

Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically delivered February 2, 2018

Ms. Jean Cole, Administrator Augustana Health Care Center of Minneapolis 1007 East 14th Street Minneapolis, MN 55404

Subject: Augustana Health Care Center of Minneapolis - Independent Dispute Resolution (IDR) CMS Certification Number (CCN): 245242 Project Number: S5242027

Dear Ms. Cole:

This is in response to your letter from September 28, 2017, in regard to your request for an informal dispute resolution (IDR) for the federal deficiencies at tags F225, F226, F280, F282, F310, and F315 issued pursuant to the survey event M4PX11, completed on August 24, 2017.

The information presented with your letter, the CMS 2567 dated August 24, 2017 and corresponding Plan of Correction, as well as survey documents and **discussion with representatives from your facility** and representatives of L&C staff, have been carefully considered and the following determination has been made:

**F225 Scope and severity of (S/S) - D 42 CFR § 483.12 (a)** The facility must ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately and not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in bodily injury.

**F226 S/S - D 42 CFR § 483.12(b)** Abuse: The facility must develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property.

**Summary of the facility's reason for IDR of this tag:** The facility alleges the nursing assistant providing care for R123 when R123 fell from a mechanical lift had been following R123's plan of care and all other interventions. The facility alleges the sling popped off the lift accidentally. The facility acknowledged the sling failure caused R123 to fall to the floor however, since R123 received no injury, they'd determined the incident was not reportable.

**Summary of facts:** On 8/5/17, the facility was aware the lift sling had malfunctioned, when the sling "popped" and the lift suddenly stopped moving. As a result, R123 fell to the floor from the lift without sustaining an injury. R123's Minimum Data Set (MDS) dated 9/19/17, indicated R123's weight was 361 pounds. The manufacturer's guidelines recommended a sling size of "extra-large" for the resident's weight. The incident report documentation failed to identify the size of the sling being utilized at the time of the fall. On 8/24/17, at 11:30 a.m. the director of nursing (DON) verified a sling size assessment had not been documented, indicating determination of the sling size was more of a judgement based on clinical

factors. On 8/24/17, at 3:52 p.m. the director of maintenance was interviewed and stated he was unaware of any residents ever having fallen from a mechanical lift. The director of maintenance stated staff would update him with any event and he would then inspect the lift equipment for safety and proper functioning. The facility's Vulnerable Adult Reporting and Investigation Procedure revised 8/2016, indicated: "Those criminal activities that do not result in serious harm or threat will be reported within 24 hours." Although R123 did not receive bodily harm, the facility had 24 hours to report the event to the State Agency (SA). The report was not submitted to the SA.

**Summary of findings:** Because the provider failed to have a system in place to ensure staff had assessed the size of the sling required for residents in accordance with their weight, and other factors; and because the facility had not implemented any corrective action following the resident's fall, it was determined these are valid deficiencies at F225 for failure to report an allegation of neglect of care, and at F226 for the facility's failure to implement their reporting policies, with both tags identified at the correct scope and severity (s/s) of "D."

**F280 S/S - D 42 CFR §483.21 (b)** Comprehensive Care Plans. A comprehensive care plan must be developed within 7 days after completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes but is not limited to the attending physician, a registered nurse with responsibility for the resident; a nurse aide with the responsibility for the resident; a member of food and nutrition services staff; to the extent practicable, the participation of the resident and the resident's representative(s); other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident; and reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

**Summary of the facility's reason for IDR of this tag:** The facility alleged the plan of care did not require revision as the facility had utilized R338's son, an interpreter service and staff to communicate with R338. In addition, upon return from the hospital on August 3, 2017, communication cards were utilized.

**Summary of facts:** The facility had knowledge of R338's inability to communicate in English as the Minimum Data Set (MDS) dated 2/5/17, noted the resident's preferred language was "Somali." The MDS further noted the resident needed or wanted an interpreter to communicate with a doctor or health care staff. The MDS manual 3.0 dated October 2016, identified that the "Inability to make needs known and to engage in social interaction because of language barrier can be frustrating and can result in isolation, depression, and unmet needs." The care plan process directed staff to:

"• When a resident needs or wants an interpreter, the nursing home should ensure that an interpreter is available.

• An alternate method of communication also should be made available to help to ensure that basic needs can be expressed at all times, such as a communication board with pictures on it for the resident to point to (if able).

• Identifies residents who need interpreter services in order to answer interview items or participate in consent process."

The plan of care for R338 dated 2/10/17, related to cognitive loss/dementia noted R338 had a language barrier. Staff were to provide calendars, clocks, written notes and were to communicate at eye level whenever able. In addition, staff were to provide reminders and cues as needed however, the care plan

did not specify whether this communication was to be implemented in Somali or English. The communication problem dated 2/6/17, indicated R338 made herself understood by use of an interpreter and R338's hearing was adequate. The approach was to have staff "report any changes in ability to communicate, understand others, or in ability to hear. Refer for hearing exam PRN [as needed]." Although the facility placed a phone in R338's room and utilized communication cards after August 3, 2017 (approximately three months after admission) during the survey process, R338's care plan prior to the survey, lacked evidence of any revision for other alternative ways for the staff to communicate with R338 and to meet basic needs.

**Summary of findings:** Following review of the CMS 2567, information submitted by the facility, a face to face meeting with facility staff, review of MDH surveyor documentation, and discussion with licensing and certification staff, it was determined this is a valid deficiency at this tag and at the correct scope and severity of a "D."

**F282 S/S - D 42 CFR § 483.21 (b)(3)** Comprehensive Care Plans: The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care.

**Summary of the facility's reason for IDR of this tag:** The facility dropped this deficiency from the IDR review during the face- to- face review on November 17, 2017.

**F310 S/S - G 42 CFR § 483.24** (a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:

(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section, ...(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:

(1) Hygiene -bathing, dressing, grooming, and oral care,

- (2) Mobility-transfer and ambulation, including walking,
- (3) Elimination-toileting,
- (4) Dining-eating, including meals and snacks,
- (5) Communication, including
- (i) Speech,
- (ii) Language,
- (iii) Other functional communication systems.

**Summary of the facility's reason for IDR of this tag:** The facility alleges that interpreter services were involved in resident care. The facility made use of staff, the son and an interpreter service in order to communicate with R338, therefore R338 did not suffer any harm.

**Summary of facts:** The facility had knowledge of R338's inability to communicate in English as the Minimum Data Set (MDS) dated 2/5/17, noted the resident's preferred language was "Somali." The MDS further noted the resident needed or wanted an interpreter to communicate with a doctor or health care staff. The MDS manual 3.0 dated October 2016, identified that the "Inability to make needs known and to engage in social interaction because of language barrier can be frustrating and can result in isolation, depression, and unmet needs." The care plan process directed the staff to:

"• When a resident needs or wants an interpreter, the nursing home should ensure that an interpreter is available.

• An alternate method of communication also should be made available to help to ensure that basic needs can be expressed at all times, such as a communication board with pictures on it for the resident to point to (if able).

• Identifies residents who need interpreter services in order to answer interview items or participate in consent process."

R338's Psychosocial Well-being Care Area Assessment (CAA) dated 2/5/17, indicated R338 had exhibited mood symptoms of "little interest or pleasure in doing things."

The plan of care for R338 dated 2/10/17, related to cognitive loss/dementia noted R338 had a language barrier. Staff were to provide calendars, clocks, written notes and were to communicate at eye level whenever able. In addition, staff were to provide reminders and cues as needed. However, the care plan did not specify to staff whether the communication was to be done in Somali or English language. The communication problem dated 2/6/17, indicated R338 made herself understood with the use of an interpreter and R338's hearing was adequate. The approach was to have staff "report any changes in ability to communicate, understand others, or in ability to hear. Refer for hearing exam PRN [as needed]."

The undated TCU (transitional care unit) Care Card (used by nursing assistants), lacked evidence of how staff were to communicate with R338. The card only identified R338 had a language barrier and failed to identify the preferred language to use for R338.

On 8/23/17, at 12:25 p.m. during a second interview, family member (FM)-A indicated he posted a note with telephone numbers to the wall in R338's room to help with R338's language barrier, but the facility staff did not use the telephone numbers. FM-A had been told by the facility staff R338 refused cares and did not use her call light. FM-A stated R338 would call him by telephone, and she would call the facility to get R338 assistance with toileting. FM-A stated R338 would not refuse care if she understood what the staff were offering. FM-A indicated he felt the number one issue with her care had been related to the communication barrier.

FM-A indicated he visited every day and would assist R338 with toileting, dressing and everything she needed. FM-A stated a few days ago, he had come to the facility and R338 had been incontinent of urine all over the bed and she had reported that she could not hold her urine any longer FM-A indicated he had discussed his concerns with the language barrier for R338 with facility staff many times in the past. He indicated he had suggested use of an interpreter or staff to utilize pictures of various items or objects from the Internet to use to assist communication with R338. FM-A stated he had seen pictures used "maybe once" and had not seen the pictures in R338's room since. FM-A stated the facility had not utilized an interpreter to assist in communication for cares for R338.

On 8/24/17, at 9:00 a.m. NA-J stated she was able to speak the same language as R338 and that R338 would point and/or slap her hip when she had to go to the bathroom. NA-J stated when she cared for R338, the resident remained continent and did not need a brief. NA-J stated when other staff, who could not properly communicate with R338 during care, provided cares R338 wore a brief. NA-J further explained R338 had reported to her she was afraid she would have incontinence episodes. NA-J indicated she was aware the interpreter only came to the facility when R338 had scheduled medical appointments. NA-J stated she had informed nursing staff many times of her concerns related to R338's language barrier, and confirmed the interpreter hotline posted in R338's room was not present until recently. NA-J stated, "She did not have that paper in her room before."

Although the facility utilized communication cards after August 3, 2017 (approximately three months after admission), placed a phone in R338's room and posted the interpreter hotline number during the survey process, R338's care plan prior to survey lacked evidence of any revision for other alternate ways for the staff to communicate with R338 to ensure basic needs were met.

**Summary of findings:** Following review of the CMS 2567, information submitted by the facility, a face to face conference with facility staff, review of MDH surveyor documentation, and discussion with licensing and certification staff, it was determined this is a valid deficiency at this tag and at the correct scope and severity of a "G."

**F315 S/S - G 42 CFR § 483.25 (e)** Incontinence: The facility must ensure that a resident, with or without, a catheter receives the appropriate care and services to prevent infections to the extent possible.

**Summary of the facility's reason for IDR of this tag:** The facility alleges that R338 had improved in the urinary incontinence.

**Summary of facts:** R338's quarterly MDS dated 8/5/17, indicated R338 had severely impaired cognition, required extensive assistance of one staff for all of her activities of daily living. The MDS also indicated R338 was occasionally incontinent of urine and frequently incontinent of bowel and was not on a toileting program.

R338's current care plan revised on 8/22/17, indicated R338 had incontinence of bowel and bladder with some control and history of stress incontinence. Contributing factors included: dementia, obesity, impaired mobility related to weakness, right lower extremity wounds, pain, anemia, use of narcotics, anti-depressants and language barrier. Related to confusion, R338 was not consistent with letting staff know she needed to be changed or use the bedpan. The care plan listed various interventions such as: check and change upon rising, before and after meals, before bed, night rounds and as needed, offer bed pan when not confused, peri-cares with incontinence episodes, and needed extensive assist of one or two staff depending on cognition. No interventions were identified regarding how to communicate with R338 regarding the language barrier and her incontinence or toileting needs.

R338's undated Transitional Care Plan for the NA (nursing assistant), indicated R338 required maximum assistance with toileting, and the resident called for assistance. The sheet indicated R338 was continent of bowel and bladder with occasional incontinence of bladder and wore an incontinent brief. The information on the card conflicted with most recent MDS. No interventions were listed on how to communicate with R338 regarding the language barrier and her incontinence or toileting needs.

