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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LWJ3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00164

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245242**
2.STATE VENDOR OR MEDICAID NO.
(L2) **159540700**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS**
(L4) **1007 EAST 14TH STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/18/2019** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **255** (L18)
13.Total Certified Beds **255** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	255			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

An increase in the number of certified SNF/NF beds from 255 beds to 286 beds, effective August 1, 2019, in accordance with a change in licensure. Due to 31 beds being relicensed (in accordance with Minn. Stat. 144A.071, Subd. 4b., as amended by the Minnesota State Licensure) effective August 1, 2019, all 286 facility beds are certified SNF/NF. After this change they will have zero (0) beds on layaway.

17. SURVEYOR SIGNATURE — Date :
Eva Loch, Unit Supervisor — 08/13/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 08/13/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/23/2019
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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.

Please contact me if you have any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
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

DEPARTMENT OF HEALTH

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
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LWJ3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00164

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(L1) **245242**

2.STATE VENDOR OR MEDICAID NO.
(L2) **159540700**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS**
(L4) **1007 EAST 14TH STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/06/2019** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **250** (L18)
13.Total Certified Beds **250** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	250			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

An increase in the number of certified SNF/NF beds from 255 beds to 286 beds, effective August 1, 2019, in accordance with a change in licensure. Due to 31 beds being relicensed (in accordance with Minn. Stat. 144A.071, Subd. 4b., as amended by the Minnesota State Licensure) effective August 1, 2019, all 286 facility beds are certified SNF/NF. After this change they will have zero (0) beds on layaway.

17. SURVEYOR SIGNATURE Date :
Laura Glenn, HFE NE II 07/16/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 07/22/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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.

- 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
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

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

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
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245242	A. BUILDING _____ B. WING _____	C 06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	**1007 EAST 14TH STREET MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for CMS Emergency Preparedness Requirements was conducted on 6/3/19 through 6/6/19 during a recertification survey. The facility was found IN COMPLIANCE with the CMS Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 6/3/19-6/6/19, a standard survey was completed at your facility by the Minnesota Department of Health. The facility was found NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. Additionally, complaints were investigated on 6/3/19-6/6/19, H5242120C, H5242122C, H5242121C, H5242119C. H5242120C was substantiated with no deficiency issued. H5242122C was substantiated and a deficiency was issued at F609. H5242121C was unsubstantiated with a deficiency issued at F610. H5242119C was substantiated at F725, F755. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to	F 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245242	A. BUILDING _____ B. WING _____	C 06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	**1007 EAST 14TH STREET MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were accessible for 2 of 2 residents (R20, R174) who were capable of using the call light. Findings include: R20's quarterly Minimum Data Set (MDS) dated 3/5/19, indicated R20's cognition was impaired and R20 needed extensive assistance with transfers. On 6/5/19, at 10:07 a.m. R20 was sitting back in her recliner calling out for toast and egg. Surveyor walked into the room and observed R20's call light approximately 20 feet from resident placed in the bottom of a flower vase on a stand next to the bed. R20 was interviewed and stated she did not know where her call light was and was unable to get out of her chair. R20 stated she wanted some juice. On 6/5/19, at 10:14 a.m. nursing assistant (NA)-K	F 558	Augustana Health Care Center of Minneapolis' Plan of correction is a written credible assertion of substantial compliance with the Federal and State requirement of Nursing facilities and/or skilled nursing facilities participating in the Federal Medicare or State Medical Assistance programs. Please note that nothing set forth in this document is to be or should be construed to be an admission by Augustana Health Care Center of Minneapolis, or the validity or accuracy of any of the deficiencies cited by the Minnesota Department of Health relative to the survey, certification, and enforcement effort at issue. Further please note that nay and all documents transmitted or otherwise provided by Augustana Health Care Center of Minneapolis, in relation to the plan of correction, as well as any and all other communications in writing or otherwise by or on the behalf of Augustana Health Care	7/16/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245242	A. BUILDING _____ B. WING _____	C 06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 2 walked into R20's room and verified R20's call light in the vase. NA-K stated she must have forgotten to put the call light on R20's recliner where she could reach it. NA-K stated R20 was able to use her call light, has used her call light and stated call light was supposed to be in the resident reach. NA-K handed the call light to R20 and she pressed the call light button a couple of times and activated it. On 6/5/19, at 11:07 a.m. licensed practical nurse (LPN)-B stated she expected residents' call lights to be within reach for the residents who can 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. R174's care plan dated 11/20/18, included: Impaired self-performance with bathing due to multiple fractures, range of motion limitations. R174's progress note dated 5/29/19, at 1:56 p.m. included R174 was alert and oriented and used call light effectively.	F 558	Center of Minneapolis, at law and/or in equity, all of which are not waived and all of which are reserved and retained by, for and on behalf of Augustana Health Care Center of Minneapolis. F558 It is the policy of the Augustana Health Care Center to provide services with reasonable accommodation of resident needs and preferences including ensuring call lights are accessible for residents capable or using the call light. Corrective Action: Immediate re-education of NAR's who incorrectly place call lights for the 2 identified residents Identification of Other Residents: Facility wide call light placement audit was completed for all beds on 7-2-19 Measures Put In Place: Mandatory education for all Nursing staff was conducted in regards to facility practice in regards to call light placement and response. 7-15-19 Monitoring Mechanisms: Call light audits were conducted on all units at various times to ensure standard of practice for call light placement and response was being followed July 1- 15, 2019 Call lights audits will continue 1 time monthly on all units for the next 90 days QAPI committee will review call light audits for maintaining facility standard for call light placement and response for the next 90 days on or before: 7-31-19	

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	245242	A. BUILDING _____ B. WING _____	C 06/06/2019

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F 558	Continued From page 3 Clinical manager (CM)-A stated on 6/6/19, at 8:29 a.m. her expectation would be for staff to ensure all resident's call lights were in the proper place before leaving the room and R174 was capable of using his call light. The director of nursing stated on 6/6/19, at 10:48 a.m. her expectation would be for call lights to be within reach for all facility residents. The facility's call light policy dated 12/31/18, directed staff to place call light so it would be accessible to the resident at all times when in resident room. Secure the call light to stay within access of the resident.	F 558	8-31-19 9-30-19 Responsible Person/s Administrator Director of Nursing or their designee Assistant Administrator/Quality Improvement Director 7-16-19	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact	F 561		7/16/19

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F 561	Continued From page 4 with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to determine resident bathing preferences or provide documented proof of bathing for 2 of 7 residents (R104 and R174) who were reviewed for choices. Findings include: R104 stated on 6/3/19, at 10:19 a.m. he was told by staff he would get one shower a week and since his admission he had only received two showers. R104 stated he told direct care staff often he would like to take more than one and he did not like to take showers in the evening because he could not sleep afterwards. R104 further stated the facility staff had not asked him what his bathing preferences were upon admission and he would just clean up the best he could but was a little smelly and dirty due to not having showers. R104's admission date was 4/3/19, when he had a skin check with no areas of concern noted. R104's admission care area assessment (CAA) dated 4/10/19, indicated R104 required improvement with activities of daily living (ADL's) and participated in skilled therapy and to refer to his care plan.	F 561	F561 It is the policy of the Augustana Health Care Center to promote resident self-determination in observing resident bathing preferences Corrective Action: Clinical Manager interviewed both identified residents for bathing preferences and documented any needed changes to their bath preferences Identification of Other Residents: Bathing preferences audit was conducted for all residents on or before 6-27-19 Measures Put in Place: Bathing preferences will be included in the baseline care conference with a documented progress note of preferences for all new admits. Bathing preferences will be reviewed with changes noted on the care conference summary form for all scheduled care conferences for all residents. Mandatory education for all nursing staff will be conducted on observing resident's bathing preferences. Monitoring Mechanism: 10% random audits for bathing preferences being documented and	

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F 561	Continued From page 5 R104's care plan dated 4/15/19, indicated R104 had impaired self performance with bathing related to weakness, depression with anxiety, and asthma. The care plan included approaches of extensive assist of one person and encourage resident to participate as able but no information regarding bathing preferences. R104's progress notes were reviewed from 4/3/19, to 6/5/19, with 4/5/19, the only documented bathing reference which indicated he refused a shower. There was no documentation of R104 being reapproached or receiving another shower in subsequent progress notes. R104's electronic medical record (EMR) and treatment administration record (TAR) for May, 2019, review on 6/5/19, at 1:40 p.m. revealed R104 lacked documentation of bathing preferences or bathing having been completed. R104 was observed in his room on 6/5/19, at 3:49 p.m. with his hair stringy appearing and was wearing the same clothes as the day before with small stains on them. Nursing assistant (NA)-F stated on 6/5/19, at 3:32 p.m. she would chart all resident's showers and refusals and would tell the registered nurse (RN) if there was a refusal. NA-F also stated she was not aware R104 preferred showers during the day or had missed some. RN-G stated on 6/6/19, at 8:29 a.m. R104 was assessed for choices when he was admitted however his bathing preferences were missed. RN-G also stated there was no evidence of his bathing preferences in the electronic medical	F 561	observed will be conducted monthly for the next 90 days. Audits will be reviewed by the QAPI committee to ensure bathing preferences are being observed per standard of care for the next 90 days on or before: 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	

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F 561	Continued From page 6	F 561		

record (EMR) and showers and refusals were not documented weekly as they should have been. If a resident refused a shower they should be approached shortly after and the shower and one should be given as soon as possible after the refusal or the next day.

R174 stated on 6/3/19, at 9:42 a.m. he asked direct care staff for two showers a week but would not get them regularly and sometimes would not even get one a week. R174 stated it was real hot in his room sometimes and when he did not get his shower or bath he felt sticky and smelly.

R174 stated on 6/4/19, at 6:37 p.m. the nursing assistant (NA) came by his room and told him he would not get a shower tonight because it was not his bath day. R174 further stated it had been hot out today and he felt sweaty and sticky and was disappointed he would not get a shower tonight.

R174's EMR and TAR review on 6/5/19, at 1:30 p.m. revealed R174 had one documented bath in April on 4/9/19, and one in May on 5/26/19, and no documented bathing preferences.

R174's care plan dated 11/20/18, indicated R174 had impaired self performance with bathing due to multiple fractures and range of motion (ROM) limitations. The care plan included approaches of total assist with one to two persons as needed to ensure comfort during task but did not include bathing preferences.

R174 stated on 6/5/19, at 3:55 p.m. his wife approached the staff last night to inquire as to why his shower day was changed. Shortly after that the NA came back to the room, apologized

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F 561	Continued From page 7 for saying this was not his shower day and gave him a shower. R174 also stated he would not be asked about his bathing preferences at care conferences and he had not been asked how many or when he would like showers. RN-G stated on 6/6/19, at 8:29 a.m. R174 was not assessed for bathing preferences upon admission and it was missed. RN-G also stated she was not aware he had missed showers but could see there was missing documentation of him being bathed weekly. The director of nursing (DON) stated on 6/6/19, her expectation would be for staff to review bathing choices for all newly admitted residents within 48 hours and regularly after that to ensure the patient was satisfied with their bathing schedule. Bathing preferences should also be addressed at care conferences and the care plans updated with any changes. The Facility's Bathing: Shower or Tub Bath policy dated 12/5/18, included: Each resident will be interviewed at the time of admission to identify their bathing preferences regarding tub, bath or shower, time of day and/or day of the week and frequency.	F 561		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring	F 580		7/16/19

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F 580	Continued From page 8	F 580		

physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to

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F 580	Continued From page 9 room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the primary care provider regarding the development of a facility acquired sacral pressure ulcer for 1 of 1 resident (R9) reviewed for pressure ulcer. Findings include: R9's quarterly Minimum Data Set (MDS) dated 3/2/19, identified R9 had intact cognition and did not reject cares during the reference period. The MDS indicated R9 required extensive assistance with bed mobility and total dependence for toileting needs. The MDS indicated R9 was at risk for pressure ulcers and had a pressure reducing device for his chair and bed. R9's Pressure Ulcer Care Area Assessment dated 6/10/18, indicated R9 was at risk for skin breakdown and had a history of pressure ulcers. R9's Skin Risk/ Wound Care Plan edited 6/5/19, indicated R9 was at risk for skin impairment and directed staff to offer R9 to lay in bed with 30 degree wedge document refusals, air mattress, pressure mapping completed 5/30/19, wound care per orders, adjust position in wheelchair every hour, glidewear shorts, turn and reposition every 2-3 hours and pressure relieving wheelchair cushion. R9's progress notes (PN), skin observations and treatment administration record (TAR) were reviewed from 4/1/19, through 6/5/19, and indicated the following:	F 580	F580 It is the policy of Augustana Health Care Center to notify the physician of change of condition Corrective Action: Immediate re-education of Nurse who failed to notify physician of change of condition. Identified Resident's current wound status was reviewed and physician was notified of current Pressure Ulcer status on 6-5-19 by wound nurse. Identification of Other Residents: All residents with identified Pressure Ulcers on 6-6-19 were audited to ensure proper notification of physician. Measures Put in Place: Mandatory Education of Nursing staff on facility policy and procedure and standard of care for timely notification of change of condition to physician will be conducted 7-15-19 Monitoring Mechanisms: Audits of all residents with Pressure Ulcers to ensure proper notification of changes to physician will be conducted monthly for the next 90 days. The QAPI committee will review audits of notifications to physician for compliance with facility policy and procedures for the next 90 days on or before: 7-31-19 8-31-19 9-30-19 Responsible Person/s	

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F 580	Continued From page 10 -The skin observation dated 4/29/19, indicated "has a new pressure sore in back and coccyx area," however lacked evidence of assessment, measurements, interventions, provider notification or treatments; -The TAR dated 4/1/19, through 4/30/19, lacked evidence of wound care treatments; -The TAR dated 5/1/19, through 5/31/19, indicated wound care to right buttock pressure injury which start date 5/6/19, discontinue date 5/8/19. A subsequent order included wound care lower right side of sacrum start date 5/7/19; -The PN dated 5/7/19, identified R9 had a new pressure injury of the right sacrum provider updated on 5/7/19. R9's medical record lacked evidence regarding physician notification of the pressure ulceration noted on 4/29/19. R9 was interviewed on 6/4/19, at 12:30 p.m. and stated he had a sore on his bottom. RN-C was interviewed on 6/5/19, at 9:38 a.m. and confirmed R9's skin observation dated 4/29/19, indicated R9 had a pressure ulcer. RN-C stated the wound nurse first assessment the wound was completed on 5/7/19, and was unable to find wound care orders and/ or documentation if the physician was updated from 4/29/19, through 5/6/19, in R9's medical record. RN-E was interviewed on 6/5/19, at 9:51 a.m. and stated they were not aware R9's sacrum pressure ulcer until 5/6/19. RN-E stated once they were notified a resident had a new open area they were to see them within 24 hours. RN-E explained she updated R9's physician on 5/7/19, and obtained treatment orders after assessment	F 580	Clinical Managers Director of Nursing or Designee Assistant Administrator/Director of Quality Improvement 7-16-19	

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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 580		
F 609 SS=D	Reporting of Alleged Violations 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 is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not 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 established procedures.	F 609		7/16/19

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F 609	Continued From page 12 §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 report to the Administrator and to the State Agency (SA) an allegation of abuse for 1 of 4 residents (R368) and an allegation of mistreatment for 1 of 4 residents (R167) reviewed. 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. R368's face sheet indicated R368's Significant Other (Other)-A had trespassed and was not allowed on campus. Campus Incident Report dated 5/25/19, indicated Other-A was loud inside R368's room and was asked to quiet down. The report also indicated Other-A was intoxicated, had alcohol with him, and was verbally aggressive and disruptive toward registered nurse (RN)-A. The report indicated this was the second time this had happened with Other-A and RN-A had asked Security Officer to have Other-A" trespassed." On 6/6/19, at 10:52 a.m. R368's daughter (Family Member-A) stated a couple of days ago Other-A had come back to the facility and started arguing	F 609	F609 It is the policy of the Augustana Health Care Center to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, and misappropriation of resident property are reported immediately Corrective Action: Identified resident #368 was interviewed by Social Worker on 6-5-19 ensuring she felt safe and felt the facility had handled the incident with boyfriend to her satisfaction ACP services were offered and accepted by resident. Social Services completed Abuse Assessment on 7-1-19 resident has no current concerns in regards to abuse past or present. identified resident's #368 daughter was interviewed on 6-28-19 inquiring if she had any other concerns and to ensure she feels the facility has put measures in place that are appropriate for her daughter Identified Resident #167 was interviewed and VA report filed on 6-5-19 Identification of Other Residents: Review of all security reports involving	

