facility is unable ember or designated within 24 hours after the lity shall notify the county cy or local law enforcement ident has been admitted and a unable to notify a family ated emergency contact. The reagency and local law enforcement agency of a family member or ency contact. A county social local law enforcement agency y in implementing this able to the resident for ounds that the notification of or emergency contact or the family member was improper				

6899

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N		` ′	LE CONSTRUCTION	(X3) DATE COMP	SURVEY
				A. BOILDING.			
		00164		B. WING			6/2019
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MIN		T 14TH STR OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCE MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21830	Continued From parthis MN Requirements: Based on observation review, the facility for bathing preferences of bathing for 2 of 7 who were reviewed. Findings include: R104 stated on 6/3 by staff he would graince his admission showers. R104 state often he would like did not like to take a because he could refurther stated the far what his bathing preadmission and he would but was a little having showers. R104's admission of a skin check with now R104's admission of dated 4/10/19, indicting improvement with a little and participated in his care plan. R104's care plan dath impaired self prelated to weakness asthma. The care president to participaregarding bathing pregarding bathing pregarding bathing president in the care president to participaregarding bathing president in the care president in the care president in the care president to participaregarding bathing president in the care president	ent is not met as ever ion, interview and deailed to determine resorre provide documer residents (R104 ar for choices. In at 10:19 a.m. het one shower a went he had only received he told direct cate to take more than conshowers in the ever not sleep afterwards acility staff had not a deferences were upon the smelly and dirty designed at the was 4/3/19, who areas of concernicate area assessment at the was 4/3/19, who areas of concernicate area assessment at the was 4/3/19, indicated 4/15/19, indicated 4/15/19, indicated 4/15/19, indicated 4/15/19, indicated as able but no indicate as able as a ble a	e was told ek and ed two re staff one and he ning s. R104 asked him on the best he ue to not en he had noted. ent (CAA) dent (CAA) d	21830	Corrected		
	R104's progress no	tes were reviewed	from				

6899

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		E SURVEY PLETED
		00164	B. WING		I	C 06/2019
	PROVIDER OR SUPPLIER	CENTER OF MIN 1007 EAS	DRESS, CITY, S T 14TH STRI OLIS, MN 59			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21830	4/3/19, to 6/5/19, will documented bathin refused a shower. To f R104 being reap shower in subseque R104's electronic material treatment administr 2019, review on 6/5 R104 lacked docum preferences or bathor R104 was observed p.m. with his hair st wearing the same of small stains on their Nursing assistant (It p.m. she would charefusals and would if there was a refus not aware R104 preor had missed som RN-G stated on 6/6 assessed for choice however his bathing RN-G also stated the bathing preferences record (EMR) and sed documented weekly a resident refused a approached shortly should be given as refusal or the next of the state of the	greference which indicated he There was no documentation proached or receiving another ent progress notes. nedical record (EMR) and ration record (TAR) for May, 5/19, at 1:40 p.m. revealed nentation of bathing ling having been completed. d in his room on 6/5/19, at 3:49 ringy appearing and was clothes as the day before with m. NA)-F stated on 6/5/19, at 3:32 rt all resident's showers and tell the registered nurse (RN) al. NA-F also stated she was before decreased showers during the day e. 1/19, at 8:29 a.m. R104 was es when he was admitted greferences were missed. The electronic medical showers and refusals were not as they should have been. If a shower they should be after and the shower and one soon as possible after the	21830			
	direct care staff for would not get them	two showers a week but regularly and sometimes one a week. R174 stated it				

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 44 of 58

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00164	B. WING			C 06/2019
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
AUGUST	TANA HEALTH CARE	CENTER OF MIN	ST 14TH STR			
(VA) ID	CHMMADV CTA	TEMENT OF DEFICIENCIES	POLIS, MN 5	PROVIDER'S PLAN OF C	CORRECTION	(VF)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21830	Continued From pa	ge 44	21830			
		room sometimes and when he wer or bath he felt sticky and				
	assistant (NA) cam would not get a sho his bath day. R174 out today and he fe	/19, at 6:37 p.m. the nursing e by his room and told him he wer tonight because it was not further stated it had been hot It sweaty and sticky and was uld not get a shower tonight.				
	p.m. revealed R174	AR review on 6/5/19, at 1:30 had one documented bath in one in May on 5/26/19, and hing preferences.				
	had impaired self poto multiple fractures limitations. The care total assist with one	ated 11/20/18, indicated R174 erformance with bathing due is and range of motion (ROM) e plan included approaches of to two persons as needed to ing task but did not include is.	f			
	approached the sta why his shower day that the NA came b for saying this was him a shower. R174 asked about his bat	1/19, at 3:55 p.m. his wife ff last night to inquire as to was changed. Shortly after ack to the room, apologized not his shower day and gave 4 also stated he would not be thing preferences at care a had not been asked how would like showers.				
	not assessed for ba admission and it wa she was not aware	1/19, at 8:29 a.m. R174 was athing preferences upon as missed. RN-G also stated he had missed showers but as missing documentation of reekly.				