During observation on 8/23/17, at 8:56 a.m. R338 wore a hospital gown and sat on the edge of her bed with her call light on. NA-G entered R338's room, deactivated the call light and asked R338 what she needed. R338 proceeded to repeat foreign words, and repeatedly tapped her thigh with her left hand. NA-G stated she was unable to understand what R338 was trying to tell her. R338 continued to repeat the foreign words, proceeded to place both of her hands out in front her, and spread her legs. R338 extended her fingers open and arms out in front of her groin while making a "sheeeew" sound repeatedly. R338 continued make the "sheeeew" sounds and gestures for NA-G until NA-G exited the room at 8:59 a.m.

At 8:59 a.m. on 8/23/17, NA-G stated she did not know what R338 wanted, but thought she was having pain. She stated, "No one here speaks this language, it's very hard, I don't understand her." NA-G indicated she was not aware of anyone in the facility who spoke R338's language and felt it was hard to communicate with R338 utilizing hand gestures or movements. NA-G indicated the hand gestures and movements staff utilized to attempt to communicate with R338 were not effective when working with R338.

On 8/23/17, at 12:25 p.m. family member (FM)-A indicated he visited every day and would assist R338 with toileting, dressing and anything else she needed. FM-A stated a few days ago, he had come to the facility and R338 had been incontinent of urine all over the bed and R338 had reported she could not hold her urine any longer. FM-A indicated he discussed his concerns related to R338's language barrier with facility staff many times in the past. He indicated he suggested the use of an interpreter or staff to utilize pictures of various items or objects from the Internet to assist with communication. FM-A stated he noted pictures were used "maybe once" and had not seen the pictures in R338's room since. FM-A stated the facility had not utilized an interpreter to assist in communication with cares for R338.

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Although the facility placed a phone and posted the number for the interpreter hotline in R338's room during the survey process, the facility failed to implement alternative communication interventions to promote urinary incontinence. However, R338 did not experience a decline in urinary incontinence as a result.

**Summary of findings:** Following review of the CMS 2567, information submitted by the facility, a face to face conference with facility staff, review of MDH surveyor documentation, and discussion with licensing and certification staff, it was determined this is a valid deficiency at this tag and the scope and severity will be reduced to a "D."

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Naria King

Maria King, Assistant Program Manager Licensing and Certification Program Health Regulation Division Telephone: (507) 344-2716 Fax: (507) 344-2723

cc: Office of Ombudsman for Long-Term Care
 Maria King, Assistant Program Manager
 Licensing and Certification File
 Gail Anderson, Fergus Falls District Office Unit Supervisor

		& MEDICAID SERVICES					APPROVED . 0938-0391
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	F 225 Continued From page 2		F 22	25		
	administrator or his representative and with State law, inclu Agency, within 5 wo if the alleged violati corrective action m This REQUIREMEN by: Based on interview facility failed to imm agency (SA) and th incident of potential residents (R123) wi the facility. Findings include: R123's face sheet of current diagnoses of bilateral leg weakned disorder with seizur depression, pain in and repeated falls p R123's admission N dated 1/5/17, identi and required extern Review of Event Re p.m. indicated R122 her chair to bed, E place causing resid Staff re-educated o to ensure correct si Further, the report I suddenly stopped m	to other officials in accordance uding to the State Survey orking days of the incident, and on is verified appropriate ust be taken. NT is not met as evidenced v and document review, the nediately report to the State oroughly investigate an I neglect of care for 1 of 3 ho fell from a mechanical lift in dated 12/29/16, identified of chronic pain, muscle and ess, lymphedema, conversion res or convulsions, anxiety, left ankle and joints of left foot		Augustana Health Care Cente Minneapolis' Plan of correction credible assertion of substantia compliance with the Federal ar requirements of Nursing facilitie skilled nursing facilities particip Federal Medicare or State Med Assistance programs. Please nothing set forth in this docume or should be construed to be at admission by Augustana Health Center of Minneapolis, or the v accuracy of any of the deficient by the Minnesota Department of relative to the survey, certificatie enforcement effort at issue. Fu please note that any and all do transmitted or otherwise provid Augustana Health Care Center Minneapolis in relation to the P correction, as well as any and a communications in writing or of or on behalf of Augustana Heal Center of Minneapolis, at law a equity, all of which are not waiw of which are reserved and retait and on behalf of Augustana Heal Center of Minneapolis F225	is a written I ad State es and/or ating in the lical note that ent is to be n a Care alidity or cies cited of Health on, and urther cuments ed by of lan of all other herwise by th Care nd/or in ed and all ned by, for	

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	-	AND HUMAN SERVICES				02/02/2018 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
		245242	B. WING	i	08/2	24/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 225	Continued From pa	ige 3	F 2	225			
	one side of the sling resident landed on was helped off the to no pain or injuries w Review of R123's Ir 8/7/17, indicated R <sup>2</sup> no injury. The inter and documented th concerns, environm condition noted. Th intervention of staff EZ stand and to en- obtained large sling During interview on reported a few wee the EZ stand lift use reported when the s the lift, the staff me safety belt around h attached the loops of R123 reported sinc hooking up all of the any further falls. During interview on registered nurse (R the EZ stand lift dur talking with staff sh- off or open, and the maybe incorrect. R given to the staff m lift use and sling siz no further investiga regarding R123's fall When interviewed of	g was out of place and the floor on buttocks. Resident floor utilizing a hoyer lift, and were evident at that time. Incident Review Form, dated 123 had a fall on 8/5/17, with disciplinary team reviewed here were no medication mental concerns or change of the form listed the new re-educated on proper use of sure the proper sling used, g. 8/23/17, at 8:07 a.m. R123 eks ago she had fallen from ed during a transfer. R123 staff member hooked her up to mber had not hooked the the rabdomen, and had only on to the hooks of the lift. e that fall, all staff had been e belts, and she had not had 8/23/17, at 11:43 a.m. tN)-C confirmed R123 fell from ring a transfer, and stated after e believed the strap snapped ought the size of the sling was tN-C stated re-education was ember involved regarding the tes. RN-C verified there were tions or documentation		It is the policy of August Center to ensure that all involving mistreatment, including injuries of unki misappropriation of resid immediately reported to and other state officials with state law and to have all violations are thoroug Corrective Action: Staff person was educat original incident on prop stand, and using the cor identified resident R123 8-7-17 All care sheets were upo size for all residents to e transfers 10-3-17 Identification of Other R All current (August 1 - S incident reports were re- appropriate and immedi Adult reporting of abuse reported if indicated. 10-4-17 Measures Put In Place: Incident review summar revised to add an additio measure related to any of Abuse or Neglect to e investigation has been of Mandatory all staff educ completed to review Vul reporting, investigation, abuse and neglect Mandatory all staff educ completed to review app and size, and use of train	a alleged violations neglect, or abuse nown source and dent property are the administrator in accordance ve evidence that ghly investigated. ted at time of the er use of the EZ rect sling size for dated with sling ensure safe esidents: eptember 30) viewed to ensure ate Vulnerable and/or neglect is y form was onal review possible indication ensure a full completed ation was nerable Adult and definitions of ation was propriate sling use		

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	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION		(X3) DATE SURVEY	
ND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED	
		245242	B. WING			08/2	24/2017	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIC DATE	
F 225	Continued From pa	age 4	F 2	25				
	had the fall from the analysis was comp R123 let go of the h felt the harness wa further investigated in the incident repo loop "popped off." T not complete a repor not feel this was a n no negative outcom During group interv with the administrati the current faciilty p confirmed she expe suspected neglect on eeded to be repor administrator and th feel R123's fall from was reportable due negative outcome, negative intent. Th stated they expected of care possible, an be followed. Review of the facility and Investigation P indicated incidents immediately to MDI Health) included net the Administrator and person to investigation review of the incidents	e EZ stand lift, a root cause leted. The DON reported nandles on the lift because she s a little tight, and as staff l, the wording "popped off" was rt, due to being too tight or the The DON stated the facility did ort to the SA as the facility did reportable event as there was ne for R123. iew on 8/24/17, at 3:41 p.m. tor and DON, they confirmed policy, and the administrator ected all neglect of care and or not providing care as ted to the SA. The he DON stated they did not n the EZ stand mechanical lift to the fact there was no no harm, no abuse or no re administrator and DON ed staff to give the highest level nd expected the care plan to ty's Vulnerable Adult Reporting rocedure policy dated, 8/2016 that must be reported H (Minnesota Department of eglect. The policy indicated nd DON would appoint a te the alleged incident, thent dical record to determine o the incident		S	10-11-17 Monitoring Mechanisms: Per facility policy all incident report reviewed by the Administrator, Dire Nursing, and Medical Director for p completion and appropriate interver This review now includes the addit measure to review for any possible indication of abuse or neglect. Incident report patterns/trends are reviewed at the quarterly QAA/QAI meetings for maintaining an accep standard of practice in regards to investigation of all incidents. We w review on-going for the next year a track and incident review that indic abuse or neglect on or before: 10-19-17 11-30-17 12-31-17 1-31-18 2-27-18 3-31-18 4-30-18 5-31-18 6-30-18 7-31-18 8-31-18 9-30-18 Responsible Person/s Administrator Director of Nursing Clinical Managers Quality Improvement Director	ector of proper entions. ional e PI table ill and		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY	
			A. BUILDING	<u> </u>			
		245242	B. WING		08/24/2017		
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 225	Continued From pa	ige 5	F 22	5			
F 226 SS=D	indicated - interview other resemployee provides Review of the facili Vulnerable Adults F indicated all allegat abuse must be repo- immediately. The p is unexplainable, or reported or witness neglect a report muthe Minnesota Dep- call the administrate also indicated an in- reports will be comp- DEVELOP/IMPLME POLICIES CFR(s): 483.12(b)(- 483.12 (b) The facility mus- written policies and (1) Prohibit and pre- exploitation of resid- resident property, (2) Establish policies investigate any suc-	ity's Maltreatment of Policy, dated 10/2016, ions and/or suspicious of orted to the administrator policy further indicated if injury r allegation of abuse is ed, if there is caregiver ust immediately be reported to artment of Health (MDH) and or immediately. The policy ternal, facility investigation of pleted. ENT ABUSE/NEGLECT, ETC 1)-(3), 483.95(c)(1)-(3) t develop and implement procedures that:				10/12/17	

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		AND HUMAN SERVICES & MEDICAID SERVICES			RINTED: 02/02/20 FORM APPROV MB NO: 0938-03	
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245242	B. WING		08/24/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLET	
F 226	<ul> <li>(c) Abuse, neglect, the freedom from a requirements in § 4 provide training to t educates staff on-</li> <li>(c)(1) Activities that exploitation, and miproperty as set forth</li> <li>(c)(2) Procedures for neglect, exploitation resident property</li> <li>(c)(3) Dementia maprevention. This REQUIREMENDES</li> <li>(c)(3) Dementia maprevention. This REQUIRES</li> <li>(c)(4) the facility failed to improve of the facility failed to improve of the incide need the Administrator and person to investigation person to investigation. The resident's maprevention. This REQUIRES</li> </ul>	and exploitation. In addition to buse, neglect, and exploitation 83.12, facilities must also heir staff that at a minimum constitute abuse, neglect, sappropriation of resident in at § 483.12. or reporting incidents of abuse, n, or the misappropriation of anagement and resident abuse NT is not met as evidenced v and document review, the lement their abuse prevention ly report to the State agency v investigate potential 1 of 1 resident (R123) who cal lift in the facility. ry's Vulnerable Adult Reporting rocedure policy dated, 8/2016 that must be reported H (Minnesota Department of glect. The policy indicated ind DON would appoint a te the alleged incident, ent dical record to determine	F 220		vritten it and ation of esident gations glect, of ie EZ ize for	