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F 609	Continued From page 13 with R368. FM-A stated she had concerns with Other-A that he had put his hands on her mother and verbally abuses her. FM-A stated she had told the night nurse a couple of weeks ago in May that she did not want Other-A visiting her mother as he verbally abuses her mother and had dumped her mother out of her wheelchair (w/c) while out at the park. On 6/6/19, at 1:41 p.m. RN-A stated one night she had heard Other-A arguing loudly with R368 and had told him 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 in R368's progress notes. RN-A stated FM-A had not told her about Other-A dumping her mother out of the w/c, but that FM-A had told her Other-A pushes her mother too fast in the w/c, and had tipped her mother's w/c forward and tried tripping her. RN-A stated she had not documented in the progress notes about Other-A regarding R368 and her w/c nor had she told the DON or the Administrator.	F 609	visitors with trespass notice and/or visiting restrictions was completed to ensure all required Vulnerable Adult reporting had been completed 7-1-19 Review of all VA reports completed since 6-6-19 to ensure immediate reporting to the administrator and a complete investigation including appropriate residents and staff was conducted. 7-12-19 Measures Put in Place Facility Abuse assessment was expanded to add questions on abuse that include: "Is there anyone you do not feel safe around, Is there anyone that you do not want to visit here, and if yes please indicate who should not visit. Mandatory education for all Nursing Staff, all IDT team members, security staff and the facility management team will be conducted on appropriate VA reporting, immediate notification to administrator and complete investigation of all incidences. 7-15-19 Monitoring Mechanisms: Security reports and documentation of verbally abusive or behavioral incidences involving visitors and residents will be reviewed to ensure facility protocols for Vulnerable Adult reporting and investigation were followed. The QAPI committee will review audits of security reports and documented abusive or behavioral incidences for the next 90 days to ensure compliance with facility protocols for Vulnerable Adult reporting and investigation were followed on or	

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	245242	A. BUILDING _____ B. WING _____	C 06/06/2019

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F 609	Continued From page 14 R368's progress note dated 5/25/19, by RN-A indicated that FM-A "acknowledged that [Other-A] is very disrespectful and verbally abusive to [R368] and agreed [Other-A] should not be allowed to visit [R368] anymore in front of PM and NOC supervisor and security personal [personnel]." Review of R368's medical record lacked evidence the allegation of verbal abuse was reported to the SA or Administrator. On 6/6/19, at 3:13 p.m. Licensed Social Worker (LSW)-A stated allegations of verbal abuse were to be reported to the DON and to the administrator "immediately, as soon as possible". LSW stated he had been notified of the incident on Tuesday 5/28/19, at a morning meeting. He said the issue of concern was with Other-A with interference with security. LSW-A stated he was unaware of any concerns between Other-A and R368 and had spoken with R368 on 5/31/19, and she had not mentioned it. On 6/6/19, at 3:46 p.m. DON stated she had not been notified of the incident with Other-A, nor the allegation of verbal abuse, nor the incident with the w/c. DON stated the supervisor should have notified her of the allegation of verbal abuse right away and stated she would have wanted to be notified of any disruption on the floor. DON stated if she would have been made aware she would have told the nurse to ask Other-A to leave, and then to interview R368 and FM-A. DON stated she would have wanted questions to be asked to find out if abuse had occurred or had been witnessed. DON stated she had not known of this and had just learned of it "today" and had not	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	

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F 609	Continued From page 15	F 609		

reported to SA.

R167's quarterly MDS dated 5/7/19, indicated R167's cognition was intact and R167 needed two staff physical assistance with transfer.

On 6/3/19, at 12:44 p.m. R167 stated nursing assistant (NA)-G had verbally abused her and it was the first time she had ever felt vulnerable at the facility. R167 stated NA-G had argued with her and would not listen to her when she told her to stop transferring her alone with the hoyer lift. R167 stated she had told NA-G to get help as she did not feel safe with NA-A assisting her alone. R167 stated NA-G refused to listen to her and proceeded anyway. R167 stated she more than once asked NA-G to leave her room and was told by NA-G, "No, I am not your slave, I do not have to leave your room and I am not going to leave your room". R167 stated she felt helpless and vulnerable at the time and started screaming out loudly so help would come. R167 stated NA-G just stared, looking down at R167, "grinning." R167 stated the nurse on duty told NA-G to leave the room and NA-G had told the nurse no she did not have to but then left the room. R167 stated she did not want NA-G working with her again and that licensed practical nurse (LPN)-B also knew of the incident.

On 6/4/19, at 5:48 p.m. NA-H stated R167 had told him NA-G had transferred her alone in the hoyer lift and NA-G had just smiled at her "freaking her out" and was really frightened. NA-H stated he had notified the nurse what R167 had told him. NA-H stated R167 was very alert and was good at letting staff know.

On 6/4/19, at 7:06 p.m. DON stated LPN-B had

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F 609	Continued From page 16	F 609		

interviewed R167 on 5/29/19, and R167 had not considered the incident as abuse at the time, and had felt safe. DON stated R167 told LPN-B on 6/7/19, that she had now felt it was "verbal abuse". DON stated NA-G should have not argued with R167, and should have not transferred R167 alone with the hoyer lift as this was an unsafe transfer. DON stated the definition of mistreatment in the facility VA (Vulnerable Adult) policy dated 11/21/18, read "Mistreatment: Inappropriate treatment" of a resident. DON stated transferring a resident with a hoyer lift alone without a second staff was not appropriate.

On 6/5/19, at 9:01 a.m. LPN-B stated the wound nurse had reported to her what R167 had said to her about having issues with NA-G's cares for her and that she was hurting when NA-G was trying to remove the sling in bed alone. LPN-B stated R167 told her she did not want NA-G working with her again and had said she was very mad and was visibly upset about the incident.

On 6/6/19, at 4:23 p.m. the Administrator stated all allegations of abuse including verbal abuse were to be reported immediately to him, either by text, telephone or in person at the office, and needed to be reported immediately to the SA. Administrator stated he had not been notified of the allegation of verbal abuse with Other-A to R368 and had not reported it to the SA.

The facility's policy Vulnerable Adult dated 11/21/18, indicated allegations of abuse would be reported immediately, within two hours to the Administrator and SA, and allegations of mistreatment would be reported immediately, within 24 hours to the Administrator and SA. The policy also indicated residents would be free from

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F 609	Continued From page 17 abuse, protected and all allegations of abuse and mistreatment would be investigated.	F 609		
F 610 SS=D	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 mistreatment for 1 of 4 residents (R69) 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. R368's face sheet indicated R368's Significant	F 610	F610 It is the policy of the Augustana Health Care Center to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, and misappropriation of resident property are reported immediately. Corrective Action: Identified resident #368 was interviewed by Social Worker on 6-5-19 ensuring she felt safe and felt the facility had handled the incident with boyfriend to her	7/16/19

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F 610	Continued From page 18 Other (Other)-A had trespassed and was not allowed on campus. Campus Incident Report dated 5/25/19, indicated Other-A was loud inside R368's room and was asked to quiet down. The report also indicated Other-A was intoxicated, had alcohol with him, and was verbally aggressive and disruptive toward registered nurse (RN)-A. The report indicated this was the second time this had happened with Other-A and RN-A had asked Security Officer to have Other-A" trespassed." On 6/6/19, at 10:52 a.m. R368's daughter (Family Member-A) stated a couple of days ago Other-A had come back to the facility and started arguing with R368. FM-A stated she had concerns with Other-A that he had put his hands on her mother and verbally abuses her. FM-A stated she had told the night nurse a couple of weeks ago in May that she did not want Other-A visiting her mother as he verbally abuses her mother and had dumped her mother out of her wheelchair (w/c) while out at the park. On 6/6/19, at 1:41 p.m. RN-A stated one night she had heard Other-A arguing loudly with R368 and had told him 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	F 610	satisfaction ACP services were offered and accepted by resident. Social Services completed Abuse Assessment on 7-1-19 resident has no current concerns in regards to abuse past or present. Identified resident #368 daughter was interviewed on 6-28-19 inquiring if she had any other concerns and to ensure she feels facility has put measures in place that are appropriate for her daughter. Identified resident #167 was interviewed and VA report filed on 6-5-19 Identification of Other Residents: Review of all security reports involving visitors with trespass notice or visiting restrictions was completed to ensure all required Vulnerable Adult reporting has been completed 7-1-19 Review of all VA reports completed since 6-6-19 to ensure immediate reporting to the administrator and a complete investigation including appropriate residents and staff was conducted. 7-12-19 Measures Put in Place: Facility Abuse assessment was expanded to add questions on abuse that include: "Is there anyone you do not feel safe around, Is there anyone that you do not want to visit here, and if yes please indicate who should not visit. Mandatory education for all Nursing Staff, all IDT team members, security staff and facility management team will be educated on appropriate Vulnerable Adult reporting, immediate notification to the administrator and complete investigation	

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F 610	Continued From page 19 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 in R368's progress notes. RN-A stated FM-A had not told her about Other-A dumping her mother out of the w/c, but that FM-A had told her Other-A pushes her mother too fast in the w/c, and had tipped her mother's w/c forward and tried tripping her. RN-A stated she had not documented in the progress notes about Other-A regarding R368 and her w/c nor had she told the DON or the Administrator. R368's progress note dated 5/25/19, by RN-A indicated that FM-A "acknowledged that [Other-A] is very disrespectful and verbally abusive to [R368] and agreed [Other-A] should not be allowed to visit [R368] anymore in front of PM and NOC supervisor and security personal [personnel]." Review of R368's medical record lacked evidence the allegation of verbal abuse was reported to the SA or Administrator; nor was investigated with R368, FM-A, staff interviews and other residents. On 6/6/19, at 3:13 p.m. Licensed Social Worker (LSW)-A stated allegations of verbal abuse were to be reported to the DON and to the administrator "immediately, as soon as possible". LSW stated he had been notified of the incident on Tuesday 5/28/19, at a morning meeting. He said the issue of concern was with Other-A with interference with security. LSW-A stated he was	F 610	of all incidences. 7-15-19 Monitoring Mechanisms: Security reports and documentation of verbally abusive or behavioral incidences involving visitors and resident will be reviewed to ensure facility protocols for Vulnerable Adult reporting and investigation were followed. The QAPI committee will review audits of security reports and documented abusive or behavioral incidence for the next 90 days to ensure compliance with facility protocols for Vulnerable Adult reporting and investigation were followed on or 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	

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F 610	Continued From page 20	F 610		

unaware of any concerns between Other-A and R368 and had spoken with R368 on 5/31/19, and she had not mentioned it.

On 6/6/19, at 3:46 p.m. DON stated she had not been notified of the incident with Other-A, nor the allegation of verbal abuse, nor the incident with the w/c. DON stated the supervisor should have notified her of the allegation of verbal abuse right away and stated she would have wanted to be notified of any disruption on the floor. DON stated if she would have been made aware she would have told the nurse to ask Other-A to leave, and then to interview R368 and FM-A. DON stated she would have wanted questions to be asked to find out if abuse had occurred or had been witnessed. DON stated she had not known of this and had just learned of it "today" and had not reported to SA.

On 6/6/19, at 4:23 p.m. the Administrator stated all allegations of abuse including verbal abuse were to be reported immediately to him, either by text, telephone or in person at the office, and needed to be reported immediately to the SA. Administrator stated he had not been notified of the allegation of verbal abuse with Other-A to R368 and had not reported it to the SA.

The facility's policy Vulnerable Adult dated 11/21/18, indicated allegations of abuse would be reported immediately, within two hours to the Administrator and SA, and allegations of mistreatment would be reported immediately, within 24 hours to the Administrator and SA. The policy also indicated residents would be free from abuse, protected and all allegations of abuse and mistreatment would be investigated.
R69's quarterly Minimum Data Set dated 4/6/19,

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F 610	Continued From page 21	F 610		

identified R69 had intact cognition and required extensive staff assistance with bed mobility and total dependence for toileting needs.

R69's Face Sheet dated 6/6/19, indicated R69 had diagnoses which included convulsions, depression, anxiety and weakness.

R69 was interviewed on 6/3/19, at 8:11 a.m. and stated back in February there was a nursing assistant (NA)-I who was told not to come into his room anymore. R69 explained NA-I was defensive, rude and rough while turning him in bed during pericares. R69 further explained NA-I was rough when she was rolling him; he stated she pushed him and squeezed his hip without explaining what she was doing. R69 revealed NA-I had been on her cell phone while she was providing cares laughing and speaking in a foreign language. R69 indicated NA-I remained on her cell phone talking and laughing; as she touched his genitals providing pericares and stated he felt humiliated as if he was being molested. R69 indicated he had reported this to the clinical manager and NA-I had not cared for him since.

Registered nurse (RN)-F was interviewed on 6/3/19, at 12:22 p.m. and stated she had been made aware of R69's allegations on 5/6/19, and a report had been made to the state agency (SA).

The director of nursing (DON), administrator, administrator assistant, assistant director of nursing (ADON) and RN-F were interviewed on 6/4/19, at 7:04 p.m. The DON verified only R69, NA-I and NA-J were interviewed regarding the alleged allegation of mistreatment that had been reported to the SA on 5/6/19, due to the

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F 610	Continued From page 22 investigation being straight forward. The DON explained she did not see how any additional information would have altered the outcome of the investigation. The facility investigative file dated 5/6/19, was reviewed and included an interview from R69, NA-I and NA-J. However, the file lacked evidence of additional resident and staff interviews regarding the alleged allegation of mistreatment and also lacked evidence of increased supervision or monitoring on the unit. The facility policy Vulnerable adult-MN [Minnesota] dated 11/21/18, indicated all reports of alleged abuse and mistreatment shall be promptly and thoroughly investigated. The policy included that the investigation would include interviews of any potential witnesses to the incident and other residents to whom the alleged perpetrator provided care or services.	F 610		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely toileting assistance for 2 of 5 residents (R187, R9) reviewed for activities of daily living (ADL) who were unable to perform ADL's and needed staff assistance. Findings include:	F 677	F677 It is the policy of the Augustana Health Care Center to provide the needed care and services for residents who are unable to carry out activities of daily living Corrective Action: Nursing Assistants involved in identified incidences were immediately re-educated	7/16/19

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F 677	Continued From page 23 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. R187 identified he was left on the bedpan "over one hour" and had fallen back to sleep due to waiting so long. R187 stated this was not the first time this had happened and he had complained to nursing staff, however he would be told "we are just short of help." Nursing Assistant (NA)-D was interviewed on 6/3/19, at 12:04 p.m. and confirmed four east unit was "short today" due to only 3 NAs working	F 677	per toileting needs of identified residents Identification of Other Residents: Residents identified as dependent in toileting were audited for compliance with facility standard of care for toileting. 7-15-19 Measures Put in Place: Mandatory education for all nursing staff on facilities policies and procedures for incontinence care and toileting schedules 7-15-19 Monitoring Mechanisms: 10% random audits of residents requiring toileting assistance will be conducted monthly on all units for compliance with facility standard of care for the next 90 days. The QAPI committee will review audits for compliance with facility toileting policies and procedures/ standards of practice for the next 90 days on or before: 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	

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today with a ratio of 1:12 (one NA to 12 residents) versus 1:9 when 4 NAs were present. NA-D verified R187 had to wait for assistance due to the needs of other resident and when she had arrived to his room around 7:15 a.m. she found R187 in bed seated on the bedpan with dry BM on his buttocks. NA-D explained she was unsure when R187 was assisted onto the bedpan and further stated the overnight shift did not report to her R187 would need assist as he was currently utilizing the bed pan. NA-D stated she had to "use extra wipes" due to the BM dried onto R187's buttocks. NA-D stated the overnight shift typically left at 6:30 a.m..