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED		
		00164		B. WING		06/0) 6/2019
NAME OF I				ODECC CITY O	STATE ZID CODE	1 00/0	0/2013
	PROVIDER OR SUPPLIER	100		JRESS, CITY, S T 14TH STR I	STATE, ZIP CODE FFT		
AUGUST	ANA HEALTH CARE	CENTER OF MIN		OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION))	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21830	Continued From pa	ge 45		21830			
	her expectation wou bathing choices for within 48 hours and the patient was sati schedule. Bathing p	sing (DON) stated on 6/6/uld be for staff to review all newly admitted reside regularly after that to ensisted with their bathing preferences should also be conferences and the care any changes.	nts sure				
	dated 12/5/18, incluinterviewed at the titheir bathing prefere	ng: Shower or Tub Bath p ided: Each resident will be me of admission to identi ences regarding tub, bath and/or day of the week a	e fy or				
	Social Service and/ develop /revise poli educate all facility s DON and/or design interviews to ensure	THOD OF CORRECTION or their designee could cies for resident choices taff on those policies. The ee could conduct resident resident choices are beithen audit to ensure	and e t				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty	-one				
21995	MN St. Statute 626. Maltreatment of Vul	.557 Subd. 4a Reporting - Inerable Adults	-	21995			7/16/19
	(a) Each facility sha ongoing written pro applicable licensing of suspected maltre	I reporting of maltreatmer all establish and enforce a ocedure in compliance wit rules to ensure that all ca eatment are reported. If a nal reporting procedure, a	an th ases a				

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 46 of 58

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED		
		00164		B. WING		06/0	6/2019
	PROVIDER OR SUPPLIER	CENTER OF MIN	1007 EAS	T 14TH STR		·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21995	mandated reporter requirements of this internally. However responsible for comreporting requirements of this internally. However responsible for comreporting requirements of the security for the security for the security for the security of the security	may meet the report is section by reporting, the facility remains applying with the immerate of this section. The facility remains applying with the immerate of this section. The facility remains applying with the immerate as evicents of this section. The facility remains applying to the section and the section and the section applying the facility of the section applying the facility of the section applying the section ap	ediate denced cument SA) an R368) of 4 MDS) ted to the was intact. nificant s not indicated nd was dicated th him, tive cort nad asked ssed." er (Family Other-A d arguing ns with er mother	21995	Corrected		

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 47 of 58

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
			D WING			
		00164	B. WING		06/0	6/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MIN	T 14TH STR			
		MINNEAP	OLIS, MN 5	5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
21995	Continued From page 47		21995			
	that she did not war as he verbally abus dumped her mother while out at the parl On 6/6/19, at 1:41 p she had heard Other	a couple of weeks ago in May nt Other-A visiting her mother es her mother and had rout of her wheelchair (w/c) k. o.m. RN-A stated one night er-A arguing loudly with R368 was too loud and to lower his				
	and nad told nim he was too loud and to lower his voice. RN-A stated Other-A had been a little bit aggressive and too loud in responding to her and not appropriate. RN-A stated she had told Other-A if this continued he would not be able to visit R368. RN-A stated this had happened in May. RN-A stated this was not the first occurrence of Other-A arguing loudly and stated it happened a couple of nights before that incident with another nurse. RN-A stated she remembered FM-A telling her in May that Other-A verbally abuses her mother and that she did not want him visiting her mother. RN-A stated the supervisors and security were both present at the time. RN-A stated she had not notified the Director of Nursing (DON) or the Administrator of FM-A's allegation as the supervisors and security had also been present when FM-A had told her this. RN-A stated she had documented about this					
	not told her about Cout of the w/c, but the pushes her mother tipped her mother's her. RN-A stated shaprogress notes abound her w/c nor had Administrator. R368's progress not indicated that FM-A	notes. RN-A stated FM-A had other-A dumping her mother hat FM-A had told her Other-A too fast in the w/c, and had w/c forward and tried tripping he had not documented in the ut Other-A regarding R368 d she told the DON or the ote dated 5/25/19, by RN-A a "acknowledged that [Other-A] I and verbally abusive to				