Facility ID: 00164

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION	OMB NO.	E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		VG		PLETED	
		245242	B. WING _		08/2	24/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC			
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 226	Continued From pa	ige 7	F 22	26			
1 220	<ul> <li>interview the witnet interview the residemembers, interview roommate, family mindicated</li> <li>interview other resemployee provides</li> <li>R123's face sheet of current diagnoses of bilateral leg weakned disorder with seizur depression, pain in and repeated falls p</li> <li>R123's admission for the resemployee of Event Review of Event Rep.m. indicated R122 her chair to bed, E place causing resident landed on the resident landed on was helped off the no pain or injuries with a fall and requires with seized of the sling resident landed on the sling re</li></ul>	esses to the incident dent, interview the staff w the the resident's physician, nember, and visitors as sidents to whom the accused care or services. dated 12/29/16, identified of chronic pain, muscle and ess, lymphedema, conversion res or convulsions, anxiety, left ankle and joints of left foot	F 22	<ul> <li>All current (August 1 - Septerincidents reports were review appropriate and immediate M Adult reporting of abuse and reported if indicated.</li> <li>10-4-17 Measures Put in Place:</li> <li>Incident review summary form revised to add an additional measure related to any poss of Abuse or Neglect to ensurinvestigation has been comp Mandatory all staff education completed to review Vulneral reporting, investigation, and abuse and neglect.</li> <li>Mandatory all staff education completed to review appropriand size and use of transfer 10-11-17 Monitoring Mechanisms:</li> <li>Per facility policy all incident reviewed by the Administrato Nursing, and Medical Directo completion and appropriate i This review now includes the measure to review for any poindication of abuse or neglect incident report patterns/trend reviewed at the quarterly/mo QAA/QAPI meetings for ma acceptable standard of pract to investigation of all incident review on-going for the next track any incident review that abuse or neglect on or before 10-19-17</li> </ul>	ved to ensure /ulnerable /or neglect is m was review ible indication e a full leted. was ble Adult definitions of was iate sling use equipment. reports are r, Director of or for proper nterventions. additional ossible t. Is are nthly intaining an ice in regards is. We will year and t indicated		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY
		245242	B. WING		08	/24/2017
AME OF	PROVIDER OR SUPPLIER		Ş	STREET ADDRESS, CITY, STATE, ZIP CODE		
UGUST	ANA HEALTH CARE (	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 226	intervention of staff EZ stand and to en- obtained large sling During interview on reported a few wee the EZ stand lift use reported when the staff the lift, the staff me safety belt around h attached the loops of R123 reported since hooking up all of the any further falls. During interview on registered nurse (R the EZ stand lift dur talking with staff sho off or open, and tho maybe incorrect. R given to the staff me lift use and sling siz no further investigar regarding R123's fa When interviewed of director of nursing ( had the fall from the analysis was compl R123 let go of the h felt the harness was further investigated in the incident repoil loop "popped off." T not complete a repoint	re-educated on proper use of sure the proper sling used, 8/23/17, at 8:07 a.m. R123 eks ago she had fallen from ed during a transfer. R123 staff member hooked her up to mber had not hooked the her abdomen, and had only on to the hooks of the lift. e that fall, all staff had been e belts, and she had not had 8/23/17, at 11:43 a.m. N)-C confirmed R123 fell from ring a transfer, and stated after e believed the strap snapped ught the size of the sling was N-C stated re-education was ember involved regarding the res. RN-C verified there were tions or documentation all on 8/5/17. In 8/24/17, at 11:30 a.m. the DON) reported after R123 e EZ stand lift, a root cause eted. The DON reported handles on the lift because she is a little tight, and as staff , the wording "popped off" was rt, due to being too tight or the The DON stated the facility did ort to the SA as the facility did portable event as there was	F 226	1-31-18 2-27-18 3-31-18 4-30-18 5-31-18 8-31-18 9-30-18 Responsible Person/S Administrator Director of Nursing Clinical Managers Quality Improvement Director		

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 02/02/2018 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245242	B. WING		08/	/24/2017
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		007 EAST 14TH STREET /INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226 F 280 SS=D	During group interv with the administrat the current faciilty p confirmed she expe- suspected neglect of needed to be report administrator and th feel R123's fall from was reportable due negative outcome, in negative outcome, in negative outcome, in negative outcome, in stated they expecte of care possible, and be followed. RIGHT TO PARTIC CARE-REVISE CP CFR(s): 483.10(c)(2 483.10 (c)(2) The right to p and implementation plan of care, includie (i) The right to partic including the right to be included in the p request meetings a revisions to the person (ii) The right to partic expected goals and amount, frequency, other factors related plan of care.	iew on 8/24/17, at 3:41 p.m. or and DON, they confirmed olicy, and the administrator acted all neglect of care and or not providing care as ted to the SA. The ne DON stated they did not in the EZ stand mechanical lift to the fact there was no no harm, no abuse or no e administrator and DON id staff to give the highest level ad expected the care plan to IPATE PLANNING 2)(i-ii,iv,v)(3),483.21(b)(2) articipate in the development of his or her person-centered ng but not limited to: cipate in the planning process, o identify individuals or roles to anning process, the right to nd the right to request son-centered plan of care.	F 226			10/12/17

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		AND HUMAN SERVICES					FORM	02/02/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION			E SURVEY PLETED
		245242	B. WING				08/2	24/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZI	P CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			007 EAST 14TH STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD	BE	(X5) COMPLETION DATE
F 280	<ul> <li>(v) The right to see right to sign after sign of care.</li> <li>(c) (3) The facility shright to participate in shall support the replanning process m</li> <li>(i) Facilitate the incleresident representa</li> <li>(ii) Include an assess strengths and need</li> <li>(iii) Incorporate the cultural preferences</li> <li>483.21</li> <li>(b) Comprehensive</li> <li>(2) A comprehensive</li> <li>(i) Developed within the comprehensive</li> <li>(ii) Prepared by an includes but is not I</li> <li>(A) The attending p</li> <li>(B) A registered numerication of the cultural preferences</li> </ul>	the care plan, including the gnificant changes to the plan all inform the resident of the n his or her treatment and sident in this right. The nust usion of the resident and/or tive. ssment of the resident's s. resident's personal and s in developing goals of care. Care Plans re care plan must be- n 7 days after completion of assessment. interdisciplinary team, that imited to	F 2	280				

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		AND HUMAN SERVICES			FORM	02/02/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUCTION		E SURVEY PLETED
		245242	B. WING _		08/:	24/2017
NAME OF I	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 280	F 280 Continued From page 11		F 28	80		
	the resident and the An explanation mus medical record if th and their resident re not practicable for t resident's care plan (F) Other appropria disciplines as deter or as requested by (iii) Reviewed and r team after each ass comprehensive and assessments. This REQUIREMEN by: Based on observat review, the facility fi include individualize communicate with language barrier. Findings include: R338's admission N dated 2/5/17, identi which included arth and unspecified ur indicated R338 had memory problems, cognitive skills for o preferred language wanted an interpret or health care staff. R338 required exte	te staff or professionals in mined by the resident's needs the resident. revised by the interdisciplinary sessment, including both the		F280 It is the policy of Augustana Hea Center that residents have the ri- participate in the development at implementation of his or her person-centered plan of care. Corrective Action: Communication audit was done- identified resident R338 to ensur communication needs were add Resident's electronic care plan, a Care Card were updated with individualized communication interventions. 9-27-17 Identification of Other Residents Communication Section was add TCU Care Card to ensure comminterventions will be identified for admits with a Language barrier.	ght to nd with re all ressed. and TCU : ded to nunication	

Facility ID: 00164

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/02/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245242	B. WING _			08/2	24/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE (	CENTER OF MINNEAPOLIS			007 EAST 14TH STREET IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	did not ambulate. F R338 was frequentil bowel and was not R338's Care Area A 2/9/17, indicated R3 Somali and family r times R338 thought listed various caus which included cultur recognizing caregiv risk factors included decreased progress therapies. Also, the bowel and bladder if control, history of st was not consistent needs to be change communication did addressed on the C R338's quarterly MI R338 had severely preferred language wanted an interpret or health care staff. required extensive a daily living (ADL). T was occasionally in incontinent of bowe program. R338's current care listed the problem of adequate, and indio understood through directed staff to rep communicate, under	urther, the MDS indicated y incontinent of urine and on a toileting program. Assessment (CAA) dated 338's primary language was eported confusion and at t she was in Africa. The CAA es and contributing factors ural/language barrier, not ers or medical equipment and d social isolation, confusion, s and participation in rehab CAA indicated R338 had incontinence with some tress incontinence and R338 with letting staff know she ed. The CAA for not trigger and was not	F 2	80	<ul> <li>9-27-17</li> <li>Communication audits were complall residents with an identified lang communication barrier to ensure communication needs are address Resident's electronic care plans ar care sheets were updated as need individualized communication interventions.</li> <li>10-6-17</li> <li>Measures Put in Place:</li> <li>Mandatory all staff education was completed on the importance of communication interventions as a developing a resident-centered placare.</li> <li>10-11-17</li> <li>Monitoring Mechanisms:</li> <li>20% random audits will be done of Care Cards, LTC resident care she and electronic care plans on all unimonthly for the next 60 days.</li> <li>10-10-17</li> <li>11-10-17</li> <li>12-10-17</li> <li>Audits will be reviewed by the Qual Improvement Committee for comp with providing a resident-centered care on or before</li> <li>10-19-17</li> <li>11-30-17</li> <li>12-31-17</li> <li>Responsible Person/s:</li> <li>Director of Nursing</li> <li>Clinical Managers</li> <li>Quality Improvement Director</li> </ul>	ed. ed. hd NAR ed with bart of n of TCU eets, ts lity liance	

Facility ID: 00164

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 02/02/2018 APPROVED . 0938-0391
STATEMEN	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245242	B. WING		08/	24/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	, CODE	
AUGUST	TANA HEALTH CARE	CENTER OF MINNEAPOLIS		007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 280	R338's care plan id language was Som weakness, dementi assistance with bec assist to lift legs in/i in bed. R338's care simply and clearly a environmental cues communicate at ey explain cares/treatr needed and consisis cares. The care pla opportunity for patie social services as r talk through anger a schedule an interpr practitioner/physicia upon request. No fu were listed to effect or assistive devices R338. Review of R338's u listed various interva assistance with AD lacked any interven barrier. During observations R338 wore a hospit of her bed with her (NA)-G entered R33 light and asked R33 proceeded to repeat repeatedly tapped f NA-G stated she was R338 was trying to repeat the foreign v	ge 13 entified R338's primary ali, had frequent pain, a, required extensive d mobility, boost up in bed, but of bed, and sitting position plan directed staff to speak and repeat as needed, utilize as calendars, clocks, notes, e level and establish calm, nents before beginning, as tent routine when providing n directed to provide ent to express feelings, involve needed, encourage resident to and frustration, and to eter for rehab therapies, nurse an visits, care conferences and urther care plan interventions tively communicate with R338, a to use to communicate with ndated Transitional Care Card entions which included Ls, however, the care card tions for R338's language s on 8/23/17, at 8:56 a.m. cal gown, seated on the edge call light on. Nursing assistant 38's room, deactivated the call 38 what she needed. R338 th foreign words, and her thigh with her left hand. as unable to understand what tell her. R338 continued to words, proceeded to place both front her, and spread her legs.	F 280			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/02/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245242	B. WING	ì		08/:	24/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			007 EAST 14TH STREET /INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	R338 extended her front of her groin wi sound repeatedly. F "sheeeew" sounds NA-G exited the roo At 8:59 a.m. NA-G R338 wanted, but th She stated, "No one it's very hard, I don' indicated she was r facility who spoke F hard to communica gestures or movem gestures and move to communicate wit when working with I At 9:02 a.m. R338 v bed, and R338's ca began to speak fore fast to registered nu entered her room a left hand on the left continued to repeat angry, frustrated vo hands out in front h extended her finger of her groin while m repeatedly. R338 o the "sheeeew" sour repeatedly if she wa appeared to get mo in her foreign langu her uneaten food ite waved her left arm	fingers open and arms out in hile making a "sheeeew" R338 continued make the and gestures for NA-G until om at 8:59 a.m. stated she did not know what hought she was having pain. the here speaks this language, t understand her." NA-G hot aware of anyone in the R338's language and felt it was te with R338 utilizing hand ents. NA-G indicated the hand ments staff utilized to attempt h R338 were not effective	F 2	280			