NA-E was interviewed on 6/5/19, at 6:13 a.m. and stated she would typically assist R187 during the overnight shift with his toileting needs between 4:45 a.m. to 5:15 a.m..

The Registered Nurse (RN)-F was interviewed on 6/6/19, at 8:15 a.m. and stated she had been made aware that R187 had been left on the bedpan on 6/3/19, and was looking into what had happened. RN-F explained it was her expectation staff to communicate between shifts when a resident was using the bedpan.

The director of nursing was interviewed on 6/6/19, at 11:40 a.m. and stated it was her expectation for residents toileting needs to be communicated during shift to shift report.

A facility policy regarding ADL for a dependent resident was requested but not provided.

R9's quarterly Minimum Data Set (MDS) dated 3/2/19, identified R9 had intact cognition and did

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not reject cares during the reference period. The MDS indicated R9 had total dependence for toileting.

R9's Urinary Incontinence Care Area Assessment dated 6/10/18, indicated R9 was incontinent of bladder and needed total assist with toileting needs.

R9's Elimination Care Plan edited 3/7/19, identified R9 was incontinent of bladder and directed staff to offer urinal upon arising, before and after meals, at bedtime and night rounds and to check and change with morning and bedtime cares, night rounds and every 2 hours as needed.

R9 was interviewed on 6/4/19, at 12:30 p.m. and stated the overnight shift never has enough help so they leave him in his wet "diaper" all night "that's how I got this sore." R9 stated during the evening hour when you ask for help everybody would say "we are short, we are short" which resulted in having to wait to be changed or helped multiple times.

On 6/5/19, at 6:21 a.m. during a continuous observation from 6:21 a.m. through 9:00 a.m. R9's cares were observed. At 6:21 a.m. R9 was observed lying in bed on his back on top of an air mattress sleeping and his head of bed elevated. At 8:09 a.m. R9 used the call light to ask what time his appointment was today; registered nurse (RN)-F notified R9 of his appointment time, however R9 was not offered to use of urinal and/ or check and change. At 8:20 a.m. nursing assistant (NA) entered room to assist R9 with breakfast and left R9's room at 8:47 a.m.. No urinal use and/ or check and change were offered during this time. At 9:00 a.m. NA-B and NA-C

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F 677	Continued From page 26 were observed to remove R9's brief. NA- B confirmed R9's incontinent brief was wet with urine. NA-A was interviewed on 6/6/19, at 8:43 a.m. and stated per their NA group sheet R9 was to be checked and changed every 2 hours and as needed. NA-A stated R9 was typically toileted before breakfast then at around 11:00 a.m. and then at around 1:00 p.m.. RN-F was interviewed on 6/6/19, at 8:48 a.m. and stated R9 was to be checked and changed every 2 hours and as needed. The director of nursing was interviewed on 6/6/19, at 11:40 a.m. and stated it was her expectation to toilet residents per their care plan. A facility policy regarding ADL for a dependent resident was requested but not provided.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 686		7/16/19

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F 686	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement interventions to promote healing of a facility acquired sacrum pressure ulcer for 1 of 1 resident (R9) reviewed for pressure ulcer. Findings include: R9 was interviewed on 6/4/19, at 12:30 p.m. and stated he had a sore on his bottom. R9 explained the overnight shift have not had enough help so they leave him in his wet "diaper" all night "that's how I got this sore." R9 stated during the evening hour when you ask for help everybody would say "we are short, we are short" which resulted in having to wait to be changed or helped multiple times. On 6/5/19, at 6:21 a.m. during a continuous observation from 6:21 a.m. through 9:00 a.m. R9's cares were observed. At 6:21 a.m. R9 was observed to be lying in bed on his back on top of air mattress sleeping and his head of bed elevated. At 8:09 a.m. R9 pushed call light to ask what time his appointment was today. R9 was interviewed at 8:11 a.m. and stated his dressing to his pressure ulcer had not been changed and he wondered why. R9 stated he thought his dressing was to be changed daily. At 9:00 a.m. nursing assistant (NA)-B and NA-C were observed completing pericares. R9 was observed to have two draw sheets, one pillow under right hip, incontinent pas and a towel under his lower back and bottom area; NA-B verified the items were supposed to be under R9 while in bed. On 6/5/19, at 9:19 a.m. RN-C and RN-D were	F 686	F686 It is the policy of the Augustana Health Care Center to provide the treatment and services to prevent/heal Pressure Ulcers. Corrective Action: Re-education of identified licensed staff person on facility policy per dressing changes was completed Identification of Other Residents: All residents with Pressure Ulcers on 7-1-19 were audited to ensure wound care including dressing changes was being completed per orders. 7-15-19 Measures Put in Place: Mandatory education for all Nursing staff on Prevention of Pressure Ulcers, and following facility skin policy per pressure ulcer/wound care standards of practice 7-15-19 Monitoring Mechanisms: 20% random audits of residents receiving wound care to ensure compliance with facility standard of practice for wound care will be conducted monthly for he next 90 days. The QAPI committee will review audits for compliance with facility standard of practice for pressure ulcer prevention and wound care on or before: 7-31-19 8-31-19 9-30-19 Responsible Person/s Wound Care Nurse Director of Nursing or Designee Assistant Administrator/Quality	

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F 686	Continued From page 28 observed turning R9 onto his left side. RN-C confirmed R9's dressing that covered his sacrum wound was dated 6/3/19. RN-C measured R9's sacrum wound which was 1.8 centimeters (CM) in length by 1.4 cm width and noted 100% slough (dead tissue) in the wound bed and visual depth 0.4 cm. RN-C stated there was a mild malodor noted when the dressing was removed. RN-C stated there was moderate serous exudate noted on the dressing that was removed. RN-C was interviewed on 6/5/19, at 9:38 a.m. and verified the wound was slightly larger than last week's measurements which were 1.5 cm by 1.3 cm and only had small amount of drainage and now had moderate with seropurulent (mix of watery fluid and pus) drainage and odor which she would consider a decline and planned to contact the provider for new orders. RN-C explained R9's dressing was to be changed daily due to the Santyl (medication) that was to be placed in the wound bed daily. RN-C verified the nurse on 6/4/19, did not change R9's dressing per orders and documented not completed the "nurse got too busy." RN-C stated it was her expectation if the nurse was too busy that the next shift would have completed the dressing change. RN-C verified R9 had two draw sheets, one incontinent pad and two towels behind R9's bottom area. RN-C indicated R9's air bed should not have had extra on the top of it and should only have had one draw sheet and one incontinent pad but no towels. RN-C confirmed R9's skin observation dated 4/29/19, indicated R9 had a pressure ulcer. RN-C stated the wound nurse first assessment the wound on 5/7/19, and was unable to find wound care orders from 4/29/19, through 5/6/19, in R9's medical record.	F 686	Improvement Director 7-16-19	

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RN-E was interviewed on 6/5/19, at 9:51 a.m. and stated they were not aware R9's sacrum pressure ulcer until 5/6/19. RN-E stated once they were notified a resident had a new open area they were to see them within 24 hours. RN-E explained she updated R9's physician on 5/7/19, and obtained treatment orders after assessment of the wound.

R9's quarterly Minimum Data Set (MDS) dated 3/2/19, identified R9 had intact cognition and did not reject cares during the reference period. The MDS indicated R9 required extensive assistance with bed mobility and total dependence for toileting needs. The MDS indicated R9 was at risk for pressure ulcers and had a pressure reducing device for his chair and bed.

R9's Pressure Ulcer Care Area Assessment dated 6/10/18, indicated R9 was at risk for skin breakdown and had a history of pressure ulcers.

R9's Skin Risk/ Wound Care Plan edited 6/5/19, indicated R9 was at risk for skin impairment and directed staff to offer R9 to lay in bed with 30 degree wedge, document refusals, air mattress, pressure mapping completed 5/30/19, wound care per orders, adjust position in wheelchair every hour, glidewear shorts, turn and reposition every 2-3 hours and pressure relieving wheelchair cushion.

R9's skin observations and treatment administration record (TAR) was reviewed from 4/1/19, through 6/5/19, and indicated the following:
- The skin observation dated 4/29/19, indicated "has a new pressure sore in back and coccyx area," however lacked evidence of assessment,

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F 686	Continued From page 30 measurements, interventions and treatment, or provider notification. - The TAR dated 4/1/19, through 4/30/19, lacked evidence of wound care treatments; - The TAR dated 5/1/19, through 5/31/19, indicated wound care to right buttock pressure injury which start date 5/6/19, discontinue date 5/8/19. A subsequent order included wound care lower right side of sacrum start date 5/7/19, however indicated "not completed due to workload" on 5/15/19; -The TAR dated 6/1/19, through 6/5/19, indicated wound care lower right side of sacrum, however indicated "not completed due to workload" on 6/4/19. The director of nursing (DON) 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 utilize the standing house orders and implement a treatment then they should update the wound nurse so the wound can be thoroughly assessed that day or the next. The DON further stated it was her expectation to complete dressing changes per orders. The facility policy Skin Integrity dated 8/6/18, indicated a new wound should have had appropriate treatment wound care initiated into the electronic medical record. The policy further indicated to document the skin alteration and measurements in the electronic medical record and to complete a comprehensive skin risk assessment.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		7/16/19

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F 689	Continued From page 31 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and complete ongoing monitoring and evaluation for safe smoking for 1 of 3 residents (R130) reviewed for smoking. Findings Include: R130's diagnosis included dementia without behavioral disturbances, vascular dementia, altered mental status, nicotine dependence and dependence on supplemental oxygen. R130's annual Minimum Data Set (MDS) dated 8/10/18, identified R130 was a smoker. A Care Assessment Area (CAA) related to smoking was not completed. A smoking assessment, dated 2/14/19, noted R130 had actual alteration in behavior which included smoking in unsafe areas. Another smoking assessment dated 4/29/19, indicated R130 had impaired cognition and refused to participate in the smoking assessment. The assessment directed staff set-up R130's smoking material and to keep her smoking materials at the nursing station. A smoking care plan, edited 6/4/19, identified R130 had been observed smoking in	F 689	F689 It is the policy of the Augustana Health Care Center that each resident receives adequate supervision and assistance devices to prevent accidents. Corrective Action: Identified resident was re-assessed for smoking safety on 6-4-19 Resident Smoking Policy and Procedure was reviewed and updated on 6-14-19 Resident re-assessed to ensure continued safe smoking practice on 7-3-19 Identification of Other residents: Smoking assessments for all residents who smoke were audited for accuracy to resident's current smoking status All Care sheets were audited and updated if needed to reflect resident's current smoking status and any needed safety interventions. 7-15-19 Measures Put in Place: Employee Communication was distributed Re: Importance of safe smoking for residents Mandatory education was conducted for the Therapeutic Activities staff on facility resident smoking policy, and proper assessment methods, content and procedures.	

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F 689	Continued From page 32 non-designated areas (2016). Burn hole found in clothing due to movement when smoking. Resident is able to smoke independently with a smoking apron. A cognition care plan, revised 6/5/19, identified R130 made poor healthcare decisions and was unable to foresee consequences of decisions with moderately impaired cognition. The Care plan also noted R130 had a history of lacking personal safety awareness especially related to smoking and consequences of smoking in undesignated areas. R130 was observed in her bed on 6/4/19, at 1:05 p.m. When asked, R130 stated she smoked cigarettes and was allowed to independently manage her smoking supplies, including lighters. R130 untied a plastic bag placed on her wheelchair next to her bed. R30 opened the bag and exposed four disposable lighters, two opened packs of cigarettes and one unopened pack of cigarettes. Registered nurse (RN-I) was interviewed on 6/4/19, at 1:27 p.m. and stated R130 smoked either in the smoking room in the facility or the designated smoking area in the front of the building. RN-I further explained R130 was deemed to be safe while smoking and did not have any safety precautions in place related. RN-I stated R130 kept her cigarettes and lighters with her and staff did not monitor R130 while smoking or monitor her smoking materials. On 6/4/19, at 1:31 p.m. a RN-H stated R130 was safe to smoke and keep her smoking supplies in her room. RN-H further explained the therapeutic recreation (TR) department was in charge of conducting smoking assessments for residents who smoked. RN-H stated TR would alert nursing	F 689	Mandatory education for all Nursing staff, on resident smoking policies and procedures. 7-15-19 Monitoring Mechanism: Random audits will be conducted 3 times weekly for the next 90 days, of the designated facility smoking areas to ensure that interventions for identified residents related to smoking are in place and to ensure other residents who smoke are continuing to practice safe smoking behaviors. QAPI committee will review audits to ensure compliance with facility policy and procedures related to smoking safety and assessment for residents for the next 90 days on or before: 7-31-19 8-31-19 9-30-19 Responsible Person/s Therapeutic Activity Director or Designee Assistant Administrator/Quality Improvement Director 7-16-19	

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with changes or problems found during a smoking assessment. RN-H stated smoking assessments were done quarterly and as needed. At 1:45 p.m. RN-H verified R130 had four disposable lighters, two opened packs of cigarettes and two unopened packs of cigarettes her room RN-H stated R130 was a "safe smoker" and was not aware of a smoking assessment that indicated R130 was not safe to smoke without safety precautions in place.

R130 was observed in her bed on 6/5/19, at 6:18 a.m. R130's smoking supplies were in her wheelchair which was placed next to her bed. At 7:42 a.m. R130 was observed smoking a lit cigarette while sitting in a chair in the designated facility smoking room. R130's wheelchair was next to her. A smoking apron (an over-garment designed to be worn while smoking tobacco intended for individuals who smoke and require a protective shield from hot ashes and dropped cigarettes) was folded over the back of R130's wheelchair. A bag of smoking materials was on R130's wheelchair seat. Staff was not present in or near the smoking room. A total of four residents were smoking in the room.

The receptionist (R-A) was interviewed on 6/5/19, at 7:47 a.m. and stated although the she was able to visualize the smoking room by video camera from the reception area, she was unable to monitor if a resident was wearing a smoking apron. R-A further explained she did not know who what residents were identified as needing to wear an apron while smoking because the staff had never addressed it with her. R-A was unaware if the facility monitored residents' smoking habits on a regular basis.

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On 6/5/19, at 7:52 a.m. R130 was observed in the facility smoking room. R130 was wearing a smoking apron. At 8:02 a.m. R130 stated she was given a smoking apron "yesterday", which she kept it on the back of her wheelchair.
At 8:21 a.m. was continued to smoke in the designated smoking room. R130 had a smoking apron in place. Ashes from R130's cigarette were noted on the apron.

The director of therapeutic recreation (DTR) stated on 6/6/19, at 9:19 a.m. that although TR was in charge of completing resident smoking assessments, there was not a system to alert staff or implement findings. The DTR stated when a resident was found to be "unsafe while smoking, a smoking apron was put on and most kept it on all day." The DTR stated staff did not monitor this practice and the facility did not have a policy in place.

RN-H was interviewed on 6/6/19, at 9:25, and stated R130 was assessed by the TR department to need an apron on when smoking, however RN-H did not receive this information and therefore did not put it on the NA care sheets. RN-H further stated the facility did not have a system in place to ensure R130 had a smoking apron applied when she smoked. RN-H further verified R130 continued to keep her cigarettes in her procession and staff did not intervene.