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 48 of 58

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00164	B. WING			C 06/2019
	PROVIDER OR SUPPLIER	CENTER OF MIN 1007 EAS	DRESS, CITY, S T 14TH STR OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21995	[R368] and agreed allowed to visit [R36 NOC supervisor an [personnel]." Review of R368's mevidence the allegareported to the SA of the	[Other-A] should not be [68] anymore in front of PM and d security personal medical record lacked tion of verbal abuse was or Administrator. o.m. Licensed Social Worker egations of verbal abuse were e DON and to the ediately, as soon as possible". been notified of the incident of at a morning meeting. He incern was with Other-A with ecurity. LSW-A stated he was incerns between Other-A and ten with R368 on 5/31/19, and	21995			
	R167's cognition wa	DS dated 5/7/19, indicated as intact and R167 needed as istance with transfer.				

Minnesota Department of Health

Minnesota Department of Health

	ita Department of He	ealth T				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						•
		00164	B. WING			6/2019
		1 00104			1 00/0	0/2013
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
ALIGHET	ANA HEALTH CARE	CENTER OF MINI 1007 EA	ST 14TH STR	EET		
AUGUST	ANA HEALTH CARE	MINNEA	POLIS, MN 5	5404		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON NC	(X5)
PRÉFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				22.10.2.10.7		
21995	Continued From pa	ige 49	21995			
	On 6/2/10 at 12:44	n m D167 stated nursing				
		•				
			9			
	did not feel safe with NA-A assisting her alone.					
	_					
	KINGW OF THE INCIDENT	iu.				
	On 6/4/19 at 5:48 r	n m NA-H stated R167 had				
			1			
			•			
	ao good at lotting	can mov.				
	On 6/4/19 at 7:06 r	o.m. DON stated I PN-B had				
	assistant (NA)-G hawas the first time shall the facility. R167 state and would not list to stop transferring R167 stated she had did not feel safe wit R167 stated NA-G proceeded anyway. once asked NA-G to by NA-G, "No, I am to leave your room your room". R167 svulnerable at the tin loudly so help would just stared, looking R167 stated the nut the room and NA-G not have to but ther she did not want NA and that licensed piknew of the inciden On 6/4/19, at 5:48 ptold him NA-G had hoyer lift and NA-G "freaking her out" a stated he had notific told him. NA-H state was good at letting On 6/4/19, at 7:06 ptinterviewed R167 oconsidered the incidendal felt safe. DON 6/7/19, that she had abuse". DON stated	refused to listen to her and . R167 stated she more than to leave her room and was told not your slave, I do not have and I am not going to leave stated she felt helpless and me and started screaming out d come. R167 stated NA-G down at R167, "grinning." rse on duty told NA-G to leave a had told the nurse no she did not left the room. R167 stated A-G working with her again ractical nurse (LPN)-B also at. D.m. NA-H stated R167 had transferred her alone in the had just smiled at her and was really frightened. NA-Hed the nurse what R167 had ed R167 was very alert and	1			

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 50 of 58

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING.		C	
		00164	B. WING			6/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MIN	T 14TH STR OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21995	was an unsafe tran of mistreatment in the Adult) policy dated Inappropriate treatrestated transferring alone without a second on 6/5/19, at 9:01 and the about having is and that she was hear again and had a was visibly upset all allegations of abwere to be reported the allegation of version and had not in the facility's policy 11/21/18, indicated reported immediate Administrator and Smistreatment would within 24 hours to the policy also indicated abuse, protected at mistreatment would suggested to the suggested and	lone with the hoyer lift as this sfer. DON stated the definition the facility VA (Vulnerable 11/21/18, read "Mistreatment: ment" of a resident. DON a resident with a hoyer lift cond staff was not appropriate. a.m. LPN-B stated the wound to her what R167 had said to sues with NA-G's cares for her urting when NA-G was trying in bed alone. LPN-B stated did not want NA-G working with said she was very mad and cout the incident. b.m. the Administrator stated use including verbal abuse including verbal abuse including verbal abuse including verbal abuse including verbal abuse. It immediately to him, either by a person at the office, and ted immediately to the SA. It had not been notified of robal abuse with Other-A to reported it to the SA. Vulnerable Adult dated allegations of abuse would be ally, within two hours to the SA, and allegations of did be reported immediately, the Administrator and SA. The did residents would be free from and all allegations of abuse and did be investigated. THOD OF CORRECTION:	21995			
	procedures regardi	could review policies and ng reporting all allegations of reatment. The administrator				