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TATEMENT	OF DEFICIENCIES	KEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED
		045040				
		245242	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	08	/24/2017
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS	1	007 EAST 14TH STREET NINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 280	R338 continued to rapid in a loud voice cry and stated, "hul indicated she was in need to go to the be bedpan to the bed, to place the bedpan she removed R338 repeatedly moaned rapid, frustrated vo place the bedpan be out of the way of the placed under her be void on the bedpan During interview on stated staff had a he wanted when she of staff have to guess resident got frustrat On 8/21/17, at 7:53 stated in the past we facility to visit R338 stated he was away void or have a bow left on the bedpan f FM-A indicated he R338's elimination had been told the s R338. FM-A indicated R338's wall for staff communicate with On 8/23/17, at 9:21 difficult to communicate states and the second states and the second of the second states and the second communicate with second states and the second states and the second states and the second states and the second states and the second states and the secon	appear upset, talking very e and proceeded to whimper, h, huh, huh" repeatedly. RN-D unsure, but felt R338 may athroom and brought a RN-D proceeded to attempt n under R338's buttocks, while 's disposable brief. R338 d, "uhhh, uhhh, uhhh" in a ice and frantically assisted to by moving her hospital gown e bedpan. With the bedpan uttocks, R338 proceeded to a large amount of urine. N8/23/17, at 9:11 a.m. RN-D hard time knowing what R338 called for assistance and stated a lot of the time and the ted during that time. B p.m. family member (FM)-A when family have come to 8, she had been crying. FM-A re R338 had attempted to not el movement, to avoid being for extended periods of time. had reported the concerns with needs, to nursing staff and staff do not have time to assist ted he had posted a note on f to utilize to call him to help R338. a.m. RN-D indicated it was icate with R338 due to the nd indicated she only knew a				

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	02/02/2018 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE	E SURVEY PLETED
		245242	B. WING	à			08/2	24/2017
NAME OF F	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, Z	IP CODE		.,
AUGUST	ANA HEALTH CARE (	CENTER OF MINNEAPOLIS			1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD HE APPROPE	BE	(X5) COMPLETION DATE
F 280	what R338 needed On 8/23/17, at 9:41 interview with NA-G gestures to attempt and stated she was interventions to utiliz R338. NA-G indicat the family member in R338 needed assis had not utilized an in not aware how to re- interpreter services. On 8/23/17, at 9:50 communication was she pointed at object when he was availar routine was to stand point until she figure wanted. NA-H indication interpreter services On 8/23/17, at 12:12 present in the buildit services were utilized appointments with r of any other time inti- in the facility. The inti- (8/23/17), was the fit a schedule medicat today. On 8/23/17, at 12:22 the interpreter and In- not communicate w	a.m. during a follow up a, she stated she used hand to communicate with R338 not aware of any other ze while communicating with ed in the past she had called to attempt to figure out what tance with. NA-G stated she nterpreter in the past and was equest for or use needed a.m. NA-H indicated a difficult with R338 and stated cts or had her son translate ble. NA-H indicated her usual d in her room, have R338 ed out what R338 needed or ated she had not utilized	F	280				
	had been left on the	e bedpan without assistance in				If a set 1		
-ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID:M4PX1	1	Fa	acility ID: 00164	If continuation	on sheet l	Page 17 of 81

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			С	FORM. MB NO.	02/02/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245242	B. WING	i		08/;	24/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE (	CENTER OF MINNEAPOLIS			007 EAST 14TH STREET /INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	the past, she had tr so she could avoid R338 indicated she incontinent product bedpan and stated sometimes made h if she was able to c care would be better welcome staff help, then they just leave and indicated she fe education when she blamed herself and learning the langua isolated, could not g because staff could they were unable to the interpreter, R33 receive assistance and bursting. R338 her room in the pas communication, how longer in her room a pictures were. On 8/23/17 at 12:25 interview, FM-A indi telephone numbers help with R338's lar staff did not use the had been told by the cares and did not u R338 would call hin facility to get R338 stated he felt if R33 were offering, she w indicated he felt the	ge 17 ied not to go to the bathroom that from happening again. had bowel movements in her due to avoiding use of the it made her feel bad, er cry. R338 indicated she felt ommunicate with staff, her er. R338 indicated she would but staff comes in her room, without providing assistance elt regret not getting the e was younger and stated she people before her for not ge. R338 indicated she felt get up on her own, and stated not communicate with her, help her. Through the use of 8 stated when she did not at times she felt like exploding indicated she had pictures in t for assistance with wever, the pictures were no and was not aware where the 5 p.m. during second icated he posted a note with to the wall in R338's room to nguage barrier, but the facility e telephone numbers. FM-A e facility staff R338 refused se her call light. FM-A stated n on telephone, he called the assistance with toileting. FM-A 8 understood what the staff yould not refuse. FM-A e number one issue with her munication with R338's	F	280			

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		AND HUMAN SERVICES				FORM	02/02/2018 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION		E SURVEY PLETED
		245242	B. WING	i		08/:	24/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	Continued From pa	ge 18	F 2	280			
	FM-A indicated he wassist R338 with toil everything she need ago, he had come to been incontinent of had reported that sl longer. FM-A indica concerns with the la facility staff many the he had suggested u utilize pictures of va- the Internet to use to R338. FM-A stated "maybe once" and I R338's room since. not utilized an interp communication for On 8/24/17, at 8:37 edge of her bed, wi left, and was observe telephone. Above the to R338's bed, a whapproximately 8 ince the wall. On the pap- instructions for com- service. On 8/24/17 at 8:56 R338's room and in- communication care R338 was not able "so did not really we was easier to have communication and indicated the usual something, she work	visited everyday and would ileting, dressing and ded. FM-A stated a few days to the facility and R338 had urine all over the bed and she he could not hold her urine any ated he had discussed his anguage barrier for R338 with mes in the past. He indicated use of an interpreter or staff to arious items or objects from to assist communication with he had seen pictures used had not seen the pictures in FM-A stated the facility had oreter to assist in cares for R338. a.m. R338 was seated on the th a cellular telephone in her ved to dial the cellular ne night stand, which was next nite piece of paper, shes (in) by 11 in. was taped to ber, typed in black ink, were tacting an online interpreter a.m. RN-G was present in indicated staff had used ds with words on them, but to read the cards and stated, ork that well." RN-G stated it					

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		& MEDICAID SERVICES	0.00				<u>D. 0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		ATE SURVEY OMPLETED
		245242	B. WING	à		08	8/24/2017
NAME OF I	PROVIDER OR SUPPLIER	•	•	STR	EET ADDRESS, CITY, STATE, ZIP (	CODE	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			' EAST 14TH STREET NEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 280		eded assistance with. She	F	280			
	posted in R338's ro now. RN-G indicate assistance in time of incontinent of urine always continent of not aware of any co R338 and stated, "I communication." On 8/24/17 at 9:43 interview, FM-A ind respond to her, she bed and stated "hat and holds it." He ind assistance she wou FM-A stated the inter last night. On 8/24/17, at 9:00	preter hot line information oom had not in her room unti- ed of R338 did not receive or had urgency she would be and stated she felt R338 wa bowel. RN-G denied she wa ommunication concerns with don't think the problem is a.m. during a follow up licated when staff did not e would be incontinent on the ppens quite a bit, she holds i dicated when she called for uld have incontinence issues erpreter information in R338 e until they came to visit her 0 a.m. NA-J stated she was ame language (Somali) as	e as as	S			
	R338. She indicate her hip when she h stated other staff th but R338 used thes to go to the bathroo assistance with toil utilized the call light	ed R338 would point or slap ad to go to the bathroom. Sh nink this gesture was for pain se gestures to indicate she h pm. NA-J verified R338 need eting, used the bedpan and t for assistance. NA-J	as				
	incontinence with b staff who do not un cared for her. NA- R338, she was con but when staff who communicate with	her provided cares for R338, She indicated R338 had	or ef,				

ND PLAN (	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		LTIPLE CONSTRU		( )	TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING		CC	MPLETED
		245242	B. WING	i		08	8/24/2017
IAME OF	PROVIDER OR SUPPLIER			STREET ADDF	RESS, CITY, STATE, ZIP C	ODE	
UGUST	TANA HEALTH CARE	CENTER OF MINNEAPOLIS			4TH STREET DLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EAC	ROVIDER'S PLAN OF COP CH CORRECTIVE ACTION S-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 280	Continued From pa	age 20	F 2	280			
	aware the interpret when R338 had sc appointments. NA- staff many times of language barrier, a hotline posted in R until recently. She paper in her room I On 8/24/17, at 9:07	J stated she had told nursing ther concerns with R338's ind confirmed the interpreter 338's room was not present stated, "She did not have that before." 7 a.m. NA-K stated she was tame language (Somali) as					

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUL	TIPLE CONSTRUCTION		0. 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG	· · ·	MPLETED
		245242	B. WING		08	/24/2017
NAME OF I	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP (	CODE	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 280	Continued From pa	age 21	F 2	80		
	communicating with	ot aware of any problems h R338. SW-A confirmed no				
		had been put in place to assis communicate with staff.	t			
	(DON) confirmed F	33 p.m. director of nursing 338's current care plan and				
	plan, staff to assist	ed staff to follow R338's care as needed, and meet her DON indicated she would				
	expect staff to assi	st the resident to stay resident with cares, answer				
	call lights. DON ind barrier due to not s	licated R338 had a language peaking English and would				
	available, or use pi	an interpreter, family if cture cards or online service. had access to the online				
	interpreter services utilize the resource	and she would expect staff to s available to communicate				
	aware of any conce	DN indicated she was not erns with R338's language				
	admitted who have facility practice was	ndicated when residents were language barriers, the usual to send an email notification				
	to all staff to notify resident's primary l	them of the individual				
		anguage and if the family was				
	available to assist. we have family to a The DON indicated	anguage and if the family was She stated "90%" of the time accommodate for their needs. I the facility routinely scheduled	b			
	available to assist. we have family to a The DON indicated an interpreter for th medical appointme not schedule any fu	anguage and if the family was She stated "90%" of the time accommodate for their needs. I the facility routinely scheduled herapy appointments and ints, and stated the facility did urther services unless they felt				
	available to assist. we have family to a The DON indicated an interpreter for the medical appointme not schedule any fu the communication indicated 338's sort	anguage and if the family was She stated "90%" of the time accommodate for their needs. I the facility routinely scheduled herapy appointments and ints, and stated the facility did				
	available to assist. we have family to a The DON indicated an interpreter for the medical appointme not schedule any fu the communication indicated 338's son and stated she had	anguage and if the family was She stated "90%" of the time accommodate for their needs. I the facility routinely scheduled herapy appointments and onts, and stated the facility did urther services unless they felt was unclear. The DON in came to the facility quite a lot				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 02/02/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245242	B. WING		08/	24/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIC X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 280 F 282 SS=D	assessment or as c will be reviewed at 1 needed. The policy personal and cultur incorporated into th plan goals. The policy provide written guid the resident to mee care and psychosolo person-centered de plan of care. This p sheets and /or profit changes to ensure plan of care." SERVICES BY QU/ CARE PLAN CFR(s): 483.21(b)(3) (b)(3) Comprehens The services provide as outlined by the c must- (ii) Be provided by c accordance with ea care. This REQUIREMEN by: Based on observat review, the facility fa interventions for us of 2 residents (R12)	npletion of the comprehensive changes occur. The care plan least quarterly and revised as also indicated the residents al references will be e development of the care icy further indicated care plans les for intervention, assisting t their needs for ADL's, health cial needs and to provide for evelopment of the resident's olicy also indicated "NAR Care les are updated per care plan the practice of following the ALIFIED PERSONS/PER 3)(ii) ive Care Plans led or arranged by the facility, omprehensive care plan,	F 2		by the ensive Ilified	10/12/17

Event ID: M4PX11

Facility ID: 00164

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/02/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245242	B. WING		08/2	24/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 282	R123's care plan da required extensive transfers, staff to cu transfers, R123 ma resident reports fee plan dated 8/14/17, for sling related to a EZ stand strap/sling R123's undated car fall risk, required ex stand pivot transfer protective boot, OR sling when resident following words we underlined and in r LG(large) sling with During observation was observed lying (NA)-A present in th she was ready to ge yes, NA-A proceede At 7:55 a.m. NA-A mechanical lift and lift had a sling with over the top of the I lift up to the edge o her feet on the lift's lift into place. NA-A R123's back, attach the hooks of the EZ safety belt around F R123's calves. NA- and utilized the hyd while R123 wore bla held on to both han unlock the EZ stand	ated 8/22/17, indicated R123 assistance of one staff with ue resident before and during y use the EZ stand when ling weak. R123's fall care indicated R123 was resized a fall, appropriate large fitting	F2	<ul> <li>proper use of the EZ stand, sling size for identified resided 8-23-17</li> <li>Staff were immediately re-enecessity to use the proper equipment per resident's plaidentified resident R228</li> <li>8-24-17</li> <li>Identification of Other Reside All residents were audited for transfer equipment and sling weight, transfer ability and care plans and care sheets and revised if needed statim sling size and appropriate trequipment for each resident 9-30-17</li> <li>Measures Put in Place: Mandatory education for all was conducted on use of EZ proper sling size, and safety resident transfers.</li> <li>10-11-7</li> <li>Monitoring Mechanisms: Staff skill checks will be conresidents requiring the use of equipment to ensure proper and sling size is used.</li> <li>10-10-17</li> <li>Random staff skill checks will checks will equipment and sling size is used.</li> <li>10-17-17</li> <li>10-24-17</li> <li>10-31-17</li> <li>11-4-17</li> <li>Random staff skill checks will ch</li></ul>	lents F123 ducated on transfer an of care for lents: or appropriate g size per care plan. All were reviewed g the correct cansfer t. nursing staff Z stand, EZ lift, y protocols for nducted for all of transfer r equipment <i>i</i> ll be all units weekly ire proper used.	