The director of nursing (DON) stated on 6/6/19, at 10:20 a.m. that if staff put smoking interventions in place for a resident who had been assessed to be at risk while smoking, these interventions should be followed by the staff. The DON further stated the facility should have a system in place to ensure safety and compliance. The DON

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F 689	Continued From page 35 concluded, "A good first step would be to monitor their smoking supplies. We need to take a look at that." A nursing progress note (PN), dated 6/5/19, noted R130 had burn holes in her clothing but was able to smoke independently when wearing a smoking apron, The PN directed staff to "encourage" R130 to "use it." The current nursing assistant (NA) care sheet, undated, did not identify R130 was a smoker or direct staff to "encourage" the use of a smoking apron. The Cassia, an Augustana/Elim Affiliation, care plan policy, dated 12/5/19, stated a resident who smokes will be assessed for safe smoking practices and would indicate if cognitive function require smoking materials be kept in a secured area. The policy also stated if a resident was assessed to be unsafe in their smoking practices, interventions may be put in place which included: use of a smoking apron, use of adaptive cigarette holders or ash trays, supervised smoking, and rationed smoking materials and/or kept at the nursing station. The policy lacked direction for monitoring these interventions.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and	F 725		7/16/19

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AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

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F 725	Continued From page 36 diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staff was available to meet resident needs related to assistance of 1 of 2 residents (R187) reviewed for activities of daily living (ADL) of the dependent resident and 3 of 3 residents (R89, R133, R81) reviewed for medication administration. In addition, the facility failed to ensure wound care was provided per physician orders for 1 of 1 residents (R9) reviewed for pressure ulcer. Findings include: 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	F 725	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 incidences 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 care including dressing changes is being completed per orders	

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F 725	Continued From page 37 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 assist off of the bedpan. R187 identified he was left on the bedpan "over one hour" and had fallen back to sleep due to waiting so long. R187 stated this was not the first time this had happened and he had complained to nursing staff, however he would be told "we are just short of help." Nursing Assistant (NA)-D was interviewed on 6/3/19, at 12:04 p.m. and confirmed four east unit was "short today" due to only 3 NA today with a ratio of 1:12 versus 1:9 when 4 NA were present. NA-D verified R187 had to wait for assistance due to the needs of other resident and when she had arrived to his room around 7:15 a.m. she found R187 in bed seated on the bedpan with dry BM on his buttocks. NA-D explained she was unsure when R187 was assisted onto the bedpan and further stated the overnight shift did not report to her R187 would need assist as he was currently utilizing the bed pan. NA-D stated she had to "use extra wipes" due to the BM dried onto R187's buttocks. NA-D stated the overnight shift typically left at 6:30 a.m. R89 was interviewed on 6/3/19, at 7:55 a.m. and stated he had not been receiving his Sinemet timely per his neurologist orders. R89 stated the late administration resulted in neck and shoulder spasms. R89's Physician Order Report dated 5/6/19, through 6/6/19, included Sinemet to be administered at 6:00 a.m., 9:00 a.m., 12:00 p.m., 3:00 p.m., 6:00 p.m. and 8:00 p.m. for Parkinson disease.	F 725	Medication administration audits were completed to identify residents with medication preferences or demonstrated clinical need for time sensitive medication administration. 7-15-19 Measures Put in Place Facility continues to staff significantly above the state minimum requirements. Facility is developing different staffing protocols around shift change and employee breaks, and continues to look at best practice for medication administration and meeting the needs or residents in a timely manner. Mandatory education for all Nursing staff was conducted on facility staffing protocols and Medication Administration 7-15-19 Monitoring Mechanisms: 10% random audits of residents requiring toileting assistance will be conducted monthly on all units for compliance with facility standard of care for the next 90 days. 20% random audits of all residents receiving wound care to ensure compliance with facility standard or practice for wound care will be conducted monthly for the next 90 days 10% random audits of timely medication administration will be conducted monthly on all units for the next 90 days. The QAPI committee will review audits for compliance with facility standard of care for toileting assistance , pressure ulcer reduction and timely medication administration on or before: 7-31-19	

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F 725	Continued From page 38 R89's medication administration record (MAR) was reviewed 3/1/19, through 6/5/19, and revealed the following: -3/1/19, through 3/31/19, MAR indicated R89 did not receive his Sinemet five times due to "resident unavailable," four times administered late due to "helping with cares," 18 times administered late due to "charted late" and one time the medication was not administered due to "drug/ item unavailable;" -4/1/19, through 4/30/19, MAR indicated R89 did not receive his Sinemet once due to "resident unavailable," three times administered late due to "helping with cares," nine times "administered late," 11 times administered late due to "charted late" and twice the medication was not administered due to "drug/ item unavailable;" -5/1/19, through 5/31/19, MAR indicated R89 did not receive his Sinemet once due to "resident unavailable," administered late once due to "helping with cares," twice "administered late," 10 times administered late due to "charted late;" -6/1/19, through 6/5/19, MAR indicated R89 administered late once due to "charted late." The trained medication aide (TMA)-A was interviewed on 6/4/19, at 6:08 p.m. and explained when a medication was administered beyond one hour after the scheduled time the MAR would prompt her to indicate a reason it was administered late. TMA-A indicated when the unit was "short" staffed with 3 nursing assistants (NA) opposed to 4 NA's it was the expectation of the facility for the TMA to assist with resident cares. TMA-A stated this would cause her to run behind when administering medications causing medications to be administered late. TMA-A verified in R89's MAR when documented "helping with cares" was times the unit only had 3 NAs	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	

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F 725	Continued From page 39	F 725		

and she needed to help with resident cares so R89's Sinemet was administered over an hour beyond the scheduled time.

R133
On 6/5/19, at 10:42 a.m. during a medication administration pass observation for R133; the following medications were administered aspirin, citalopram (antidepressant), eliquis (anticoagulant), metoprolol (treats high blood pressure), and multivitamin.

R133's Physician Order Report dated 6/1/19, through 6/5/19, included the following medications to be administered at 8:00 a.m. aspirin, metoprolol, multivitamin and eliquis. The report indicated citalopram was to be administered daily at 7:30 a.m.

R81
On 6/5/19, at 10:50 a.m. during a medication administration pass observation for R81; the following medications were administered diltiazem (treats high blood pressure), Flonase (treats allergies), fluoxetine (anti-depressant), furosemide (diuretic), metoprolol, omeprazole (treats acid reflux), Qvar inhaler (treats asthma), spironolactone (diuretic), tums (anti-acid) and acetaminophen (analgesic).

R81's Physician Order Report dated 6/1/19, through 6/5/19, included the following medications to be administered at 8:00 a.m. omeprazole, tums, fluoxetine, Flonase, acetaminophen, diltiazem, metoprolol, furosemide, spironolactone, and Qvar inhaler.

TMA-B was interviewed on 6/5/19, at 10:54 a.m. and verified R133 and R81's medications were

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F 725	Continued From page 40	F 725		

administered late and should have been administered no later than 9:00 a.m. however due to one nurse not coming in TMA-B was pulled to administered medications so she got a late start. TMA-B reviewed the work list for the unit and verified five additional resident's names were outlined in red which indicated their medications had not been administered and would be administered late.

R9
R9 was interviewed on 6/4/19, at 12:30 p.m. and stated he had a sore on his bottom. R9 explained the overnight shift have not had enough help so they leave him in his wet "diaper" all night "that's how I got this sore." R9 stated during the evening hour when you ask for help everybody would say "we are short, we are short" which resulted in having to wait to be changed or helped multiple times. During a subsequent interview on 6/5/19, at 8:11 a.m. R9 stated his dressing to his pressure ulcer had not been changed and he wondered why. R9 stated he thought his dressing was to be changed daily.

On 6/5/19, at 9:19 a.m. registered nurse (RN)-C and RN-D were observed turning R9 onto his left side. RN-C confirmed R9's dressing that covered his sacrum wound was dated 6/3/19.

RN-C was interviewed on 6/5/19, at 9:38 a.m. and verified the nurse on 6/4/19, did not change R9's dressing per orders and documented not completed the "nurse got too busy." RN-C stated it was her expectation if the nurse was too busy that the next shift would have completed the dressing change.

R9's skin observations and treatment

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F 725	Continued From page 41	F 725		

administration record (TAR) was reviewed from 5/1/19, through 6/5/19, and indicated the following:
- The TAR dated 5/1/19, through 5/31/19, indicated wound care lower right side of sacrum start date 5/7/19, however indicated "not completed due to workload" on 5/15/19. Staff member who documented on TAR regarding unable to complete due to workload on 5/15/19, was unavailable for interview.
-The TAR dated 6/1/19, through 6/5/19, indicated wound care lower right side of sacrum, however indicated "not completed due to workload" on 6/4/19. Staff member who documented on TAR regarding not completed due to workload on 6/4/19, was unavailable for interview.

The facility staff coordinator (SC) was interviewed on 6/6/19, at 10:33 a.m. and stated the facility had 30 positions open between nurses and nursing assistants. The SC stated they had been offering pick up bonuses and working on their recruitment efforts. The SC explained the 4 east long term care unit with a census of 36 were to have 1 nurse, 1 TMA, 4 NA's when fully staffed. 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

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F 725	Continued From page 42 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.	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in	F 755		7/16/19

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F 755	Continued From page 43 the facility. §483.45(b)(2) Establishes a system of records of 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 in order and that an account of all controlled drugs 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 medications were 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 4/13/19, identified R89 had intact cognition and diagnosis which included Parkinson disease. R89 was interviewed on 6/3/19, at 7:55 a.m. and stated he had not been receiving his Sinemet timely per his neurologist orders. R89 stated the late administration resulted in neck and shoulder spasms. R89's Physician Order Report dated 5/6/19, through 6/6/19, included Sinemet to be administered at 6:00 a.m., 9:00 a.m., 12:00 p.m., 3:00 p.m., 6:00 p.m. and 8:00 p.m. for Parkinson disease.	F 755	F755 It is the policy of Augustana Health Care Center to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident. Corrective Action: Employees involved in the identified medication administration instances were re-educated Identification of Other Residents: Medication administration audit was completed to identify residents with medication preferences or demonstrated clinical need for time sensitive medication administration. 7-15-19 Measures Put in Place All TMA's completed a read and sign education specific to timely medication administration. Mandatory education for all Nursing staff was conducted on the importance of timely medication administration and facility changes in medication	

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F 755	Continued From page 44 R89's medication administration record (MAR) was reviewed 3/1/19, through 6/5/19, and revealed the following: -3/1/19, through 3/31/19, MAR indicated R89 did not receive his Sinemet five times due to "resident unavailable," four times administered late due to "helping with cares," 18 times administered late due to "charted late" and one time the medication was not administered due to "drug/ item unavailable;" -4/1/19, through 4/30/19, MAR indicated R89 did not receive his Sinemet once due to "resident unavailable," three times administered late due to "helping with cares," nine times "administered late," 11 times administered late due to "charted late" and twice the medication was not administered due to "drug/ item unavailable;" -5/1/19, through 5/31/19, MAR indicated R89 did not receive his Sinemet once due to "resident unavailable," administered late once due to "helping with cares," twice "administered late," 10 times administered late due to "charted late;" -6/1/19, through 6/5/19, MAR indicated R89 administered late once due to "charted late." The trained medication aide (TMA)-A was interviewed on 6/4/19, at 6:08 p.m. and explained when a medication was administered beyond one hour after the scheduled time the MAR would prompt her to indicate a reason it was administered late. TMA-A indicated when the unit was "short" staffed with 3 nursing assistants (NA) opposed to 4 NA's it was the expectation of the facility for the TMA to assist with resident cares. TMA-A stated this would cause her to run behind when administering medications causing medications to be administered late. TMA-A verified in R89's MAR when documented "helping	F 755	administration protocols 7-15-19 Monitoring Mechanism: 10% random audits will be conducted monthly for the next 90 days of medication records to ensure timely medication administration 10% random audits will be conducted monthly for the next 90 days of residents will medication preferences or demonstrated clinical need for time sensitive medication administration to ensure timely medication administration. The QAPI committee will review medication administration audits for maintaining facility standards for timely medication administration on or before: 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	

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F 755	Continued From page 45	F 755		

with cares" was times the unit only had 3 NAs and she needed to help with resident cares so R89's Sinemet was administered over an hour beyond the scheduled time.

The registered nurse (RN)-F was interviewed on 6/6/19, at 8:18 a.m. and explained it was the expectation that medications were administered within the time frame of one hour before and after the scheduled administration time. RN-F stated they do their best to accommodate resident preferences for administration times. RN-F explained when the MAR indicated charted late it was likely due to the person not being able to sign off that the medication was administered timely. RN-F further explained helping with cares indicated the TMA stopped with medications administrations to assist a resident with their call light, causing the TMA to get behind. RN-F verified when a medication was administered beyond one hour of the scheduled time it was considered administered late.

The director of nursing was interviewed on 6/6/19, at 11:40 a.m. and stated it was her expectation for mediations to be administered according to the scheduled time and any deviation would be noted on the MAR.

The facility pharmacist was interviewed via telephone on 6/6/19, at 2:07 p.m. and stated Sinemet should be administered within 15 minutes of scheduled administration time to avoid Parkinson symptoms.

The facility Medication Administration policy revised ate 5/2019, indicated medications would be administered to residents as prescribed by the primary care provider and that medications would

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F 755	Continued From page 46	F 755		

be administered one hour before or after scheduled administration time. The policy further indicated medication administration is to be documented promptly after administration.

R133
On 6/5/19, at 10:42 a.m. during a medication administration pass observation for R133; the following medications were administered: aspirin, citalopram (antidepressant), eliquis (anticoagulant), metoprolol (treats high blood pressure), and multivitamin.

R133's Physician Order Report dated 6/1/19, through 6/5/19, included the following medications to be administered at 8:00 a.m. aspirin, metoprolol, multivitamin and eliquis. The report indicated citalopram was to be administered daily at 7:30 a.m..

R81
On 6/5/19, at 10:50 a.m. during a medication administration pass observation for R81; the following medications were administered: diltiazem (treats high blood pressure), Flonase (treats allergies), fluoxetine (anti-depressant), furosemide (diuretic), metoprolol, omeprazole (treats acid reflux), Qvar inhaler (treats asthma), spironolactone (diuretic), tums (anti-acid) and acetaminophen (analgesic).

R81's Physician Order Report dated 6/1/19, through 6/5/19, included the following medications to be administered at 8:00 a.m. omeprazole, tums, fluoxetine, Flonase, acetaminophen, diltiazem, metoprolol, furosemide, spironolactone, and Qvar inhaler.