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 51 of 58

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00164	B. WING		06/0	6/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
AUGUST	ANA HEALTH CARE	CENTER OF MIN	T 14TH STR OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
21995	Continued From pa	ge 51	21995			
	policies and proced develop a monitorir compliance.	ould re-educate all staff on the ures. The administrator could be system to ensure ongoing R CORRECTION: Fourteen				
22000		i.557 Subd. 14 (a)-(c) tment of Vulnerable Adults	22000			7/16/19
	facility, except hom personal care atten establish and enformere prevention plan. The assessment of the environment, and it factors which may early and a statement of to minimize the risk comply with any rule promulgated by the (b) Each facility, agency and person providers, shall dever prevention plan for residing there or reacting there or reacting there or reacting there or reacting the plan shall contains assessment of: (1) abuse by other individual vulnerable adults; (1) other vulnerable adults; (2) other vulnerable adults; (3) other vulnerable adults. For the puriterm "abuse" includes	s population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan licensing agency. Including a home health care all care attendant services elop an individual abuse each vulnerable adult ceiving services from them. In an individualized the person's susceptibility to viduals, including other (2) the person's risk of abusing ults; and (3) statements of the to be taken to minimize the to person and other vulnerable poses of this paragraph, the				

6899

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	<u></u>	COMPLETED	
		00164	B. WING		06/0	6/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MIN	T 14TH STR OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	knows that the vuln violent crime or an toward others, the iplan must detail the minimize the risk threasonably be experimental facility and persons unsupervised. Uncof a vulnerable aduration information from the information from the authority or through another facility, and	attendant services providers, perable adult has committed a act of physical aggression individual abuse prevention are measures to be taken to eat the vulnerable adult might exted to pose to visitors to the coutside the facility, if the ler this section, a facility knows lt's history of criminal sical aggression if it receives om a law enforcement in a medical record prepared by other health care provider, or in grassessments of the	22000			
	by: Based on observatireview, the facility fallegation of verbal (R368) and failed to allegation of mistre (R69) reviewed for Findings include: R368's Admission I dated 5/9/19, indicated facility on 5/9/19, and R368's face sheet in Other (Other)-A had allowed on campus	Minimum Data Set (MDS) ated R368 was admitted to the nd R368's cognition was intact. ndicated R368's Significant d trespassed and was not		Corrected		

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 53 of 58

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION :	(X3) DATE S	
					C	
		00164	B. WING			/2019
NAME OF	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY,	STATE, ZIP CODE		
AUGUST	TANA HEALTH CARE	CENTER OF MIN	EAST 14TH STE			
	TANA TIERETTI GARE	MINI	NEAPOLIS, MN	55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
22000	Continued From page 53		22000			
	asked to quiet down Other-A was intoxic and was verbally ag toward registered n indicated this was thappened with Other Security Officer to he of 6/6/19, at 10:52 Member-A) stated a had come back to the with R368. FM-A stoucher-A that he had and verbally abuses told the night nurse that she did not war as he verbally abuses.	nside R368's room and wan. The report also indicated atted, had alcohol with him agressive and disruptive urse (RN)-A. The report he second time this had er-A and RN-A had asked have Other-A" trespassed. a.m. R368's daughter (Fala couple of days ago Other he facility and started argulated she had concerns with a put his hands on her motes her. FM-A stated she had a couple of weeks ago in the Other-A visiting her mothes her mother and had rout of her wheelchair (w/ok).	d mily r-A ing h her d May her			
	she had heard Othe and had told him he voice. RN-A stated aggressive and too not appropriate. RN Other-A if this contivisit R368. RN-A stated to occurrence of Othe happened a couple with another nurse. remembered FM-A verbally abuses her want him visiting he supervisors and set time. RN-A stated so Director of Nursing	r-A arguing loudly and stat of nights before that incide	and and and are to are			