Facility ID: 00164

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	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION		E SURVEY
ID PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COM	PLETED
245242		B. WING	B. WING			08/24/2017	
AME OF PROVIDER OR SUPPLIER				ST	REET ADDRESS, CITY, STATE, ZIP CODE		
UGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			07 EAST 14TH STREET INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
F 282	Continued From pa	ge 24	F 2	282			
	front of her wheelch control to lower R12 R123 was seated in NA-A was really goo on. NA-A unlocked removed her feet fr belts were released sling with beige colo NA-A confirmed the was a size medium tag attached to the During interview on reported she fell fro weeks ago. R123 r member hooked he member did not hoo abdomen, and had the hooks of the lift from the lift all staff the belts, and she h R123 reported after her ribs all the way stated she still gets picture in her mind transferred. R123 s gloves to make sur- the handles of the l reported prior to he not always attachina abdomen, then stat information to any r from the EZ stand I admission.	e lift in place once R123 was in hair, and used the remote 23 into her wheelchair. Once in the wheelchair, she stated od about putting all the belts the EZ stand lift, R123 om the platform, both safety d, loops unhooked, and the ored binding was removed. e sling used to transfer R123 , as she visualized the white sling with a letter M on the tag. 8/23/17, at 8:07 a.m. R123 om the EZ stand lift a few reported when the staff ok the safety belt around her only attached the loops on to . R123 reported since she fell had been hooking up all of has not had any further falls. r she fell she had pain from down to her bottom. R123 scared, and repeats the of falling when she gets stated she now wears gripper e she has a secure hold on ift during transfers. R123 r fall from the lift, staff were g the safety belt around her red she had not reported that nurses. R123 stated the fall ift has been her only fall since		S	monthly for the next 60 days to e proper equipment and sling size 12-4-17 1-4-18 All skills checks will be reviewed monthly QI/QAA meetings for col- with standard of care for the next on or before 10-31-17 11-30-17 12-31-17 1-31-18 Responsible Person/s Director of Nursing Clinical Managers Staff Development Director Quality Improvement Director	is used. at the mpliance	

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM OMB NO.	: 02/02/2018 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED
		245242	B. WING _		08/	24/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE (	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 282	of eating which she reported staff carry indicate what each NA-A reported R122 she was aware of, s because the lift was staff decide and che for each resident, a use it. NA-A confirr sling to transfer R12 marked with a M or color guide attached transfer which indic colored binding wer indicated the sling s During interview or stated sling size wa discretion and to the staff document the sheet. RN-C was n be transferred with stated R123's ident plan and care shee but reported the res sling felt comfortabl R123. When interviewed of licensed practical n were measured aro sling sizes were def like a girdle. LPN-E used was documen and confirmed R12 sling with all transfer	was independent. NA-A care guide sheets that resident needs for assistance. 3 did have one fall only that stated R123 fell from the lift a not working. NA-A verified bose which size sling to use nd stated if the sling fits, we ned she used a medium sized 23, and verified the tag n it. NA-A also indicated a d to the lift used for R123's ated slings with a beige re size medium. NA-A also size was on R123's care plan. n 8/24/17, at 9:44 a.m. RN-C s determined by staff e resident's comfort level, then size on the care plan and care totified R123 was observed to a medium sized sling, RN-C ified sling size on her care t indicated a large size sling, sident stated the medium sized le for her when she visited with on 8/23/17, at 11:50 a.m. urse (LPN)-B stated residents und their abdomen, then the termined by the measurement, 8 stated the sling size to be ted in the resident's care plan, 3 should use a large sized	F 28			

If continuation sheet Page 26 of 81

					OMB NO			
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245242	B. WING		08	08/24/2017		
NAME OF	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	•		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE		
F 282	Continued From pa	ge 26	F 2	82				
	not have the correct laundry to obtain th NA-B believed R12 sling. When interviewed of verified R123 used transfers and exten NA-C stated R123 sized sling for all tra- information was alse verified she was give the mechanical lifts When interviewed of indicated R123 req one staff and the E a large sized sling. When interviewed of LPN-C confirmed F for all transfers, and always transferred. completed the asses appropriate sling si correct size was do and care plan. When interviewed of director of nursing of had the fall from the analysis was comp R123 let go of the f felt the harness wa investigated, the wo	3 required an extra large sized on 8/24/17, at 9:30 a.m. NA-C an EZ stand lift for all sive assistance of one staff. required the use of a large ansfers, and indicated this so on the care sheets. NA-C ven education on the use of						

TATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         ND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	· · /	(X3) DATE SURVEY COMPLETED		
		245242	B. WING		09	/04/0017
	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	08	/24/2017
		CENTER OF MINNEAPOLIS	10	INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 282	ensure the sling fit The DON stated at believed a different The DON confirme a medium sized sli determining the pro- weight, but weights according the man She stated we take resident's comfort width, and what loo sling size assessm was more of a judg factors, then the si care sheet and car should use a large transfers with R123 reason there need would be reviewed DON stated staff d sling size changes indicated on the ca size. The DON sta- manager re-assess sling size, and bas did, the sling shoul all staff should be p the care sheets an indicates a large si confirmed there we assessments regal stand lift, other tha stated the interdisc of a discussion, tal picture of what hap new interventions s	age 27 properly and was comfortable. Iter the investigation, staff t size sling should be used. ed prior to the fall R123 utilized ng. The DON stated when oper size sling, staff look at a were pretty fluid and variable ufacture's chart and guidelines e in to consideration the level of sling, generalized oks safe. The DON verified the ent was not documented, as it gement based on clinical ze was documented on the e plan. The DON verified staff sized sling for all EZ stand lift 3, unless there was some ed to be a change, the change by the clinical manager. The o not routinely document if the , then stated it would be are sheet as being a different ated she had the clinical s R123 on 8/23/17 for proper ed on the assessment that she d be a large size, and verified providing care as directed by d care plan which also ze sling to be used. The DON ere no other documents or rding R123's fall from the EZ n the event report. The DON siplinary team (IDT) had more ks with people to get more of a opened, so we know what the should be, and verified this is cord" as the IDT talked. The				

DEPARTMENT OF HEALTH AND HUMAN SERVICES							
						DMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,			E SURVEY IPLETED		
			7.1. 20122.1.1				
		245242	B. WING _		08/	24/2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
AUGUST	ANA HEALTH CARE (	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)	
PRÉFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR		COMPLÉTION DATE	
				DEFICIENCY)			
F 000		22	<b>_</b>				
F 282	Continued From pa	ge 28 r to each use, and stated	F 28	32			
		ely inspects the lifts and					
	slings.						
		ision dated 8/19/17, indicated st with transfers due to					
		lated to Parkinson disease.					
	R228 careplan dire	cted staff "transfers with assist					
	of two via an EZ lift.	."					
	The untitled, undate	ed nursing assistant care					
	sheet updated 8/21, "Transfers: EZ-Lift."	/17, indicated for R228					
	Transfers. EZ-Lift.						
		ion on 8/24/17, at 1:14 p.m.					
		and nurses aide (NA)-P rolled					
		he hallway and entered R228 y cued R228 she was going to					
	use the EZ stand to	transfer him from his wheel					
		-O and NA-P placed an EZ					
		ack and cued R228 "lean sling behind you, your weaker					
	arm is on right." NA	-O cued R228 to hold onto					
		vith his arms. NA-O placed his					
		ansfer R228 from his ed. NA-O and NA-P continued					
	with transfer from w	heelchair to the bed. As R228					
		edge of bed he said "wait a					
		ied to right side as legs EZ stand. NA-O and NA-P					
	lifted R228 legs up	onto the bed and positioned					
	him in bed.						

If continuation sheet Page 29 of 81

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE			AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/02/2018 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS         X(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)       COMPLE COMPLE DAT         F 282       Continued From page 29 During an interview on 8/24/17, at 1:30 p.m. with clinical manager (CM)-A stated R228 had a recent accident with the EZ stand. CM-A stated R228 legs and arms were not strong enough for him to safely be transferred with an EZ stand.       F 282		S						
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)       COMPLE COMPLE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLE COMPLE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLE CROSS-REFERENCED TO THE APPROPRIATE DEFI			245242	B. WING	i		08/	24/2017
AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS         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 COMPLE DAT         F 282       Continued From page 29 During an interview on 8/24/17, at 1:30 p.m. with clinical manager (CM)-A stated R228 had a recent accident with the EZ stand. CM-A stated R228 legs and arms were not strong enough for him to safely be transferred with an EZ stand.       F 282	NAME OF PROVIDER OR SUI	PPLIER						
PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)COMPLE DATF 282Continued From page 29 During an interview on 8/24/17, at 1:30 p.m. with clinical manager (CM)-A stated R228 had a recent accident with the EZ stand. CM-A stated R228 legs and arms were not strong enough for him to safely be transferred with an EZ stand.F 282	AUGUSTANA HEALTH	CARE	CENTER OF MINNEAPOLIS					
During an interview on 8/24/17, at 1:30 p.m. with clinical manager (CM)-A stated R228 had a recent accident with the EZ stand. CM-A stated R228 legs and arms were not strong enough for him to safely be transferred with an EZ stand.	PREFIX (EACH DEF	ICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE	(X5) COMPLETION DATE
<ul> <li>been changed to use of a EZ lift to ensure a safe transfer. CM-A stated staff were made aware of care plan changes through shift communication, careplan review and aid care sheets. OM-A stated the NA-O and NA-P should have been using the EZ lift with R228. During the interview with CM-A, NA-O approached the desk area and stated R228 was hollering and said he didn't want a strap between his legs so she used an EZ stand. CM-A stated to NA-O, he was supposed to be transferred with the EZ lift. NA-O did not respond.</li> <li>During an interview on 8/24/17, at 3:59 p.m. with director of nursing (DON) stated R228 care plan had been updated on 8/19/17 for an EZ lift to be used as R228 had weakness in arms and legs and was not safe to use on a EZ stand. DON also stated staff had been informed of the changes and were provided education.</li> <li>The facility's Care Plan policy dated 11/2016, indicated care plans are developed to provide written guides for intervention, assisting the resident to meet their needs for ADL's, health care and psychosocial needs and to provide for person-centered development of the resident's plan of care.</li> </ul>	During an intr clinical mana recent accide R228 legs an him to safely CM-A stated been change transfer. CM- care plan cha careplan revi the NA-O and EZ lift with R3 , NA-O appro R228 was ho strap betwee CM-A stated transferred w During an intr director of nu had been upp used as R220 and was not stated staff h and were pro The facility's indicated car written guide resident to m care and psy person-cente plan of care. ADLS DO NO UNAVOIDAB CFR(s): 483.	erview ger (C ent with d arm be tra R228 d to us A state anges ew and d NA-F 228. D bached llering n his k to NA- ith the erview rrsing ( dated of 8 had of safe to ad bee vided Care F e plans s for in eet the choso of FLE 24(a) (I	on 8/24/17, at 1:30 p.m. with M)-A stated R228 had a the EZ stand. CM-A stated s were not strong enough for insferred with an EZ stand. careplan interventions had se of a EZ lift to ensure a safe ed staff were made aware of through shift communication, d aid care sheets. CM-A stated P should have been using the uring the interview with CM-A the desk area and stated and said he didn't want a egs so she used an EZ stand. O, he was supposed to be EZ lift. NA-O did not respond. on 8/24/17, at 3:59 p.m. with DON) stated R228 care plan on 8/19/17 for an EZ lift to be weakness in arms and legs o use on a EZ stand. DON also en informed of the changes education. Plan policy dated 11/2016, s are developed to provide tervention, assisting the eir needs for ADL's, health cial needs and to provide for evelopment of the resident's CLINE UNLESS b)					10/12/17