TMA-B was interviewed on 6/5/19, at 10:54 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245242	A. BUILDING _____ B. WING _____	C 06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	**1007 EAST 14TH STREET MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 47 and verified R133 and R81's medications were administered late and should have been administered no later than 9:00 a.m. however due to one nurse not coming in TMA-B was pulled to administered medications so she got a late start. TMA-B reviewed the work list for the unit and verified five additional resident's names were outlined in red which indicated their medications had not been administered and would be administered late. RN-F was interviewed on 6/6/19, at 8:18 a.m. and confirmed medications should be administered one hour before and no later than one hour after the scheduled administration time. The director of nursing was interviewed on 6/6/19, at 11:40 a.m. and stated it was her expectation for medications to be administered according to the scheduled time. The facility pharmacist was interviewed via telephone on 6/6/19, at 2:07 p.m. and stated it was his expectation for medications to be administered within one hour before or after the scheduled time. The facility Medication Administration policy revised ate 5/2019, indicated medications would be administered to residents as prescribed by the primary care provider and that medications would be administered one hour before or after scheduled administration time.	F 755		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		7/16/19

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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 State and 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 preclude residents from consuming foods not procured by the facility. §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 out 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 opened, not dated, and pork base opened and not dated. DA stated the foods should all be dated and thrown out after seven days. DA verified a sign on the refrigerator that indicated foods should be thrown out seven days after opening. DA verified in the walk in freezer three containers of mint ice	F 812	F812 It is the policy of the Augustana Health Care Center to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Corrective Action Food Service Director completed an audit of all kitchen areas to ensure compliance with proper storage and dating of all food items. Identified tomato product was discontinued due to possible confusion with dating, alternate product will be acquired Identification of Other Residents Food Service Director will be auditing 2 times weekly for he next 30 days to ensure compliance with proper food storage and dating for all kitchen areas	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245242	A. BUILDING _____ B. WING _____	C 06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

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F 812	Continued From page 49 cream opened, covers not secured with dates opened 11/14/18, 2/15/19, and 4/10/19. DA stated she was going to dispose of the ice cream. DA verified a bag of french toast, opened and undated. DA tossed the bag of the french toast into the garbage and stated it should have been dated to know how long it had been opened. DA verified in the walk in cooler four mighty shakes and five juices without a label indicating when had been placed in the cooler from the freezer. DA stated shakes were to be labeled and disposed of on the 14th day after placing in the cooler. DA verified in the cooler a box of 28 tomato juice cups with the outside of the box label indicating "KEEP FROZEN". DA stated the tomato juice cups were placed in the cooler 4/26/19, and would needed to be disposed as were only good for 14 days after thawing. On 6/3/19, at 7:57 a.m. cook stated the turkey slices were good for seven days after opened. Cook stated he did not know how long the pork base was good for after opened. On 6/3/19, at 8:32 a.m dietary aide was making up trays with food for the residents and verified trays that had six juices and three mighty shakes on them unlabeled and not dated when placed in cooler. Dietary aide stated evening shift made up the trays and labeled the drinks. Dietary aide took the juices and shakes off the trays and threw in the garbage can. On 6/3/19, at 8:28 a.m. dietitian stated turkey slices were good for seven days, mayonnaise good for two to three months after opened, french toast when dated was good up to 12 months, and ice cream when the covers were on tight were good up to 12 months. Dietitian stated she would	F 812	and food items. Measures Put in Place All dietary employees were educated with a read and sign document on proper food storage and dating 7-15-19 Monitoring Mechanisms: Unplanned audits of the kitchen for proper food storage and dating of food items will be conducted by QAPI committee members at random times and days 4 times monthly for the next 90 days. The QAPI committee will review audits to ensure compliance with proper food storage and dating per facility policy and standards of practice on or before: 7-31-19 8-31-19 9-30-19 Responsible Person/s Director of Food Service or Designee Assistant Administrator/Director of Quality Improvement 7-16-19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 50 ask the manufacturer about the pork base. Dietitian stated the mighty shakes and tomato juice were good for 14 days after thawing and then needed to be disposed. Facility policy was requested, not made available.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		7/16/19

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F 880	Continued From page 51 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement procedures to sanitize multi resident use glucometer between	F 880	F880 It is the policy of the Augustana Health Care Center to maintain an infection	

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F 880	Continued From page 52 resident use for 2 of 2 residents (R91, R23) observed for glucometer cleaning. Findings include: On 6/4/19, at 5:13 p.m. licensed practical nurse (LPN)-A was observed to use the glucometer to obtain a drop of blood and record the blood sugar of R91. Following the procedure LPN-A removed a Sani-hands from a blue top container and wrapped the glucometer in the wipe. At 5:21 p.m. LPN-A was observed to remove the Sani-hands from the glucometer and proceed to use the glucometer to obtain a drop of blood and record the blood sugar of R23. Following the procedure LPN-A removed a Sani-Wipe from a blue top container and wrapped the glucometer in the wipe. LPN-A stated he was to use the wipes with sanitizer and keep the glucometer wrapped in the wipe for five minutes. LPN-A verified the PDI Sani-hands were the correct wipes to use. Assistant director of nursing (ADON) was notified by the surveyor on 6/4/19, at 5:39 p.m. that LPN-A had used the Sani-hands wipes to cleanse the glucometer between residents. ADON verified those were not the correct wipes and identified sanitizing wipes should have been used. The facility policy Clean-disinfect glucometer dated 11/13/18, indicated the glucometer was to be sanitized with sanitizing wipes.	F 880	prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. Corrective Action: Employee involved in the identified incident was immediately re-education on 6-4-19 Identification of Other Residents ADON immediately checked all glucometer carts to ensure proper sanitizing product was being used and place on all carts. Measures Put in Place: Mandatory education for all Nursing staff will be conducted on proper sanitizing product for disinfecting glucometers and related infection control procedures. 7-15-19 Monitoring Mechanisms: Infection Control Nurse will inspect glucometer carts 2 times weekly for the next 30 days and then 1 time weekly for the next 60 days to ensure compliance with use of proper sanitizing product. Infection Control Nurse will do 10% random audits of nurses to ensure proper infection control procedures are being followed in regards to cleaning of glucometers will be conducted monthly for the next 90 days. The QAPI committee will review audits for compliance with facility infection control procedures related to cleaning and use of glucometers on or before: 7-31-19 8-31-19 9-30-19	

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F 880	Continued From page 53	F 880	Responsible Person/s Infection Control Preventionist Director of Nursing or Designee Assistance Administrator/Quality Improvement Director 7-16-19	

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	245242	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/05/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	**1007 EAST 14TH STREET MINNEAPOLIS, MN 55404**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. 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	K 000	EPOC	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 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.	K 000		

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	245242	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/05/2019**

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K 000	Continued From page 2 The facility is fully protected throughout by an automatic fire sprinkler systems and has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that are monitored for automatic fire department notification. The facility has a capacity of 250 beds and had a census of 217 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, that the facility has failed to install the facility's heating and ventilation in accordance with the NFPA Life Safety Code 101 2012 edition section 19.5.2.1 and NFPA 90A 19.5.2.2. This deficient practice could effect 250 of 250 residents. Findings include: On facility tour between 9:00 a.m. and 1:00 p.m.,	K 521	See Attached waiver and supporting documents for K521	7/16/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 521	Continued From page 3 it was observed and confirmed by interview, with the Director of Maintenance that the corridors located throughout the main building of the facility are being used as an exhaust air plenum. This deficient practice was confirmed by the Maintenance Supervisor.	K 521		

Name of Facility **2012 LIFE SAFETY CODE**

Augustana HCC MPLS

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	An annual/continuing waiver is being requested for K521. A. Compliance with this provision will cause an unreasonable hardship because: 1. The most recent cost estimate dated April 19, 2019 for a complying ducted HVAC system is $2,181,000.00 (See attached letterhead from Metropolitan Mechanical for costs and scope of project work) 2. This project would displace residents for several months, many would need to be transferred out to other facilities as we rarely have available beds in the facility due to census of 90% or higher as a monthly average. This displacement of residents would cause significant emotional distress to residents which could also affect their physical health status in many cases 3. Other projects that would need to occur to support this HVAC system replacement include but are not limited too: a. The building electrical system would need to be upgraded to support a new ducted system. b. The system would also require a new meter at additional costs to the ducted HVAC bid. c. Installation of a ducted system would require asbestos abatement which would also increase the cost. Under the current CMS reimbursement system our costs could not be re-coup as we currently operate at a loss.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date
[signature] 12/24/	Fire Safety Supervisor	MN State Fire Marshal	07-08-2019

Name of Facility	**2012 LIFE SAFETY CODE**
Augustana HCC MPLS	

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	An annual/continuing waiver is being requested for K521. A. Compliance with this provision will cause an unreasonable hardship because: 1. The most recent cost estimate dated April 19, 2019 for a complying ducted HVAC system is $2,181,000.00 (See attached letterhead from Metropolitan Mechanical for costs and scope of project work) 2. This project would displace residents for several months, many would need to be transferred out to other facilities as we rarely have available beds in the facility due to census of 90% or higher as a monthly average. This displacement of residents would cause significant emotional distress to residents which could also affect their physical health status in many cases 3. Other projects that would need to occur to support this HVAC system replacement include but are not limited too: a. The building electrical system would need to be upgraded to support a new ducted system. b. The system would also require a new meter at additional costs to the ducted HVAC bid. c. Installation of a ducted system would require asbestos abatement which would also increase the cost. Under the current CMS reimbursement system our costs could not be re-coup as we currently operate at a loss.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date
[signature] 12/24	Fire Safety Supervisor	MN State Fire Marshal	07-08-2019

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	An annual/continuing waiver is being requested for K521. A. Compliance with this provision will cause an unreasonable hardship because: 1. The most recent cost estimate dated April 19, 2019 for a complying ducted HVAC system is $2,181,000.00 (See attached letterhead from Metropolitan Mechanical for costs and scope of project work) 2. This project would displace residents for several months, many would need to be transferred out to other facilities as we rarely have available beds in the facility due to census of 90% or higher as a monthly average. This displacement of residents would cause significant emotional distress to residents which could also affect their physical health status in many cases 3. Other projects that would need to occur to support this HVAC system replacement include but are not limited too: a. The building electrical system would need to be upgraded to support a new ducted system. b. The system would also require a new meter at additional costs to the ducted HVAC bid. c. Installation of a ducted system would require asbestos abatement which would also increase the cost. Under the current CMS reimbursement system our costs could not be re-coup as we currently operate at a loss.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date
[signature] 12/4/24	Fire Safety Supervisor	MN State Fire Marshal	07-08-2019

Name of Facility **2012 LIFE SAFETY CODE**

Augustana HCC MPLS

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	An annual/continuing waiver is being requested for K521. A. Compliance with this provision will cause an unreasonable hardship because: 1. The most recent cost estimate dated April 19, 2019 for a complying ducted HVAC system is $2,181,000.00 (See attached letterhead from Metropolitan Mechanical for costs and scope of project work) 2. This project would displace residents for several months, many would need to be transferred out to other facilities as we rarely have available beds in the facility due to census of 90% or higher as a monthly average. This displacement of residents would cause significant emotional distress to residents which could also affect their physical health status in many cases 3. Other projects that would need to occur to support this HVAC system replacement include but are not limited too: a. The building electrical system would need to be upgraded to support a new ducted system. b. The system would also require a new meter at additional costs to the ducted HVAC bid. c. Installation of a ducted system would require asbestos abatement which would also increase the cost. Under the current CMS reimbursement system our costs could not be re-coup as we currently operate at a loss.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date
[signature] 12424	Fire Safety Supervisor	MN State Fire Marshal	07-08-2019

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program

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

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HEALTH CARE CENTER OF MIN	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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. State licensing orders are delineated on 2567, under the Minnesota Department of Health	2 000		

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2 000	Continued From page 1 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, 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, H5242119C. H5242120C was substanitated no deficiencies issued. H5242122C was substantiated and a deficiecny was issued at 1995. H5242121C was unsubstantiated with a deficiency issed at 2000. H5242119C was substantiated at 0800, 1525 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 found out of compliance is listed in the "Summary Statement of Deficiencies"	2 000		

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2 000	Continued From page 2 column, and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidence by ...". Following the surveyors findings are the " Suggested Method of Correction " and the "Time Period for Correction " . PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN, WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention;	2 265		7/16/19

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2 265	Continued From page 3 B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify the primary care provider regarding the development of a facility acquired sacral pressure ulcer for 1 of 1 resident (R9) reviewed for pressure ulcer. Findings include: R9's quarterly Minimum Data Set (MDS) dated 3/2/19, identified R9 had intact cognition and did not reject cares during the reference period. The MDS indicated R9 required extensive assistance with bed mobility and total dependence for toileting needs. The MDS indicated R9 was at risk for pressure ulcers and had a pressure reducing device for his chair and bed. R9's Pressure Ulcer Care Area Assessment dated 6/10/18, indicated R9 was at risk for skin breakdown and had a history of pressure ulcers.	2 265	Corrected	

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2 265	Continued From page 4 R9's Skin Risk/ Wound Care Plan edited 6/5/19, indicated R9 was at risk for skin impairment and directed staff to offer R9 to lay in bed with 30 degree wedge document refusals, air mattress, pressure mapping completed 5/30/19, wound care per orders, adjust position in wheelchair every hour, glidewear shorts, turn and reposition every 2-3 hours and pressure relieving wheelchair cushion. R9's progress notes (PN), skin observations and treatment administration record (TAR) were reviewed from 4/1/19, through 6/5/19, and indicated the following: -The skin observation dated 4/29/19, indicated "has a new pressure sore in back and coccyx area," however lacked evidence of assessment, measurements, interventions, provider notification or treatments; -The TAR dated 4/1/19, through 4/30/19, lacked evidence of wound care treatments; -The TAR dated 5/1/19, through 5/31/19, indicated wound care to right buttock pressure injury which start date 5/6/19, discontinue date 5/8/19. A subsequent order included wound care lower right side of sacrum start date 5/7/19; -The PN dated 5/7/19, identified R9 had a new pressure injury of the right sacrum provider updated on 5/7/19. R9's medical record lacked evidence regarding physician notification of the pressure ulceration noted on 4/29/19. R9 was interviewed on 6/4/19, at 12:30 p.m. and stated he had a sore on his bottom. RN-C was interviewed on 6/5/19, at 9:38 a.m. and confirmed R9's skin observation dated 4/29/19, indicated R9 had a pressure ulcer. RN-C	2 265		

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2 265	Continued From page 5	2 265		

stated the wound nurse first assessment the wound was completed on 5/7/19, and was unable to find wound care orders and/ or documentation if the physician was updated from 4/29/19, through 5/6/19, in R9's medical record.

RN-E was interviewed on 6/5/19, at 9:51 a.m. and stated they were not aware R9's sacrum pressure ulcer until 5/6/19. RN-E stated once they were notified a resident had a new open area they were to see them within 24 hours. RN-E explained she updated R9's physician on 5/7/19, and obtained treatment orders after assessment 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.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or their designee could develop /revise policies related to notification of physician with changes and educate all facility staff on those policies. DON and/or designee could conduct resident interviews and complete audits to ensure physicians are being notified to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty-one

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2 265	Continued From page 6 (21) days	2 265		
2 430	MN Rule 4658.0210 Subp. 1 Room Assignments Subpart 1. Room assignments and furnishings. A nursing home must attempt to accommodate a resident's preferences on room assignments, roommates, and furnishings whenever possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were accessible for 2 of 2 residents (R20, R174) who were capable of using the call light. Findings include: R20's quarterly Minimum Data Set (MDS) dated 3/5/19, indicated R20's cognition was impaired and R20 needed extensive assistance with transfers. On 6/5/19, at 10:07 a.m. R20 was sitting back in her recliner calling out for toast and egg. Surveyor walked into the room and observed R20's call light approximately 20 feet from resident placed in the bottom of a flower vase on a stand next to the bed. R20 was interviewed and stated she did not know where her call light was and was unable to get out of her chair. R20 stated she wanted some juice. On 6/5/19, at 10:14 a.m. nursing assistant (NA)-K walked into R20's room and verified R20's call light in the vase. NA-K stated she must have forgotten to put the call light on R20's recliner where she could reach it. NA-K stated R20 was	2 430	Corrected	7/16/19

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2 430	Continued From page 7 able to use her call light, has used her call light and stated call light was supposed to be in the resident reach. NA-K handed the call light to R20 and she pressed the call light button a couple of times and activated it. On 6/5/19, at 11:07 a.m. licensed practical nurse (LPN)-B stated she expected residents' call lights to be within reach for the residents who can 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. R174's care plan dated 11/20/18, included: Impaired self-performance with bathing due to multiple fractures, range of motion limitations. R174's progress note dated 5/29/19, at 1:56 p.m. included R174 was alert and oriented and used call light effectively. Clinical manager (CM)-A stated on 6/6/19, at 8:29 a.m. her expectation would be for staff to ensure all resident's call lights were in the proper place before leaving the room and R174 was capable of using his call light.	2 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 430	Continued From page 8 The director of nursing stated on 6/6/19, at 10:48 a.m. her expectation would be for call lights to be within reach for all facility residents. The facility's call light policy dated 12/31/18, directed staff to place call light so it would be accessible to the resident at all times when in resident room. Secure the call light to stay within 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.	2 430		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by:	2 800		7/16/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 800	Continued From page 9 Based on observation, interview and document review, the facility failed to ensure sufficient staff was available to meet resident needs related to assistance of 1 of 2 residents (R187) reviewed for activities of daily living (ADL) of the dependent resident and 3 of 3 residents (R89, R133, R81) reviewed for medication administration. In addition, the facility failed to ensure wound care was provided per physician orders for 1 of 1 residents (R9) reviewed for pressure ulcer. Findings include: 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 assist off of the bedpan. R187 identified he was left on the bedpan "over one hour" and had fallen back to sleep due to waiting so long. R187 stated this was not the first time this had happened and he had complained to nursing staff, however he would be told "we are just short of help." Nursing Assistant (NA)-D was interviewed on 6/3/19, at 12:04 p.m. and confirmed four east unit was "short today" due to only 3 NA today with a ratio of 1:12 versus 1:9 when 4 NA were present. NA-D verified R187 had to wait for assistance due to the needs of other resident and when she had arrived to his room around 7:15 a.m. she found R187 in bed seated on the bedpan with dry BM on his buttocks. NA-D explained she was	2 800	Corrected	

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	00164	A. BUILDING: _____ B. WING _____	C 06/06/2019

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AUGUSTANA HEALTH CARE CENTER OF MIN	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

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2 800	Continued From page 10	2 800		

unsure when R187 was assisted onto the bedpan and further stated the overnight shift did not report to her R187 would need assist as he was currently utilizing the bed pan. NA-D stated she had to "use extra wipes" due to the BM dried onto R187's buttocks. NA-D stated the overnight shift typically left at 6:30 a.m.