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 54 of 58

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
ANDILA	OF CONTROLON	IDENTIFICATION NOMBER.	A. BUILDING:			
		00164	B. WING			C 06/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUS	TANA HEALTH CARE	CENTER OF MIN	T 14TH STR OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
22000	had also been pressent this. RN-A stated so in R368's progress not told her about to out of the w/c, but to pushes her mother tipped her mother's her. RN-A stated so progress notes abound her w/c nor had Administrator. R368's progress notes abound her w/c nor had Administrator. R368's progress notes abound her w/c nor had Administrator. R368's progress notes abound her w/c nor had Administrator. R368's progress notes abound her w/c nor had Administrator. R368's progress notes abound her w/c nor had Administrator. R368's progress notes abound her w/c nor had Administrator. R368's progress notes abound her w/c nor had agreed allowed to visit [R30 NOC supervisor and [personnel]." Review of R368's revidence the allegare ported to the SA investigated with R and other residents. On 6/6/19, at 3:13 (LSW)-A stated allegare ported to the administrator "imm LSW stated he had not Tuesday 5/28/19 said the issue of cointerference with sequence of any cor R368 and had spots she had not mention. On 6/6/19, at 3:46 (D) Advisor and the state of any cor R368 and had spots she had not mention.	sent when FM-A had told her he had documented about this notes. RN-A stated FM-A had other-A dumping her mother that FM-A had told her Other-A too fast in the w/c, and had s w/c forward and tried tripping he had not documented in the out Other-A regarding R368 d she told the DON or the ote dated 5/25/19, by RN-A a "acknowledged that [Other-A] and verbally abusive to [Other-A] should not be 68] anymore in front of PM and and security personal medical record lacked ation of verbal abuse was or Administrator; nor was 368, FM-A, staff interviews and security as soon as possible". It been notified of the incident son of the potential of the incident son of the was more nother-A and wen with R368 on 5/31/19, and	22000			

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 55 of 58

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00164	B. WING			C 06/2019
	PROVIDER OR SUPPLIER	STREET <i>A</i>	DDRESS, CITY, STR	STATE, ZIP CODE		
AUGUS	TANA HEALTH CARE	MINNEA	POLIS, MN 5	5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
22000	allegation of verbal the w/c. DON state notified her of the a away and stated sh notified of any disruif she would have be have told the nurse then to interview R3 she would have wa find out if abuse hawitnessed. DON state and had just learne reported to SA. On 6/6/19, at 4:23 pall allegations of abwere to be reported text, telephone or in needed to be reported text, telephone or in needed to be reported the allegation of verballegation of	abuse, nor the incident with ed the supervisor should have illegation of verbal abuse right in would have wanted to be uption on the floor. DON stated to ask Other-A to leave, and 368 and FM-A. DON stated inted questions to be asked to did occurred or had been ated she had not known of this did of it "today" and had not on				
	had diagnoses which	ch included convulsions, and weakness.				

Minnesota Department of Health

STATE FORM 6899 LWJ311 If continuation sheet 56 of 58

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION		SURVEY PLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING	:	COM	-LETED
		00164	B. WING			C 06/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
ALIGUST	ANA HEALTH CARE	CENTER OF MINI	AST 14TH STR	REET		
AUGUSI	ANA HEALTH CARE	MINNE	APOLIS, MN 5	55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
22000	Continued From page 56		22000			
	stated back in Februs assistant (NA)-I who room anymore. R6 defensive, rude and bed during pericare was rough when shape pushed him an explaining what she NA-I had been on horoviding cares lau foreign language. Fon her cell phone to touched his genital stated he felt humil molested. R69 indicases	ed on 6/3/19, at 8:11 a.m. an ruary there was a nursing to was told not to come into 1/9 explained NA-I was d rough while turning him in es. R69 further explained NA ne was rolling him; he stated ad squeezed his hip without e was doing. R69 revealed ner cell phone while she was ghing and speaking in a R69 indicated NA-I remained alking and laughing; as she s providing pericares and liated as if he was being cated he had reported this to er and NA-I had not cared for	nis -I			
	6/3/19, at 12:22 p.r made aware of R69 report had been made aware of R69 report had been made administrator assis nursing (ADON) and 6/4/19, at 7:04 p.m NA-I and NA-J wer alleged allegation or reported to the SA investigation being explained she did rinformation would be the investigation.	RN)-F was interviewed on m. and stated she had been 9's allegations on 5/6/19, and ade to the state agency (SA) sing (DON), administrator, tant, assistant director of nd RN-F were interviewed on . The DON verified only R69 e interviewed regarding the of mistreatment that had bee on 5/6/19, due to the straight forward. The DON not see how any additional have altered the outcome of	,			
	reviewed and inclu	ative file dated 5/6/19, was ded an interview from R69,	ce l			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00164	B. WING		I	C 06/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MIN	T 14TH STR Polis, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
22000	regarding the allege and also lacked evisupervision or monitor of the facility policy V [Minnesota] dated 1 of alleged abuse an promptly and thorou included that the invincement of the facility of any policident and other reperpetrator provider SUGGESTED MET. The administrator of procedures regarding all allegations of ab administrator and of all staff on the policident and or the policident and of the policident and of the policident and of the policident and of the policident and procedure on the policident and procedure of the procedure of th	Int and staff interviews and allegation of mistreatment dence of increased itoring on the unit. Juliarable adult-MN Juliarabl	22000	DEFICIENCY)		

6899