If continuation sheet Page 30 of 81

CENTERS FOR MEDICARE & MEDICAID SERVICES		FORM APPROVED OMB NO. 0938-0391
	NULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
<b>245242</b> B. WI	NG	08/24/2017
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR	ID PROVIDER'S PLAN OF CORREC EFIX (EACH CORRECTIVE ACTION SHO AG CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE COMPLETION
<ul> <li>F 310 Continued From page 30 resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: <ol> <li>A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section,</li> <li>Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: <ol> <li>Hygiene -bathing, dressing, grooming, and oral care,</li> <li>Mobility-transfer and ambulation, including walking,</li> <li>Elimination-toileting,</li> <li>Dining-eating, including meals and snacks,</li> <li>Communication, including</li> <li>Speech,</li> <li>Language,</li> <li>Other functional communication systems. This REQUIREMENT is not met as evidenced by:</li> </ol> </li> </ol></li></ul>	F 310	

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/02/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245242	B. WING _		08/2	24/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 310	Based on observat review, the facility facommunication ser- living to ensure bas resident (R338) with deficient practice re- for R338, who expe- emotional distress in her basic needs we inadequate commu- Findings include: R338's admission M dated 2/5/17, identi- which included arth and unspecified ur indicated R338 had memory problems, cognitive skills for co- preferred language wanted an interpret or health care staff. R338 required exter mobility, dressing, t did not ambulate. F R338 was frequent bowel and was not R338's Care Area A 2/9/17, indicated R3 Somali and family r times R338 thought listed various caus which included cultur recognizing caregiv- risk factors included decreased progress	ge 31 ion, interview and document ailed to provide sufficient vices for activities of daily ic needs were met for 1 of 1 n a language barrier. This isulted in psychosocial harm rienced isolation and related to incontinence when re unable to be met due to nication with facility staff. <i>M</i> inimum Data Set (MDS) fied R338 had diagnoses ritis, chronic pain syndrome, inary incontinence. The MDS both short and long term had moderately impaired laily decision making, her was Somali and needed or er to communicate with doctor The MDS also indicated nsive assistance for bed oileting, personal hygiene and urther, the MDS indicated y incontinent of urine and on a toileting program. Assessment (CAA) dated 338's primary language was eported confusion and at a she was in Africa. The CAA es and contributing factors ural/language barrier, not ers or medical equipment and d social isolation, confusion, a and participation in rehab CAA indicated R338 had	F 3	<ul> <li>F310</li> <li>It is the policy of the Augustana He Care Center to provide the necess care and services to ensure that a resident's abilities in activities of da living do not diminish unless circumstances of the individual's c condition demonstrates that such diminution was unavoidable. corrective Action:</li> <li>Identified resident R338 was assess incontinence and communication careas and appropriate changes we made to the care plan.</li> <li>Resident was supplied with wall m communication cards that can be a staff to speak her language and for resident to point to when communication Section was adder TCU Care Card to ensure communication barrier.</li> <li>9-28-17</li> <li>Identification of Other Residents: Communication section was adder TCU Care Card to ensure communimiterventions will be identified for a admits with a language barrier.</li> <li>9-27-17</li> <li>Communication barrier to ensure communication barrier to ensure communication barrier to ensure communication barrier to ensure communication sector are plans ar care sheets were updated as need individualized communication interventions.</li> <li>10-6-17</li> <li>Measures Put in Place:</li> <li>Mandatory all staff education was completed to review communication</li> </ul>	ary aily linical seed for are ounted used by r the cating d to nication Il new leted on uage or uage or red. nd NAR led with	

Facility ID: 00164

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED	
		245242	B. WING		0.0/0	04/0017	
	PROVIDER OR SUPPLIER	210212		STREET ADDRESS, CITY, STATE, ZIP CODE	00/2	24/2017	
		CENTER OF MINNEAPOLIS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIOI DATE	
F 310	control, history of st was not consistent needs to be change communication did addressed on the C R338's quarterly MI R338 had severely preferred language wanted an interpret or health care staff. required extensive daily living (ADL). T was occasionally in incontinent of bowe program. R338's current care listed the problem of adequate, and indi understood through directed staff to rep communicate, unde hear and to refer fo R338's care plan id language was Som weakness, dementi assistance with beo assist to lift legs in/o in bed. R338's care simply and clearly a environmental cuess communicate at eye explain cares/treatr needed and consist cares. The care pla	incontinence with some tress incontinence and R338 with letting staff know she ed. The CAA for not trigger and was not	F 31		will be a ill ency s/tools becific to will be ext 60		

Facility ID: 00164

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CONSTRUCTION		<u>1B NO. 09</u> X3) DATE SI		
	F CORRECTION	IDENTIFICATION NUMBER:		ING		COMPLE		
		245242	B. WING			08/24/	2017	
IAME OF F	PROVIDER OR SUPPLIER	• •		STREET ADDRESS,	CITY, STATE, ZIP CODE			
UGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CO	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD E ERENCED TO THE APPROPRI DEFICIENCY)		(X5) OMPLETIO DATE	
F 310	Continued From pa	ige 33	F3	10				
	talk through anger	and frustration, and to		12-31-17				
	schedule an interpr	eter for rehab therapies, nurse		1-31-18				
		an visits, care conferences and	b	Responsible				
		urther care plan interventions tively communicate with R338.		Director of N Clinical Mana				
		s to use to communicate with hose,			ovement Director			
	R338.	s to use to communicate with		Quality impre	Svement Director			
	Review of R338's u	Indated Transitional Care Carc	1					
		rentions which included	-					
		Ls, however, the care card						
	lacked any interven barrier.	tions for R338's language						
		s on 8/23/17, at 8:56 a.m. tal gown, seated on the edge						
	of her bed with her	call light on. Nursing assistant						
		38's room, deactivated the cal						
		38 what she needed. R338						
		at foreign words, and her thigh with her left hand.						
		as unable to understand what						
		tell her. R338 continued to						
		vords, proceeded to place both						
		front her, and spread her legs	•					
		fingers open and arms out in hile making a "sheeeew"						
		R338 continued make the						
		and gestures for NA-G until						
	NA-G exited the roo	om at 8:59 a.m.						
		stated she did not know what	t					
		hought she was having pain. e here speaks this language,						
		't understand her." NA-G						
		not aware of anyone in the						
	facility who spoke F	R338's language and felt it was	6					
		te with R338 utilizing hand nents. NA-G indicated the hand						
						1		

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	OF DEFICIENCIES	KANNER STATE STREET STREE		E CONSTRUCTION	X3) DATE S (X3) DATE S COMPLE	URVEY
		245242	B. WING		08/24	/2017
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS	10	TREET ADDRESS, CITY, STATE, ZIP CODE D07 EAST 14TH STREET IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE C	(X5) COMPLETIC DATE
F 310	gestures and move to communicate wi when working with At 9:02 a.m. R338 bed, and R338's ca began to speak for fast to registered n entered her room a left hand on the left continued to repea angry, frustrated vo hands out in front h extended her finge of her groin while n repeatedly. R338 of the "sheeew" soun repeatedly if she w appeared to get m in her foreign langu her uneaten food it waved her left arm her head. NA-G sta she wants." R338 continued to rapid in a loud voic cry and stated, "hu indicated she was need to go to the b bedpan to the bed, to place the bedpan out of the way of the	ements staff utilized to attempt th R338 were not effective	F 310			

		AND HUMAN SERVICES			FORM	APPROVED
STATEMENT OF		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		0938-0391 E SURVEY
AND PLAN OF C		IDENTIFICATION NUMBER:		NG		PLETED
		245242	B. WING _		08/:	24/2017
NAME OF PRO	VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUSTAN	A HEALTH CARE (	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET		
				MINNEAPOLIS, MN 55404		T
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 310 C	ontinued From pag	ge 35	F 31	0		
Di sta va sta re Re 8/ -5 ha m re tro ap dia m Th ar -5 ini -6 sc ini -6 sc ini -7 pa dia ur -7	uring interview on ated staff had a ha anted when she ca aff have to guess esident got frustrati eview of R338's pr /21/17, revealed th i/5/17, Somali inter ad moderately imp oderate risk for m ported trouble falli puble concentratin opetite. R338 did r agnoses, not rece edications, refuse he note listed soci- nd assist as needed i/7/17, alert and or terpreter, no Engli 6/6/17, care confer on will attend and i terpreter service. i/8/17, wound nurs anslated for the vis- uestions.	8/23/17, at 9:11 a.m. RN-D ard time knowing what R338 alled for assistance and stated a lot of the time and the ed during that time. rogress notes from 5/1/17 to ne following: rpreter used for assessment, vaired cognition and was at ood disturbance. R338 had ing asleep, feeling tired and g because of pain and poor not have mental health iving psychotropic d psychiatric services referral, al services would follow up ed.				

TATEMENT	OF DEFICIENCIES F CORRECTION	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED
			A. BUILDII	NG		
		245242	B. WING _			8/24/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1007 EAST 14TH STREET	CODE	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 310	Continued From pa	ge 36	F 3	10		
	indicated that he is requested that an in assessments. - 8/3/17, son expres language barrier. S needs were not bei as she was not able Facility staff sugges pictures as well as resident to use to c indicated he would implemented, and f flash cards and pro -8/4/17, resident un language barrier. F with communicating communication by cards. No further de implementation of f of the flash cards o	lash cards, the effectiveness				
	service assessmen reported R338 had problems, had diffic	pitalized at this time, social t done by staff interview. Staff no short or long term memory culty in new situations only with ng skills and minimal disorder.				
		n, teaching not effective due ability to understand.				
	stated in the past w	p.m. family member (FM)-A hen family have come to , she had been crying. FM-A				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED	
		245242	B. WING		08/2	24/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 310	void or have a bow left on the bedpan f FM-A indicated he l R338's elimination had been told the s R338. FM-A indicat R338's wall for staf communicate with l On 8/23/17, at 9:21 difficult to communi- language barrier an few words such as primary language. I contacted R338's s what R338 needed On 8/23/17, at 9:41 interview with NA-G gestures to attempt and stated she was interventions to utili R338. NA-G indicat the family member R338 needed assis had not utilized an in not aware how to re- interpreter services On 8/23/17, at 9:50 communication was she pointed at obje when he was availa- routine was to stan- point until she figure	<ul> <li>a.m. RN-D indicated it was indicated she had posted a note on f to utilize to call him to help R338.</li> <li>a.m. RN-D indicated it was indicated she only knew a medication, pain in R338's RN-D indicated she had on when she was not sure or wanted.</li> <li>a.m. during a follow up a, she stated she used hand it to communicate with R338 on the was not sure or wanted.</li> <li>a.m. during a follow up a, she stated she used hand called to attempt to figure out what tance with. NA-G stated she interpreter in the past and was equest for or use needed .</li> <li>a.m. NA-H indicated her usual d in her room, have R338</li> </ul>	F3				