R89 was interviewed on 6/3/19, at 7:55 a.m. and stated he had not been receiving his Sinemet timely per his neurologist orders. R89 stated the late administration resulted in neck and shoulder spasms.
R89's Physician Order Report dated 5/6/19, through 6/6/19, included Sinemet to be administered at 6:00 a.m., 9:00 a.m., 12:00 p.m., 3:00 p.m., 6:00 p.m. and 8:00 p.m. for Parkinson disease.
R89's medication administration record (MAR) was reviewed 3/1/19, through 6/5/19, and revealed the following:
-3/1/19, through 3/31/19, MAR indicated R89 did not receive his Sinemet five times due to "resident unavailable," four times administered late due to "helping with cares," 18 times administered late due to "charted late" and one time the medication was not administered due to "drug/ item unavailable;"
-4/1/19, through 4/30/19, MAR indicated R89 did not receive his Sinemet once due to "resident unavailable," three times administered late due to "helping with cares," nine times "administered late," 11 times administered late due to "charted late" and twice the medication was not administered due to "drug/ item unavailable;"
-5/1/19, through 5/31/19, MAR indicated R89 did not receive his Sinemet once due to "resident unavailable," administered late once due to "helping with cares," twice "administered late," 10 times administered late due to "charted late;"

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2 800	Continued From page 11 -6/1/19, through 6/5/19, MAR indicated R89 administered late once due to "charted late." The trained medication aide (TMA)-A was interviewed on 6/4/19, at 6:08 p.m. and explained when a medication was administered beyond one hour after the scheduled time the MAR would prompt her to indicate a reason it was administered late. TMA-A indicated when the unit was "short" staffed with 3 nursing assistants (NA) opposed to 4 NA's it was the expectation of the facility for the TMA to assist with resident cares. TMA-A stated this would cause her to run behind when administering medications causing medications to be administered late. TMA-A verified in R89's MAR when documented "helping with cares" was times the unit only had 3 NAs and she needed to help with resident cares so R89's Sinemet was administered over an hour beyond the scheduled time. R133 On 6/5/19, at 10:42 a.m. during a medication administration pass observation for R133; the following medications were administered aspirin, citalopram (antidepressant), eliquis (anticoagulant), metoprolol (treats high blood pressure), and multivitamin. R133's Physician Order Report dated 6/1/19, through 6/5/19, included the following medications to be administered at 8:00 a.m. aspirin, metoprolol, multivitamin and eliquis. The report indicated citalopram was to be administered daily at 7:30 a.m. R81 On 6/5/19, at 10:50 a.m. during a medication administration pass observation for R81; the following medications were administered	2 800		

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2 800	Continued From page 12 diltiazem (treats high blood pressure), Flonase (treats allergies), fluoxetine (anti-depressant), furosemide (diuretic), metoprolol, omeprazole (treats acid reflux), Qvar inhaler (treats asthma), spironolactone (diuretic), tums (anti-acid) and acetaminophen (analgesic). R81's Physician Order Report dated 6/1/19, through 6/5/19, included the following medications to be administered at 8:00 a.m. omeprazole, tums, fluoxetine, Flonase, acetaminophen, diltiazem, metoprolol, furosemide, spironolactone, and Qvar inhaler. TMA-B was interviewed on 6/5/19, at 10:54 a.m. and verified R133 and R81's medications were administered late and should have been administered no later than 9:00 a.m. however due to one nurse not coming in TMA-B was pulled to administered medications so she got a late start. TMA-B reviewed the work list for the unit and verified five additional resident's names were outlined in red which indicated their medications had not been administered and would be administered late. R9 R9 was interviewed on 6/4/19, at 12:30 p.m. and stated he had a sore on his bottom. R9 explained the overnight shift have not had enough help so they leave him in his wet "diaper" all night "that's how I got this sore." R9 stated during the evening hour when you ask for help everybody would say "we are short, we are short" which resulted in having to wait to be changed or helped multiple times. During a subsequent interview on 6/5/19, at 8:11 a.m. R9 stated his dressing to his pressure ulcer had not been changed and he wondered why. R9 stated he thought his dressing was to be changed daily.	2 800		

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2 800	Continued From page 13 On 6/5/19, at 9:19 a.m. registered nurse (RN)-C and RN-D were observed turning R9 onto his left side. RN-C confirmed R9's dressing that covered his sacrum wound was dated 6/3/19. RN-C was interviewed on 6/5/19, at 9:38 a.m. and verified the nurse on 6/4/19, did not change R9's dressing per orders and documented not completed the "nurse got too busy." RN-C stated it was her expectation if the nurse was too busy that the next shift would have completed the dressing change. R9's skin observations and treatment administration record (TAR) was reviewed from 5/1/19, through 6/5/19, and indicated the following: - The TAR dated 5/1/19, through 5/31/19, indicated wound care lower right side of sacrum start date 5/7/19, however indicated "not completed due to workload" on 5/15/19. Staff member who documented on TAR regarding unable to complete due to workload on 5/15/19, was unavailable for interview. -The TAR dated 6/1/19, through 6/5/19, indicated wound care lower right side of sacrum, however indicated "not completed due to workload" on 6/4/19. Staff member who documented on TAR regarding not completed due to workload on 6/4/19, was unavailable for interview. The facility staff coordinator (SC) was interviewed on 6/6/19, at 10:33 a.m. and stated the facility had 30 positions open between nurses and nursing assistants. The SC stated they had been offering pick up bonuses and working on their recruitment efforts. The SC explained the 4 east long term care unit with a census of 36 were to have 1 nurse, 1 TMA, 4 NA's when fully staffed.	2 800		

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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 compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	2 800		

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2 830	Continued From page 15	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and complete ongoing monitoring and evaluation for safe smoking for 1 of 3 residents (R130) reviewed for smoking. Findings Include: R130's diagnosis included dementia without behavioral disturbances, vascular dementia, altered mental status, nicotine dependence and dependence on supplemental oxygen. R130's annual Minimum Data Set (MDS) dated 8/10/18, identified R130 was a smoker. A Care Assessment Area (CAA) related to smoking was not completed. A smoking assessment, dated 2/14/19, noted	2 830	Corrected	7/16/19

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2 830	Continued From page 16 R130 had actual alteration in behavior which included smoking in unsafe areas. Another smoking assessment dated 4/29/19, indicated R130 had impaired cognition and refused to participate in the smoking assessment. The assessment directed staff set-up R130's smoking material and to keep her smoking materials at the nursing station. A smoking care plan, edited 6/4/19, identified R130 had been observed smoking in non-designated areas (2016). Burn hole found in clothing due to movement when smoking. Resident is able to smoke independently with a smoking apron. A cognition care plan, revised 6/5/19, identified R130 made poor healthcare decisions and was unable to foresee consequences of decisions with moderately impaired cognition. The Care plan also noted R130 had a history of lacking personal safety awareness especially related to smoking and consequences of smoking in undesignated areas. R130 was observed in her bed on 6/4/19, at 1:05 p.m. When asked, R130 stated she smoked cigarettes and was allowed to independently manage her smoking supplies, including lighters. R130 untied a plastic bag placed on her wheelchair next to her bed. R30 opened the bag and exposed four disposable lighters, two opened packs of cigarettes and one unopened pack of cigarettes. Registered nurse (RN-I) was interviewed on 6/4/19, at 1:27 p.m. and stated R130 smoked either in the smoking room in the facility or the designated smoking area in the front of the building. RN-I further explained R130 was deemed to be safe while smoking and did not have any safety precautions in place related. RN-I	2 830		

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2 830	Continued From page 17 stated R130 kept her cigarettes and lighters with her and staff did not monitor R130 while smoking or monitor her smoking materials. On 6/4/19, at 1:31 p.m. a RN-H stated R130 was safe to smoke and keep her smoking supplies in her room. RN-H further explained the therapeutic recreation (TR) department was in charge of conducting smoking assessments for residents who smoked. RN-H stated TR would alert nursing with changes or problems found during a smoking assessment. RN-H stated smoking assessments were done quarterly and as needed. At 1:45 p.m. RN-H verified R130 had four disposable lighters, two opened packs of cigarettes and two unopened packs of cigarettes her room RN-H stated R130 was a "safe smoker" and was not aware of a smoking assessment that indicated R130 was not safe to smoke without safety precautions in place. R130 was observed in her bed on 6/5/19, at 6:18 a.m. R130's smoking supplies were in her wheelchair which was placed next to her bed. At 7:42 a.m. R130 was observed smoking a lit cigarette while sitting in a chair in the designated facility smoking room. R130's wheelchair was next to her. A smoking apron (an over-garment designed to be worn while smoking tobacco intended for individuals who smoke and require a protective shield from hot ashes and dropped cigarettes) was folded over the back of R130's wheelchair. A bag of smoking materials was on R130's wheelchair seat. Staff was not present in or near the smoking room. A total of four residents were smoking in the room. The receptionist (R-A) was interviewed on 6/5/19, at 7:47 a.m. and stated although the she was able to visualize the smoking room by video	2 830		

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2 830	Continued From page 18	2 830		

camera from the reception area, she was unable to monitor if a resident was wearing a smoking apron. R-A further explained she did not know who what residents were identified as needing to wear an apron while smoking because the staff had never addressed it with her. R-A was unaware if the facility monitored residents' smoking habits on a regular basis.

On 6/5/19, at 7:52 a.m. R130 was observed in the facility smoking room. R130 was wearing a smoking apron. At 8:02 a.m. R130 stated she was given a smoking apron "yesterday", which she kept it on the back of her wheelchair. At 8:21 a.m. was continued to smoke in the designated smoking room. R130 had a smoking apron in place. Ashes from R130's cigarette were noted on the apron.

The director of therapeutic recreation (DTR) stated on 6/6/19, at 9:19 a.m. that although TR was in charge of completing resident smoking assessments, there was not a system to alert staff or implement findings. The DTR stated when a resident was found to be "unsafe while smoking, a smoking apron was put on and most kept it on all day." The DTR stated staff did not monitor this practice and the facility did not have a policy in place.

RN-H was interviewed on 6/6/19, at 9:25, and stated R130 was assessed by the TR department to need an apron on when smoking, however RN-H did not receive this information and therefore did not put it on the NA care sheets. RN-H further stated the facility did not have a system in place to ensure R130 had a smoking apron applied when she smoked. RN-H further verified R130 continued to keep her cigarettes in her procession and staff did not intervene.

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2 830	Continued From page 19 The director of nursing (DON) stated on 6/6/19, at 10:20 a.m. that if staff put smoking interventions in place for a resident who had been assessed to be at risk while smoking, these interventions should be followed by the staff. The DON further stated the facility should have a system in place to ensure safety and compliance. The DON concluded, "A good first step would be to monitor their smoking supplies. We need to take a look at that." A nursing progress note (PN), dated 6/5/19, noted R130 had burn holes in her clothing but was able to smoke independently when wearing a smoking apron, The PN directed staff to "encourage" R130 to "use it." The current nursing assistant (NA) care sheet, undated, did not identify R130 was a smoker or direct staff to "encourage" the use of a smoking apron. The Cassia, an Augustana/Elim Affiliation, care plan policy, dated 12/5/19, stated a resident who smokes will be assessed for safe smoking practices and would indicate if cognitive function require smoking materials be kept in a secured area. The policy also stated if a resident was assessed to be unsafe in their smoking practices, interventions may be put in place which included: use of a smoking apron, use of adaptive cigarette holders or ash trays, supervised smoking, and rationed smoking materials and/or kept at the nursing station. The policy lacked direction for monitoring these interventions. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure the facility properly assessed residents for safe smoking procedures.	2 830		

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2 830	Continued From page 20 The DON or designee could develop monitoring systems to ensure ongoing compliance and report the results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.]	2 840		7/16/19

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2 840	Continued From page 21 Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely toileting assistance for 2 of 5 residents (R187, R9) reviewed for activities of daily living (ADL) who were unable to perform ADL's and needed staff assistance. Findings include: 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	2 840	Corrected	

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2 840	Continued From page 22 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. R187 identified he was left on the bedpan "over one hour" and had fallen back to sleep due to waiting so long. R187 stated this was not the first time this had happened and he had complained to nursing staff, however he would be told "we are just short of help." Nursing Assistant (NA)-D was interviewed on 6/3/19, at 12:04 p.m. and confirmed four east unit was "short today" due to only 3 NAs working today with a ratio of 1:12 (one NA to 12 residents) versus 1:9 when 4 NAs were present. NA-D verified R187 had to wait for assistance due to the needs of other resident and when she had arrived to his room around 7:15 a.m. she found R187 in bed seated on the bedpan with dry BM on his buttocks. NA-D explained she was unsure when R187 was assisted onto the bedpan and further stated the overnight shift did not report to her R187 would need assist as he was currently utilizing the bed pan. NA-D stated she had to "use extra wipes" due to the BM dried onto R187's buttocks. NA-D stated the overnight shift typically left at 6:30 a.m.. NA-E was interviewed on 6/5/19, at 6:13 a.m. and	2 840		

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2 840	Continued From page 23	2 840		

stated she would typically assist R187 during the overnight shift with his toileting needs between 4:45 a.m. to 5:15 a.m..

The Registered Nurse (RN)-F was interviewed on 6/6/19, at 8:15 a.m. and stated she had been made aware that R187 had been left on the bedpan on 6/3/19, and was looking into what had happened. RN-F explained it was her expectation staff to communicate between shifts when a resident was using the bedpan.

The director of nursing was interviewed on 6/6/19, at 11:40 a.m. and stated it was her expectation for residents toileting needs to be communicated during shift to shift report.

A facility policy regarding ADL for a dependent resident was requested but not provided.

R9's quarterly Minimum Data Set (MDS) dated 3/2/19, identified R9 had intact cognition and did not reject cares during the reference period. The MDS indicated R9 had total dependence for toileting.

R9's Urinary Incontinence Care Area Assessment dated 6/10/18, indicated R9 was incontinent of bladder and needed total assist with toileting needs.

R9's Elimination Care Plan edited 3/7/19, identified R9 was incontinent of bladder and directed staff to offer urinal upon arising, before and after meals, at bedtime and night rounds and to check and change with morning and bedtime cares, night rounds and every 2 hours as needed.

R9 was interviewed on 6/4/19, at 12:30 p.m. and

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2 840	Continued From page 24	2 840		

stated the overnight shift never has enough help so they leave him in his wet "diaper" all night "that's how I got this sore." R9 stated during the evening hour when you ask for help everybody would say "we are short, we are short" which resulted in having to wait to be changed or helped multiple times.

On 6/5/19, at 6:21 a.m. during a continuous observation from 6:21 a.m. through 9:00 a.m. R9's cares were observed. At 6:21 a.m. R9 was observed lying in bed on his back on top of an air mattress sleeping and his head of bed elevated. At 8:09 a.m. R9 used the call light to ask what time his appointment was today; registered nurse (RN)-F notified R9 of his appointment time, however R9 was not offered to use of urinal and/ or check and change. At 8:20 a.m. nursing assistant (NA) entered room to assist R9 with breakfast and left R9's room at 8:47 a.m.. No urinal use and/ or check and change were offered during this time. At 9:00 a.m. NA-B and NA-C were observed to remove R9's brief. NA- B confirmed R9's incontinent brief was wet with urine.

NA-A was interviewed on 6/6/19, at 8:43 a.m. and stated per their NA group sheet R9 was to be checked and changed every 2 hours and as needed. NA-A stated R9 was typically toileted before breakfast then at around 11:00 a.m. and then at around 1:00 p.m..

RN-F was interviewed on 6/6/19, at 8:48 a.m. and stated R9 was to be checked and changed every 2 hours and as needed.

The director of nursing was interviewed on 6/6/19, at 11:40 a.m. and stated it was her expectation to toilet residents per their care plan.

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2 840	Continued From page 25 A facility policy regarding ADL for a dependent resident was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring incontinence care is provided for each individual resident . The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.	2 900		7/16/19

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2 900	Continued From page 26 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement interventions to promote healing of a facility acquired sacrum pressure ulcer for 1 of 1 resident (R9) reviewed for pressure ulcer. Findings include: R9 was interviewed on 6/4/19, at 12:30 p.m. and stated he had a sore on his bottom. R9 explained the overnight shift have not had enough help so they leave him in his wet "diaper" all night "that's how I got this sore." R9 stated during the evening hour when you ask for help everybody would say "we are short, we are short" which resulted in having to wait to be changed or helped multiple times. On 6/5/19, at 6:21 a.m. during a continuous observation from 6:21 a.m. through 9:00 a.m. R9's cares were observed. At 6:21 a.m. R9 was observed to be lying in bed on his back on top of air mattress sleeping and his head of bed elevated. At 8:09 a.m. R9 pushed call light to ask what time his appointment was today. R9 was interviewed at 8:11 a.m. and stated his dressing to his pressure ulcer had not been changed and he wondered why. R9 stated he thought his dressing was to be changed daily. At 9:00 a.m. nursing assistant (NA)-B and NA-C were observed completing pericares. R9 was observed to have two draw sheets, one pillow under right hip, incontinent pas and a towel under his lower back and bottom area; NA-B verified the items were supposed to be under R9 while in bed. On 6/5/19, at 9:19 a.m. RN-C and RN-D were observed turning R9 onto his left side. RN-C	2 900	Corrected	

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2 900	Continued From page 27 confirmed R9's dressing that covered his sacrum wound was dated 6/3/19. RN-C measured R9's sacrum wound which was 1.8 centimeters (CM) in length by 1.4 cm width and noted 100% slough (dead tissue) in the wound bed and visual depth 0.4 cm. RN-C stated there was a mild malodor noted when the dressing was removed. RN-C stated there was moderate serous exudate noted on the dressing that was removed. RN-C was interviewed on 6/5/19, at 9:38 a.m. and verified the wound was slightly larger than last week's measurements which were 1.5 cm by 1.3 cm and only had small amount of drainage and now had moderate with seropurulent (mix of watery fluid and pus) drainage and odor which she would consider a decline and planned to contact the provider for new orders. RN-C explained R9's dressing was to be changed daily due to the Santyl (medication) that was to be placed in the wound bed daily. RN-C verified the nurse on 6/4/19, did not change R9's dressing per orders and documented not completed the "nurse got too busy." RN-C stated it was her expectation if the nurse was too busy that the next shift would have completed the dressing change. RN-C verified R9 had two draw sheets, one incontinent pad and two towels behind R9's bottom area. RN-C indicated R9's air bed should not have had extra on the top of it and should only have had one draw sheet and one incontinent pad but no towels. RN-C confirmed R9's skin observation dated 4/29/19, indicated R9 had a pressure ulcer. RN-C stated the wound nurse first assessment the wound on 5/7/19, and was unable to find wound care orders from 4/29/19, through 5/6/19, in R9's medical record. RN-E was interviewed on 6/5/19, at 9:51 a.m. and stated they were not aware R9's sacrum pressure	2 900		

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2 900	Continued From page 28	2 900		

ulcer until 5/6/19. RN-E stated once they were notified a resident had a new open area they were to see them within 24 hours. RN-E explained she updated R9's physician on 5/7/19, and obtained treatment orders after assessment of the wound.

R9's quarterly Minimum Data Set (MDS) dated 3/2/19, identified R9 had intact cognition and did not reject cares during the reference period. The MDS indicated R9 required extensive assistance with bed mobility and total dependence for toileting needs. The MDS indicated R9 was at risk for pressure ulcers and had a pressure reducing device for his chair and bed.

R9's Pressure Ulcer Care Area Assessment dated 6/10/18, indicated R9 was at risk for skin breakdown and had a history of pressure ulcers.

R9's Skin Risk/ Wound Care Plan edited 6/5/19, indicated R9 was at risk for skin impairment and directed staff to offer R9 to lay in bed with 30 degree wedge, document refusals, air mattress, pressure mapping completed 5/30/19, wound care per orders, adjust position in wheelchair every hour, glidewear shorts, turn and reposition every 2-3 hours and pressure relieving wheelchair cushion.

R9's skin observations and treatment administration record (TAR) was reviewed from 4/1/19, through 6/5/19, and indicated the following:
- The skin observation dated 4/29/19, indicated "has a new pressure sore in back and coccyx area," however lacked evidence of assessment, measurements, interventions and treatment, or provider notification.
- The TAR dated 4/1/19, through 4/30/19, lacked

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2 900	Continued From page 29 evidence of wound care treatments; - The TAR dated 5/1/19, through 5/31/19, indicated wound care to right buttock pressure injury which start date 5/6/19, discontinue date 5/8/19. A subsequent order included wound care lower right side of sacrum start date 5/7/19, however indicated "not completed due to workload" on 5/15/19; -The TAR dated 6/1/19, through 6/5/19, indicated wound care lower right side of sacrum, however indicated "not completed due to workload" on 6/4/19. The director of nursing (DON) 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 utilize the standing house orders and implement a treatment then they should update the wound nurse so the wound can be thoroughly assessed that day or the next. The DON further stated it was her expectation to complete dressing changes per orders. The facility policy Skin Integrity dated 8/6/18, indicated a new wound should have had appropriate treatment wound care initiated into the electronic medical record. The policy further indicated to document the skin alteration and measurements in the electronic medical record and to complete a comprehensive skin risk assessment. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the	2 900		

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2 900	Continued From page 30 delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN 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 out 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 opened, not dated, and pork base opened and not dated. DA stated the foods should all be dated and thrown out after seven days. DA verified a sign on the refrigerator that indicated foods should be thrown out seven days after opening. DA verified in the walk in freezer three containers of mint ice cream opened, covers not secured with dates	21015	Corrected	7/16/19

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21015	Continued From page 31	21015		

opened 11/14/18, 2/15/19, and 4/10/19. DA stated she was going to dispose of the ice cream. DA verified a bag of french toast, opened and undated. DA tossed the bag of the french toast into the garbage and stated it should have been dated to know how long it had been opened. DA verified in the walk in cooler four mighty shakes and five juices without a label indicating when had been placed in the cooler from the freezer. DA stated shakes were to be labeled and disposed of on the 14th day after placing in the cooler. DA verified in the cooler a box of 28 tomato juice cups with the outside of the box label indicating "KEEP FROZEN". DA stated the tomato juice cups were placed in the cooler 4/26/19, and would needed to be disposed as were only good for 14 days after thawing.

On 6/3/19, at 7:57 a.m. cook stated the turkey slices were good for seven days after opened. Cook stated he did not know how long the pork base was good for after opened.

On 6/3/19, at 8:32 a.m dietary aide was making up trays with food for the residents and verified trays that had six juices and three mighty shakes on them unlabeled and not dated when placed in cooler. Dietary aide stated evening shift made up the trays and labeled the drinks. Dietary aide took the juices and shakes off the trays and threw in the garbage can.

On 6/3/19, at 8:28 a.m. dietitian stated turkey slices were good for seven days, mayonnaise good for two to three months after opened, french toast when dated was good up to 12 months, and ice cream when the covers were on tight were good up to 12 months. Dietitian stated she would ask the manufacturer about the pork base. Dietitian stated the mighty shakes and tomato

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21015	Continued From page 32 juice were good for 14 days after thawing and then needed to be disposed. Facility policy was requested, not made available. SUGGESTED METHOD OF CORRECTION: The director of dietary services or designee could development and implement policies and procedures to ensure proper food storage is implemented. The director of dietary services or designee could then educate and monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	21015		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as	21390		7/16/19

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21390	Continued From page 33 defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement procedures to sanitize multi resident use glucometer between resident use for 2 of 2 residents (R91, R23) observed for glucometer cleaning. Findings include: On 6/4/19, at 5:13 p.m. licensed practical nurse (LPN)-A was observed to use the glucometer to obtain a drop of blood and record the blood sugar of R91. Following the procedure LPN-A removed a Sani-hands from a blue top container and wrapped the glucometer in the wipe. At 5:21 p.m. LPN-A was observed to remove the Sani-hands from the glucometer and proceed to use the glucometer to obtain a drop of blood and record the blood sugar of R23. Following the procedure LPN-A removed a Sani-Wipe from a blue top container and wrapped the glucometer in the wipe. LPN-A stated he was to use the wipes with sanitizer and keep the glucometer wrapped in the wipe for five minutes. LPN-A verified the PDI Sani-hands were the correct wipes to use. Assistant director of nursing (ADON) was notified by the surveyor on 6/4/19, at 5:39 p.m. that LPN-A had used the Sani-hands wipes to cleanse	21390	Corrected	

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21390	Continued From page 34 the glucometer between residents. ADON verified those were not the correct wipes and identified sanitizing wipes should have been used. The facility policy Clean-disinfect glucometer dated 11/13/18, indicated the glucometer was to be sanitized with sanitizing wipes. SUGGESTED METHOD FOR CORRECTION: The administrator,director of nursing or designee could develop and implement policies and procedures related to glucometer cleaning. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	21390		
21525	MN Rule 4658.1305 A.B.C Pharmacist Service Consultation A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who: A. provides consultation on all aspects of the provision of pharmacy services in the nursing home; B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained. This MN Requirement is not met as evidenced by: Based on observation, interview and document	21525	Corrected	7/16/19

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AUGUSTANA HEALTH CARE CENTER OF MIN	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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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 medications were 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 4/13/19, identified R89 had intact cognition and diagnosis which included Parkinson disease.

R89 was interviewed on 6/3/19, at 7:55 a.m. and stated he had not been receiving his Sinemet timely per his neurologist orders. R89 stated the late administration resulted in neck and shoulder spasms.

R89's Physician Order Report dated 5/6/19, through 6/6/19, included Sinemet to be administered at 6:00 a.m., 9:00 a.m., 12:00 p.m., 3:00 p.m., 6:00 p.m. and 8:00 p.m. for Parkinson disease.

R89's medication administration record (MAR) was reviewed 3/1/19, through 6/5/19, and revealed the following:
-3/1/19, through 3/31/19, MAR indicated R89 did not receive his Sinemet five times due to "resident unavailable," four times administered late due to "helping with cares," 18 times administered late due to "charted late" and one time the medication was not administered due to "drug/ item unavailable;"
-4/1/19, through 4/30/19, MAR indicated R89 did not receive his Sinemet once due to "resident unavailable," three times administered late due to

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"helping with cares," nine times "administered late," 11 times administered late due to "charted late" and twice the medication was not administered due to "drug/ item unavailable;"
-5/1/19, through 5/31/19, MAR indicated R89 did not receive his Sinemet once due to "resident unavailable," administered late once due to "helping with cares," twice "administered late," 10 times administered late due to "charted late;"
-6/1/19, through 6/5/19, MAR indicated R89 administered late once due to "charted late."

The trained medication aide (TMA)-A was interviewed on 6/4/19, at 6:08 p.m. and explained when a medication was administered beyond one hour after the scheduled time the MAR would prompt her to indicate a reason it was administered late. TMA-A indicated when the unit was "short" staffed with 3 nursing assistants (NA) opposed to 4 NA's it was the expectation of the facility for the TMA to assist with resident cares. TMA-A stated this would cause her to run behind when administering medications causing medications to be administered late. TMA-A verified in R89's MAR when documented "helping with cares" was times the unit only had 3 NAs and she needed to help with resident cares so R89's Sinemet was administered over an hour beyond the scheduled time.

The registered nurse (RN)-F was interviewed on 6/6/19, at 8:18 a.m. and explained it was the expectation that medications were administered within the time frame of one hour before and after the scheduled administration time. RN-F stated they do their best to accommodate resident preferences for administration times. RN-F explained when the MAR indicated charted late it was likely due to the person not being able to sign off that the medication was administered timely.

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RN-F further explained helping with cares indicated the TMA stopped with medications administrations to assist a resident with their call light, causing the TMA to get behind. RN-F verified when a medication was administered beyond one hour of the scheduled time it was considered administered late.

The director of nursing was interviewed on 6/6/19, at 11:40 a.m. and stated it was her expectation for mediations to be administered according to the scheduled time and any deviation would be noted on the MAR.

The facility pharmacist was interviewed via telephone on 6/6/19, at 2:07 p.m. and stated Sinemet should be administered within 15 minutes of scheduled administration time to avoid Parkinson symptoms.

The facility Medication Administration policy revised ate 5/2019, indicated medications would be administered to residents as prescribed by the primary care provider and that medications would be administered one hour before or after scheduled administration time. The policy further indicated medication administration is to be documented promptly after administration.

R133
On 6/5/19, at 10:42 a.m. during a medication administration pass observation for R133; the following medications were administered: aspirin, citalopram (antidepressant), eliquis (anticoagulant), metoprolol (treats high blood pressure), and multivitamin.

R133's Physician Order Report dated 6/1/19, through 6/5/19, included the following medications to be administered at 8:00 a.m.

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aspirin, metoprolol, multivitamin and eliquis. The report indicated citalopram was to be administered daily at 7:30 a.m..

R81
On 6/5/19, at 10:50 a.m. during a medication administration pass observation for R81; the following medications were administered: diltiazem (treats high blood pressure), Flonase (treats allergies), fluoxetine (anti-depressant), furosemide (diuretic), metoprolol, omeprazole (treats acid reflux), Qvar inhaler (treats asthma), spironolactone (diuretic), tums (anti-acid) and acetaminophen (analgesic).

R81's Physician Order Report dated 6/1/19, through 6/5/19, included the following medications to be administered at 8:00 a.m. omeprazole, tums, fluoxetine, Flonase, acetaminophen, diltiazem, metoprolol, furosemide, spironolactone, and Qvar inhaler.

TMA-B was interviewed on 6/5/19, at 10:54 a.m. and verified R133 and R81's medications were administered late and should have been administered no later than 9:00 a.m. however due to one nurse not coming in TMA-B was pulled to administered medications so she got a late start. TMA-B reviewed the work list for the unit and verified five additional resident's names were outlined in red which indicated their medications had not been administered and would be administered late.

RN-F was interviewed on 6/6/19, at 8:18 a.m. and confirmed medications should be administered one hour before and no later than one hour after the scheduled administration time.

The director of nursing was interviewed on

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21525	Continued From page 39 6/6/19, at 11:40 a.m. and stated it was her expectation for medications to be administered according to the scheduled time. The facility pharmacist was interviewed via telephone on 6/6/19, at 2:07 p.m. and stated it was his expectation for medications to be administered within one hour before or after the scheduled time. The facility Medication Administration policy revised ate 5/2019, indicated medications would be administered to residents as prescribed by the primary care provider and that medications would be administered one hour before or after scheduled administration time. SUGGESTED METHOD FOR CORRECTION: The administrator,director of nursing or designee could develop and implement policies and procedures related to timely medication administration. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	21525		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal	21830		7/16/19

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care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.