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		AND HUMAN SERVICES			FORM	02/02/2018 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245242	B. WING		08/	24/2017
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE	, ZIP CODE	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	۱	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 310	present in the build services were utilize appointments with a of any other time in in the facility. The ir (8/23/17), was the f a schedule medical today. On 8/23/17, at 12:2 the interpreter and not communicate w with that sometimes had been left on the the past, she had tr so she could avoid R338 indicated she incontinent product bedpan and stated sometimes made h if she was able to c care would be bette welcome staff help, then they just leave and indicated she fi education when she blamed herself and learning the langua isolated, could not g because staff could they were unable to the interpreter, R33 receive assistance and bursting. R338 her room in the pas communication, ho longer in her room in pictures were.	8 p.m. an interpreter was ing and he stated interpreter ed for scheduled medical residents and was not aware terpreter services were utilized hterpreter indicated that day first time he had met R338 for appointment with the doctor 0 p.m. during interview with R338, R338 stated she could with staff and her son helps s. R338 indicated because she bedpan without assistance in ried not to go to the bathroom that from happening again. had bowel movements in her due to avoiding use of the it made her feel bad, er cry. R338 indicated she felt ommunicate with staff, her er. R338 indicated she would but staff comes in her room, without providing assistance elt regret not getting the e was younger and stated she people before her for not ge. R338 indicated she felt get up on her own, and stated in to communicate with her, o help her. Through the use of 8 stated when she did not at times she felt like exploding indicated she had pictures in st for assistance with wever, the pictures were no and was not aware where the	F 3			
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID:M4PX1	1	Facility ID: 00164	If continuation sheet	Page 39 of 81

## PRINTED: 02/02/2018 FORM APPROVED

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/02/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		245242	B. WING _		08/	24/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 310	Continued From pa	ge 39	F 3	10		
	interview, FM-A indi telephone numbers help with R338's lar staff did not use the had been told by the cares and did not u R338 would call hin facility to get R338 is stated he felt if R33 were offering, she v indicated he felt the care had been com language barrier. FM-A indicated he v assist R338 with toi everything she need ago, he had come t been incontinent of had reported that sl longer. FM-A indica concerns with the la facility staff many til he had suggested u utilize pictures of va the Internet to use t R338. FM-A stated "maybe once" and h R338's room since. not utilized an inter communication for On 8/24/17, at 8:37 edge of her bed, wi left, and was observed	a.m. R338 was seated on the th a cellular telephone in her yed to dial the cellular ne night stand, which was next				

If continuation sheet Page 40 of 81

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245242	B. WING			
	PROVIDER OR SUPPLIER	245242		TREET ADDRESS, CITY, STATE, ZIP CODE	08/	24/2017
		CENTER OF MINNEAPOLIS	10	007 EAST 14TH STREET IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 310	approximately 8 ind the wall. On the parinstructions for con- service. On 8/24/17 at 8:56 R338's room and in communication can R338 was not able "so did not really w was easier to have communication and indicated the usual something, she wo son would call the or R338 wanted or ne confirmed the inter posted in R338's ro now. RN-G indicate assistance in time incontinent of urine always continent of not aware of any co R338 and stated, " communication." On 8/24/17 at 9:43 interview, FM-A increspond to her, she bed and stated "ha and holds it." He in assistance she wor	age 40 ches (in) by 11 in. was taped to per, typed in black ink, were stacting an online interpreter a.m. RN-G was present in ndicated staff had used rds with words on them, but to read the cards and stated, ork that well." RN-G stated it staff to assist with d to translate for her. RN-G practice if R338 needed uld call her son and then her desk to let staff know what seded assistance with. She preter hot line information bom had not in her room until ed of R338 did not receive or had urgency she would be and stated she felt R338 was f bowel. RN-G denied she was ommunication concerns with I don't think the problem is a.m. during a follow up dicated when staff did not e would be incontinent on the ppens quite a bit, she holds it, dicated when she called for uld have incontinence issues. terpreter information in R338's	F 310			

ND PLAN C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVE	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	CON	MPLETED
		245242	B. WING _		08	/24/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
F 310	Continued From pa	age 41	F 3 <sup>-</sup>	10		
	stated other staff th but R338 used these to go to the bathroo assistance with toil utilized the call ligh indicated she was incontinence with b staff who do not un cared for her. NA-	ad to go to the bathroom. She nink this gesture was for pain se gestures to indicate she has om. NA-J verified R338 needed eting, used the bedpan and t for assistance. NA-J aware R338 has had bowel and bladder when other iderstand what she wants J indicated when she cared for ntinent and did not wear a brief.	ł			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/02/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED
		245242	B. WING		08/2	24/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE (	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
TAG F 310	Continued From pa her needs, was pre- cares and did not re- On 8/24/17, at 12:0 confirmed R338 pri- and indicated he wo for R338 or use the had medical appoint his portion of the M facility practice was son to translate, oth be patient and expla- indicated staff were- plan and to utilize th having trouble com- indicated he was no communicating with other interventions R338 to effectively On 8/24/17, at 12:3 (DON) confirmed R stated she expected plan, staff to assist needs consistently. expect staff to assist continent, help the patient call lights. DON ind barrier due to not sp expect staff to call a available, or use pion	ge 42 tty pleasant, cooperative with	F 310	DEFICIENCY)	PRIATE	DATE
	utilize the resources with R338. The DC aware of any conce barrier. The DON in admitted who have	and she would expect staff to s available to communicate DN indicated she was not erns with R338's language indicated when residents were language barriers, the usual to send an email notification				

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	OF DEFICIENCIES	& MEDICAID SERVICE     (X1) PROVIDER/SUPPLIER/CL     IDENTIFICATION NUMBEF	IA (X2) ML		E CONSTRUCTION	(X3) DA	. 0938-039 E SURVEY IPLETED
		245242	B. WIN				
		240242	D. WIN			08	24/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUSI	ANA HEALTH CARE	CENTER OF MINNEAPOL	IS		007 EAST 14TH STREET IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 310	Continued From pa	age 43	F	310			
	resident's primary available to assist. we have family to a The DON indicated an interpreter for th medical appointmen not schedule any fit the communication indicated 338's sor and stated she had with communication On 8/24/17, at 4:18 medical director (M	them of the individual language and if the family She stated "90%" of the accommodate for their ne d the facility routinely sche herapy appointments and ents, and stated the facility urther services unless the n was unclear. The DON n came to the facility quite d not heard of any concer n that impacted 338's ca 8 p.m. during a phone inter ID) indicated he was not ccess to an interpreter 24	time eeds. eduled y did ey felt e a lot ns tre. erview aware				
	hours a day. The N all residents would care to meet their felt it was difficult for	AD indicated he would ex have ongoing assessme needs and also indicated or foreign speaking reside to not always tell staff the	pect nt and he ent	S			

If continuation sheet Page 44 of 81

				FOF	D: 02/02/2018 M APPROVED O. 0938-0391
F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED
	245242	B. WING			8/24/2017
	CENTER OF MINNEAPOLIS		1	TREET ADDRESS, CITY, STATE, ZIP CODE	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
RESIDENTS CFR(s): 483.24(a)(2 (a)(2) A resident wh activities of daily livi services to maintair personal and oral h This REQUIREMEN by: Based on observat review the facility fa shaving for 1 of 3 re required staff assist daily living. Findings include: R162's quarterly Mi 7/14/17, indicated F included Alzheimer' and chronic pain. T severely impaired c extensive assistance indicated R162 required hands on a Alzheimer disease fill	2) no is unable to carry out ing receives the necessary n good nutrition, grooming, and ygiene. NT is not met as evidenced tion, interview, and document iled to provide assistance with esidents (R162) reviewed who tance to complete activities of nimum Data Set (MDS) dated R162 had diagnoses which s disease, psychotic disorder he MDS indicated R162 had tognition and required the for dressing. The MDS uired set up help for al hygiene including shaving h bathing. ated 7/23/17, indicated R162 assistance at times due to for grooming and directed staff		312	F312: It is the policy of the Augustana Health Care Center to provide the necessary services to maintain good nutrition, grooming, personal, and oral hygiene. Corrective Action: Identified resident R162 received the immediate services required for facial har removal. The staff person responsible for the grooming of identified resident received a written work performance education 8-24-17 Identification of Other Residents: A facility wide shaving audit was conducted to ensure appropriate shaving services were completed and/or offered all residents. 9-29-17 Measures Put in Place: Mandatory education for all nursing staff was conducted to ensure appropriate	pr J to
undated, identified her shower on Mon On 8/22/17, at 8:37 wheelchair at dining	R162 received assistance with day mornings. a.m. R162 was seated in her g room table. She was			will continue to have the right to refuse shaving. 10-11-17 Monitoring Mechanism:	
	RS FOR MEDICARE TOF DEFICIENCIES DF CORRECTION PROVIDER OR SUPPLIER <b>FANA HEALTH CARE O</b> SUMMARY STA (EACH DEFICIENCY REGULATORY OR LA ADL CARE PROVID RESIDENTS CFR(s): 483.24(a)(2 (a)(2) A resident wh activities of daily live services to maintain personal and oral h This REQUIREMEN by: Based on observat review the facility fa shaving for 1 of 3 re required staff assist daily living. Findings include: R162's quarterly Mi 7/14/17, indicated F included Alzheimer' and chronic pain. T severely impaired of extensive assistance indicated R162 required hands on a Alzheimer disease to encourage and a Review of R162's n undated, identified her shower on Mon On 8/22/17, at 8:37 wheelchair at dining	DF CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         245242         PROVIDER OR SUPPLIER         FANA HEALTH CARE CENTER OF MINNEAPOLIS         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2)         (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 assistance with shaving for 1 of 3 residents (R162) reviewed who required staff assistance to complete activities of daily living.	RS FOR MEDICARE & MEDICAID SERVICES         TOF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MUIA A. BUILD         245242       B. WING         PROVIDER OR SUPPLIER       245242       B. WING         FROVIDER OR SUPPLIER       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PIEF PREFICIENCY MUST BE PRECEDED BY FULL RESUDENTS CFR(s): 483.24(a)(2)       PIE (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.       F 3         This REQUIREMENT is not met as evidenced by:       Based on observation, interview, and document review the facility failed to provide assistance with shaving for 1 0f 3 residents (R162) reviewed who required staff assistance to complete activities of daily living.         Findings include:       R162's quarterly Minimum Data Set (MDS) dated 7/14/17, indicated R162 had diagnoses which included Alzheimer's disease, psychotic disorder and chronic pain. The MDS indicated R162 had severely impaired cognition and required extensive assistance for dressing. The MDS indicated R162 required set up help for completing personal hygiene including shaving and supervision with bathing.         R162's care plan dated 7/23/17, indicated R162 required hands on assistance at times due to Alzheimer disease for grooming and directed staff to encourage and assist as needed for grooming.         Review of R162's nursing assistance care sheet, undated, identified R162 received assistance with her shower on Monday mornings.	RS FOR MEDICARE & MEDICAID SERVICES         TOF DEFICIENCIES         TOF DEFICIENCIES         CORRECTION         (X1) PROVIDER/SUPPLIENCIA IDENTIFICATION NUMBER:         245242         B. WING         PROVIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2)         (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 assistance with shaving for 1 of 3 residents (R162) reviewed who required staff assistance to complete activities of daily living.         Findings include:         R162's quarterly Minimum Data Set (MDS) dated 7/14/17, indicated R162 had diagnoses which included Alzheimer's disease, psychotic disorder and chronic pain. The MDS indicated R162 had severely impaired cognition and required extensive assistance for dressing. The MDS indicated R162 required set up help for completing personal hygiene including shaving and supervision with bathing.         R162's care plan dated 7/23/17, indicated R162 required hands on assistance at times due to Alzheimer disease for grooming and directed staff to encourage and assist as needed for grooming.         Review of R162's nursing assistance care sheet, undated, identified R162 received assistance with her shower on Monday mornings.	TMENT OF HEALTH AND HUMAN SERVICES       FOR         SF OR MEDICARE & MEDICAID SERVICES       OMB N         TOP DEFICIENCIES       (X1) PROVIDERSUPPLIER/CLAN       (X2) MULTIPLE CONSTRUCTION         A BUILDING       A BUILDING       (X3) D         PROVIDER OR SUPPLIER       A BUILDING       (X3) D         ANA HEALTH CARE CENTER OF MINNEAPOLIS       STREET ADDRESS, CITY, STATE, ZIP CODE       0         INVEXTMENT OF DEFICIENCIES       PROVIDER PLAN OF CORRECTION       PROVIDER PLAN OF CORRECTION NUMBER:       (X2) MULTIPLE CONSTRUCTION         REGULATORY OR LSC DENTIFYING INFORMATION;       PROVIDER PLAN OF CORRECTION NUMBER:       (X2) MULTIPLE CONSTRUCTION       (X3) D         ADL CARE PROVIDED FOR DEPENDENT RESIDENTS       F 312       FR12:       (EACH CORRECTIVE ACTION BOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)         ADL CARE PROVIDED FOR DEPENDENT RESIDENTS       F 312       F 312:       F 312:         CREGULATER MEMORY on LSC DENTIFYING INFORMATION;       F 312:       It is the policy of the Augustana Health Care Center to provide the necessary services to maintain good nutrition, grooming, personal, and oral hygiene. Corrective Action:       F 312:         Findings include:       F 112:       It is the policy of the Augustana Health Care Center to provide the necessary services to maintain good nutrition, grooming, personal, and oral hygiene. Corrective Action:         Indidity failed to provide assistance with sha