(b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the

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21830	Continued From page 41 resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.	21830		

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21830	Continued From page 42 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to determine resident bathing preferences or provide documented proof of bathing for 2 of 7 residents (R104 and R174) who were reviewed for choices. Findings include: R104 stated on 6/3/19, at 10:19 a.m. he was told by staff he would get one shower a week and since his admission he had only received two showers. R104 stated he told direct care staff often he would like to take more than one and he did not like to take showers in the evening because he could not sleep afterwards. R104 further stated the facility staff had not asked him what his bathing preferences were upon admission and he would just clean up the best he could but was a little smelly and dirty due to not having showers. R104's admission date was 4/3/19, when he had a skin check with no areas of concern noted. R104's admission care area assessment (CAA) dated 4/10/19, indicated R104 required improvement with activities of daily living (ADL's) and participated in skilled therapy and to refer to his care plan. R104's care plan dated 4/15/19, indicated R104 had impaired self performance with bathing related to weakness, depression with anxiety, and asthma. The care plan included approaches of extensive assist of one person and encourage resident to participate as able but no information regarding bathing preferences. R104's progress notes were reviewed from	21830	Corrected	

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4/3/19, to 6/5/19, with 4/5/19, the only documented bathing reference which indicated he refused a shower. There was no documentation of R104 being reapproached or receiving another shower in subsequent progress notes.

R104's electronic medical record (EMR) and treatment administration record (TAR) for May, 2019, review on 6/5/19, at 1:40 p.m. revealed R104 lacked documentation of bathing preferences or bathing having been completed.

R104 was observed in his room on 6/5/19, at 3:49 p.m. with his hair stringy appearing and was wearing the same clothes as the day before with small stains on them.

Nursing assistant (NA)-F stated on 6/5/19, at 3:32 p.m. she would chart all resident's showers and refusals and would tell the registered nurse (RN) if there was a refusal. NA-F also stated she was not aware R104 preferred showers during the day or had missed some.

RN-G stated on 6/6/19, at 8:29 a.m. R104 was assessed for choices when he was admitted however his bathing preferences were missed. RN-G also stated there was no evidence of his bathing preferences in the electronic medical record (EMR) and showers and refusals were not documented weekly as they should have been. If a resident refused a shower they should be approached shortly after and the shower and one should be given as soon as possible after the refusal or the next day.

R174 stated on 6/3/19, at 9:42 a.m. he asked direct care staff for two showers a week but would not get them regularly and sometimes would not even get one a week. R174 stated it

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was real hot in his room sometimes and when he did not get his shower or bath he felt sticky and smelly.

R174 stated on 6/4/19, at 6:37 p.m. the nursing assistant (NA) came by his room and told him he would not get a shower tonight because it was not his bath day. R174 further stated it had been hot out today and he felt sweaty and sticky and was disappointed he would not get a shower tonight.

R174's EMR and TAR review on 6/5/19, at 1:30 p.m. revealed R174 had one documented bath in April on 4/9/19, and one in May on 5/26/19, and no documented bathing preferences.

R174's care plan dated 11/20/18, indicated R174 had impaired self performance with bathing due to multiple fractures and range of motion (ROM) limitations. The care plan included approaches of total assist with one to two persons as needed to ensure comfort during task but did not include bathing preferences.

R174 stated on 6/5/19, at 3:55 p.m. his wife approached the staff last night to inquire as to why his shower day was changed. Shortly after that the NA came back to the room, apologized for saying this was not his shower day and gave him a shower. R174 also stated he would not be asked about his bathing preferences at care conferences and he had not been asked how many or when he would like showers.

RN-G stated on 6/6/19, at 8:29 a.m. R174 was not assessed for bathing preferences upon admission and it was missed. RN-G also stated she was not aware he had missed showers but could see there was missing documentation of him being bathed weekly.

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21830	Continued From page 45 The director of nursing (DON) stated on 6/6/19, her expectation would be for staff to review bathing choices for all newly admitted residents within 48 hours and regularly after that to ensure the patient was satisfied with their bathing schedule. Bathing preferences should also be addressed at care conferences and the care plans updated with any changes. The Facility's Bathing: Shower or Tub Bath policy dated 12/5/18, included: Each resident will be interviewed at the time of admission to identify their bathing preferences regarding tub, bath or shower, time of day and/or day of the week and frequency. SUGGESTED METHOD OF CORRECTION: Social Service and/or their designee could develop /revise policies for resident choices and educate all facility staff on those policies. The DON and/or designee could conduct resident interviews to ensure resident choices are being honored, reviewed then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a	21995		7/16/19

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21995	Continued From page 46 mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to report to the Administrator and to the State Agency (SA) an allegation of abuse for 1 of 4 residents (R368) and an allegation of mistreatment for 1 of 4 residents (R167) reviewed. 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. R368's face sheet indicated R368's Significant Other (Other)-A had trespassed and was not allowed on campus. Campus Incident Report dated 5/25/19, indicated Other-A was loud inside R368's room and was asked to quiet down. The report also indicated Other-A was intoxicated, had alcohol with him, and was verbally aggressive and disruptive toward registered nurse (RN)-A. The report indicated this was the second time this had happened with Other-A and RN-A had asked Security Officer to have Other-A" trespassed." On 6/6/19, at 10:52 a.m. R368's daughter (Family Member-A) stated a couple of days ago Other-A had come back to the facility and started arguing with R368. FM-A stated she had concerns with Other-A that he had put his hands on her mother and verbally abuses her. FM-A stated she had	21995	Corrected	

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told the night nurse a couple of weeks ago in May that she did not want Other-A visiting her mother as he verbally abuses her mother and had dumped her mother out of her wheelchair (w/c) while out at the park.

On 6/6/19, at 1:41 p.m. RN-A stated one night she had heard Other-A arguing loudly with R368 and had told him 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 in R368's progress notes. RN-A stated FM-A had not told her about Other-A dumping her mother out of the w/c, but that FM-A had told her Other-A pushes her mother too fast in the w/c, and had tipped her mother's w/c forward and tried tripping her. RN-A stated she had not documented in the progress notes about Other-A regarding R368 and her w/c nor had she told the DON or the Administrator.

R368's progress note dated 5/25/19, by RN-A indicated that FM-A "acknowledged that [Other-A] is very disrespectful and verbally abusive to

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21995	Continued From page 48 [R368] and agreed [Other-A] should not be allowed to visit [R368] anymore in front of PM and NOC supervisor and security personal [personnel]." Review of R368's medical record lacked evidence the allegation of verbal abuse was reported to the SA or Administrator. On 6/6/19, at 3:13 p.m. Licensed Social Worker (LSW)-A stated allegations of verbal abuse were to be reported to the DON and to the administrator "immediately, as soon as possible". LSW stated he had been notified of the incident on Tuesday 5/28/19, at a morning meeting. He said the issue of concern was with Other-A with interference with security. LSW-A stated he was unaware of any concerns between Other-A and R368 and had spoken with R368 on 5/31/19, and she had not mentioned it. On 6/6/19, at 3:46 p.m. DON stated she had not been notified of the incident with Other-A, nor the allegation of verbal abuse, nor the incident with the w/c. DON stated the supervisor should have notified her of the allegation of verbal abuse right away and stated she would have wanted to be notified of any disruption on the floor. DON stated if she would have been made aware she would have told the nurse to ask Other-A to leave, and then to interview R368 and FM-A. DON stated she would have wanted questions to be asked to find out if abuse had occurred or had been witnessed. DON stated she had not known of this and had just learned of it "today" and had not reported to SA. R167's quarterly MDS dated 5/7/19, indicated R167's cognition was intact and R167 needed two staff physical assistance with transfer.	21995		

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21995	Continued From page 49 On 6/3/19, at 12:44 p.m. R167 stated nursing assistant (NA)-G had verbally abused her and it was the first time she had ever felt vulnerable at the facility. R167 stated NA-G had argued with her and would not listen to her when she told her to stop transferring her alone with the hoyer lift. R167 stated she had told NA-G to get help as she did not feel safe with NA-A assisting her alone. R167 stated NA-G refused to listen to her and proceeded anyway. R167 stated she more than once asked NA-G to leave her room and was told by NA-G, "No, I am not your slave, I do not have to leave your room and I am not going to leave your room". R167 stated she felt helpless and vulnerable at the time and started screaming out loudly so help would come. R167 stated NA-G just stared, looking down at R167, "grinning." R167 stated the nurse on duty told NA-G to leave the room and NA-G had told the nurse no she did not have to but then left the room. R167 stated she did not want NA-G working with her again and that licensed practical nurse (LPN)-B also knew of the incident. On 6/4/19, at 5:48 p.m. NA-H stated R167 had told him NA-G had transferred her alone in the hoyer lift and NA-G had just smiled at her "freaking her out" and was really frightened. NA-H stated he had notified the nurse what R167 had told him. NA-H stated R167 was very alert and was good at letting staff know. On 6/4/19, at 7:06 p.m. DON stated LPN-B had interviewed R167 on 5/29/19, and R167 had not considered the incident as abuse at the time, and had felt safe. DON stated R167 told LPN-B on 6/7/19, that she had now felt it was "verbal abuse". DON stated NA-G should have not argued with R167, and should have not	21995		

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21995	Continued From page 50	21995		

transferred R167 alone with the hoyer lift as this was an unsafe transfer. DON stated the definition of mistreatment in the facility VA (Vulnerable Adult) policy dated 11/21/18, read "Mistreatment: Inappropriate treatment" of a resident. DON stated transferring a resident with a hoyer lift alone without a second staff was not appropriate.

On 6/5/19, at 9:01 a.m. LPN-B stated the wound nurse had reported to her what R167 had said to her about having issues with NA-G's cares for her and that she was hurting when NA-G was trying to remove the sling in bed alone. LPN-B stated R167 told her she did not want NA-G working with her again and had said she was very mad and was visibly upset about the incident.

On 6/6/19, at 4:23 p.m. the Administrator stated all allegations of abuse including verbal abuse were to be reported immediately to him, either by text, telephone or in person at the office, and needed to be reported immediately to the SA. Administrator stated he had not been notified of the allegation of verbal abuse with Other-A to R368 and had not reported it to the SA.

The facility's policy Vulnerable Adult dated 11/21/18, indicated allegations of abuse would be reported immediately, within two hours to the Administrator and SA, and allegations of mistreatment would be reported immediately, within 24 hours to the Administrator and SA. The policy also indicated residents would be free from abuse, protected and all allegations of abuse and mistreatment would be investigated.

SUGGESTED METHOD OF CORRECTION:
The administrator could review policies and procedures regarding reporting all allegations of abuse/neglect/mistreatment. The administrator

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21995	Continued From page 51 and or designee, could re-educate all staff on the policies and procedures. The administrator could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21995		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies	22000		7/16/19

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22000	Continued From page 52 and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN 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 (R69) 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. R368's face sheet indicated R368's Significant Other (Other)-A had trespassed and was not allowed on campus. Campus Incident Report dated 5/25/19, indicated	22000	Corrected	

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22000	Continued From page 53 Other-A was loud inside R368's room and was asked to quiet down. The report also indicated Other-A was intoxicated, had alcohol with him, and was verbally aggressive and disruptive toward registered nurse (RN)-A. The report indicated this was the second time this had happened with Other-A and RN-A had asked Security Officer to have Other-A" trespassed." On 6/6/19, at 10:52 a.m. R368's daughter (Family Member-A) stated a couple of days ago Other-A had come back to the facility and started arguing with R368. FM-A stated she had concerns with Other-A that he had put his hands on her mother and verbally abuses her. FM-A stated she had told the night nurse a couple of weeks ago in May that she did not want Other-A visiting her mother as he verbally abuses her mother and had dumped her mother out of her wheelchair (w/c) while out at the park. On 6/6/19, at 1:41 p.m. RN-A stated one night she had heard Other-A arguing loudly with R368 and had told him 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	22000		

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22000	Continued From page 54	22000		

had also been present when FM-A had told her this. RN-A stated she had documented about this in R368's progress notes. RN-A stated FM-A had not told her about Other-A dumping her mother out of the w/c, but that FM-A had told her Other-A pushes her mother too fast in the w/c, and had tipped her mother's w/c forward and tried tripping her. RN-A stated she had not documented in the progress notes about Other-A regarding R368 and her w/c nor had she told the DON or the Administrator.

R368's progress note dated 5/25/19, by RN-A indicated that FM-A "acknowledged that [Other-A] is very disrespectful and verbally abusive to [R368] and agreed [Other-A] should not be allowed to visit [R368] anymore in front of PM and NOC supervisor and security personal [personnel]."

Review of R368's medical record lacked evidence the allegation of verbal abuse was reported to the SA or Administrator; nor was investigated with R368, FM-A, staff interviews and other residents.

On 6/6/19, at 3:13 p.m. Licensed Social Worker (LSW)-A stated allegations of verbal abuse were to be reported to the DON and to the administrator "immediately, as soon as possible". LSW stated he had been notified of the incident on Tuesday 5/28/19, at a morning meeting. He said the issue of concern was with Other-A with interference with security. LSW-A stated he was unaware of any concerns between Other-A and R368 and had spoken with R368 on 5/31/19, and she had not mentioned it.

On 6/6/19, at 3:46 p.m. DON stated she had not been notified of the incident with Other-A, nor the

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22000	Continued From page 55	22000		

allegation of verbal abuse, nor the incident with the w/c. DON stated the supervisor should have notified her of the allegation of verbal abuse right away and stated she would have wanted to be notified of any disruption on the floor. DON stated if she would have been made aware she would have told the nurse to ask Other-A to leave, and then to interview R368 and FM-A. DON stated she would have wanted questions to be asked to find out if abuse had occurred or had been witnessed. DON stated she had not known of this and had just learned of it "today" and had not reported to SA.

On 6/6/19, at 4:23 p.m. the Administrator stated all allegations of abuse including verbal abuse were to be reported immediately to him, either by text, telephone or in person at the office, and needed to be reported immediately to the SA. Administrator stated he had not been notified of the allegation of verbal abuse with Other-A to R368 and had not reported it to the SA.

The facility's policy Vulnerable Adult dated 11/21/18, indicated allegations of abuse would be reported immediately, within two hours to the Administrator and SA, and allegations of mistreatment would be reported immediately, within 24 hours to the Administrator and SA. The policy also indicated residents would be free from abuse, protected and all allegations of abuse and mistreatment would be investigated.
R69's quarterly Minimum Data Set dated 4/6/19, identified R69 had intact cognition and required extensive staff assistance with bed mobility and total dependence for toileting needs.

R69's Face Sheet dated 6/6/19, indicated R69 had diagnoses which included convulsions, depression, anxiety and weakness.

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22000	Continued From page 56	22000		

R69 was interviewed on 6/3/19, at 8:11 a.m. and stated back in February there was a nursing assistant (NA)-I who was told not to come into his room anymore. R69 explained NA-I was defensive, rude and rough while turning him in bed during pericares. R69 further explained NA-I was rough when she was rolling him; he stated she pushed him and squeezed his hip without explaining what she was doing. R69 revealed NA-I had been on her cell phone while she was providing cares laughing and speaking in a foreign language. R69 indicated NA-I remained on her cell phone talking and laughing; as she touched his genitals providing pericares and stated he felt humiliated as if he was being molested. R69 indicated he had reported this to the clinical manager and NA-I had not cared for him since.

Registered nurse (RN)-F was interviewed on 6/3/19, at 12:22 p.m. and stated she had been made aware of R69's allegations on 5/6/19, and a report had been made to the state agency (SA).

The director of nursing (DON), administrator, administrator assistant, assistant director of nursing (ADON) and RN-F were interviewed on 6/4/19, at 7:04 p.m. The DON verified only R69, NA-I and NA-J were interviewed regarding the alleged allegation of mistreatment that had been reported to the SA on 5/6/19, due to the investigation being straight forward. The DON explained she did not see how any additional information would have altered the outcome of the investigation.

The facility investigative file dated 5/6/19, was reviewed and included an interview from R69, NA-I and NA-J. However, the file lacked evidence

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22000	Continued From page 57 of additional resident and staff interviews regarding the alleged allegation of mistreatment and also lacked evidence of increased supervision or monitoring on the unit. The facility policy Vulnerable adult-MN [Minnesota] dated 11/21/18, indicated all reports of alleged abuse and mistreatment shall be promptly and thoroughly investigated. The policy included that the investigation would include interviews of any potential witnesses to the incident and other residents to whom the alleged perpetrator provided care or services. SUGGESTED METHOD OF CORRECTION: The administrator could review policies and procedures regarding reporting and investigating all allegations of abuse/neglect/mistreatment. The administrator and or designee, could re-educate all staff on the policies and procedures. The administrator could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	22000		