Facility ID: 00164

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TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED	
			A. BUILDIN	NG	001		
		245242	B. WING _			24/2017	
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 312	room. R162 was not coarse, white hairs On 8/23/17, at 7:14 her walker down the room. R162 was ob white coarse hairs of R162 remained in t long, coarse, white During an interview nursing assistant (N many coarse, white stated the usual fact facial hair as part of R162's chin hair sh Monday with her ba hair was noticed on to be taken care of R162 dressed hers needed. During an interview licensed practical n always liked to look in the past. LPN-As care when staff re-a Review of R162's S Inspection/Observa indicated a body au R162. The form ind were completed sur-	ents present in the dining bied to have many long, under her chin. a.m. R162 ambulated with e hallway toward the dining bserved to have the same long, under her chin. At 8:58 a.m., he dining room with the same chin hairs present. NA)-M confirmed R162 had e chin hairs present. NA-M solity practice was to remove of bathing cares. NA-M stated ould have been removed on th. NA-A stated if long facial a resident, the facial hair was right away. NA-A confirmed elf, but staff assisted her as a non 8/23/17, at 11:49 a.m. with urse (LPN)-A stated R162 had a nice. but had resisted cares stated R162 typically allowed approached her later.	F 31	12 10-10-17 10-17-17 10-24-17 10-31-17 Random shaving audits wi units monthly for the next of 11-30-17 12-31-17 Audits will be reviewed by Improvement committee for with providing and/or offering services for residents on of 10-19-17 11-30-17 12-31-17 1-31-18 Responsible Person's Director of Nursing or desi Clinical Managers Quality Improvement Director	60 days. the Quality or compliance ng shaving r before. gnee		
		on 8/24/17, at 8:24 a.m. with M)-A stated the expectation					

		AND HUMAN SERVICES			FORM	): 02/02/201 / APPROVEI ). 0938-039
TATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245242	B. WING		08	/24/2017
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, 2 1007 EAST 14TH STREET		· · · -
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 312 F 315 SS=D	<ul> <li>was for all residents shower/bath, and e facial hair is remove expected staff to ler refused cares.</li> <li>Facility policy on gr was not provided.</li> <li>NO CATHETER, Pl BLADDER</li> <li>CFR(s): 483.25(e)(</li> <li>(e) Incontinence.</li> <li>(1) The facility mus continent of bladde receives services a continence unless for becomes such th to maintain.</li> <li>(2)For a resident with on the resident's continent's continent's clinical continent's clinis' clinical continent's c</li></ul>	s to be checked with veryday with cares to ensure ed. CM-A also stated she t the nurse know if a resident ooming was requested but REVENT UTI, RESTORE 1)-(3) t ensure that resident who is r and bowel on admission and assistance to maintain his or her clinical condition is nat continence is not possible the urinary incontinence, based omprehensive assessment, the e that-		112		10/12/17

TATEMENIT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	MB NO.	E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
		245242	B. WING		08/2	24/2017
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 315	Continued From pa	lge 47	F 31	5		
		t infections and to restore				
	on the resident's co facility must ensure incontinent of bowe treatment and servi bowel function as p This REQUIREMEN by: Based on observat review, the facility f bowel and bladder toileting program to and bladder to the residents (R338) w assistance with toile language barrier. R an avoidable decre function. Findings include: R338's admission N dated 2/5/17, identii which included arth and unspecified ur indicated R338 had memory problems,	NT is not met as evidenced tion, interview, and document ailed to accurately assess patterns and implement a prestore continence of bowel extent possible for 1 of 1 ho was not being provided eting routinely due to a 338 sustained harm due to ase in bowel and bladder Minimum Data Set (MDS) fied R338 had diagnoses writis, chronic pain syndrome, inary incontinence. The MDS I both short and long term had moderately impaired		F315: It is the policy of the Augustana H Care Center to accurately assess and bladder patterns and implement toileting schedule/plan to restore continence of bowel and bladder t extent possible. Corrective Action: Upon review of resident's commun- patterns related to elimination spe- interventions including the Somali for bathroom and gestures have b identified and care planned to indineed for toileting. Upon review of 60 days of bowel and bladder point care documentation improved corrivas demonstrated for identified re R338. R338 Bowel and Bladder assessment has been reviewed a	bowel ent a o the nication cific an word een cate the past the past ti of tinence sident	
	preferred language wanted an interpret or health care staff. R338 required exte mobility, dressing, t did not ambulate. F R338 was frequent	daily decision making, her was Somali and needed or ter to communicate with doctor . The MDS also indicated onsive assistance for bed toileting, personal hygiene and Further, the MDS indicated ly incontinent of urine and on a toileting program.		remains current. 9-28-17 Identification of Other Residents: Communication section was adde TCU Care Cards to ensure communication interventions will k identified for all new admits with a language barrier. 9-27-17	e	

Facility ID: 00164

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		& MEDICAID SERVICES			MB NO.	APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245242	B. WING _		08/2	24/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIOI DATE
F 315	Continued From pa	age 48	F 31	5		
	2/9/17, indicated Raincontinence with sistress incontinence mornings with confimobility related to wextremity wounds wextremity wounds were of narcotics, are barrier. Staff were the rising, before and a rounds and as needwas not consistent needed to be change with peri care with a R338's quarterly M R338 was moderate extensive assistant transfers and extern dressing, toileting a MDS also indicated incontinent of urine and had no toileting R338's quarterly M R338 had severely extensive assistant activities of daily liv R338 was occasion frequently incontinent of using a R238's quarterly M R338 had severely extensive assistant activities of daily liv R338 was occasion frequently incontinent of using toileting program. Review of R338's construction of the second continent of the second cont	DS dated 5/8/17, indicated rely impaired, needed ce of two staff for bed mobility, nsive assistance of one staff for and personal hygiene. The d R338 was frequently and always continent of bowel		Communication audits were comp all residents with an identified lang communication barrier to ensure communication needs are address Residents electronic care plans and care sheets were updated as need individualized communication interventions. 10-6-17 All bowel and bladder assessment residents with a language barrier of reviewed for decline. 10-9-17 Measures Put in Place: Mandatory all staff education was completed on the importance of identifying communication needs of residents and use of communicati interventions to ensure standard of maintained. 10-11-17 Monitoring Mechanisms: Clinical Managers are notified by I of any decline in bowel and bladde time of their quarterly assessment triggers a review of the current assessments, and any additional assessments for residents with lan barriers will be done for the next of to ensure all bowel and bladder can needs of residents with language are being met. 10-31-17 11-30-17 12-31-17 1-31-18 2-27-18	guage or sed. nd NAR ded with ts for were of on of care is RAI staff er at the c, which oleted. der nguage months are	

Facility ID: 00164

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		AND HUMAN SERVICES			FORM A	02/02/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE	
		245242	B. WING _		08/2	4/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 315	wounds, pain, anen anti-depressants ar confusion she is no know she needs to the bedpan. The ca interventions such a rising, before and a rounds and as need confused, peri care and needed extens depending on cogn listed on how to cor regarding the langu incontinence or toile Review of R338's T NA (nursing assistance was continent of bo occasional incontine incontinent brief. No how to communicat language barrier an needs. During observations R338 wore a hospit of her bed with her (NA)-G entered R33 light and asked R33 proceeded to repeat repeatedly tapped h NA-G stated she wa R338 was trying to repeat the foreign w of her hands out in R338 extended her	nia, use of narcotics, nd language barrier. Related to t consistent with letting staff be changed or when to use are plan listed various as: check and change upon fter meals, before bed, night ded, offer bed pan when not s with incontinence episodes, ive assist of one or two staff ition. No interventions were mmunicate with R338 lage barrier and her	F 3	<ul> <li>3-31-18</li> <li>Staff communication skill checks done with all residents who have language barrier. Skill checks with demonstrated staff proficiency with communication devices/tools and individualized interventions specie each resident's comprehensive assessment 10-10-17</li> <li>Staff communication skill checks done for all residents who have at language barrier weekly for the n days and monthly for the next 6 m 10-10-17</li> <li>10-10-17</li> <li>10-17-17</li> <li>10-24-17</li> <li>10-31-17</li> <li>11-21-17</li> <li>11-28-17</li> <li>12-28-17</li> <li>1-31-18</li> <li>2-27-18</li> <li>3-31-18</li> <li>All communication skill checks with reviewed at the monthly QI/QAA for compliance with staff competer communication interventions on a 10-31-17</li> <li>11-30-17</li> <li>12-31-17</li> <li>13-18</li> <li>2-27-18</li> <li>3-31-18</li> </ul>	a Il include th using fic to will be ext 60 nonths.	

Facility ID: 00164

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		AND HUMAN SERVICES				FORM	: 02/02/2018 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245242	B. WING	i		08/	24/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE (	CENTER OF MINNEAPOLIS			007 EAST 14TH STREET MNNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 315	sound repeatedly. F "sheeeew" sounds NA-G exited the roo At 8:59 a.m. NA-G R338 wanted, but th She stated, "No one it's very hard, I don' indicated she was r facility who spoke F hard to communica gestures or movem gestures and move to communicate wit when working with I At 9:02 a.m. R338 v bed, and R338's ca began to speak fore fast to registered nu entered her room a left hand on the left continued to repeat angry, frustrated vo hands out in front h extended her finger of her groin while m repeatedly. R338 c the "sheeeew" sour repeatedly if she wa appeared to get mo in her foreign langu her uneaten food ite waved her left arm her head. NA-G sta she wants."	R338 continued make the and gestures for NA-G until om at 8:59 a.m stated she did not know what hought she was having pain. here speaks this language, t understand her." NA-G not aware of anyone in the R338's language and felt it was te with R338 utilizing hand lents. NA-G indicated the hand ments staff utilized to attempt th R338 were not effective	F	315	4-30-18 5-31-18 Responsible Person/s Director of Nursing Clinical Managers Quality Improvement Director		

TATEMENT	OF DEFICIENCIES DF CORRECTION	KANDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245242	B. WING		08/	24/2017
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS	10	TREET ADDRESS, CITY, STATE, ZIP CODE 007 EAST 14TH STREET IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 315	cry and stated, "hu indicated she was need to go to the b bedpan to the bedpa she removed R338 repeatedly moaned rapid, frustrated vo place the bedpan b out of the way of th the bedpan placed proceeded to void of urine. R338's dis Review of R338's a Assessment, dated short term memory need or urge to voi was able to use the toilet sometimes, a incontinence. The a had incontinence of episodes with positi indicated R338 had recent surgery, obe assistance to trans incontinent of bowe irregularity, loose s constipation and w had urgency. The a had stress and fun documentation was voiding pattern and The analysis of the had confusion, was staff know she nee be on a check and	h, huh, huh" repeatedly. RN-D unsure, but felt R338 may athroom and brought a RN-D proceeded to attempt n under R338's buttocks, while d's disposable brief. R338 d, "uhhh, uhhh, uhhh" in a ice and frantically assisted to by moving her hospital gown he bedpan. At 9:05 a.m., with under her buttocks, R338 on the bedpan a large amount sposable brief was dry. admission Bowel and Bladder d 2/9/17, indicated R338 had d loss, was able to identify the d/defecate some of the time, e call light, ask to go to the and had been admitted with assessment indicated R338 f bladder, had incontinence tion changes. The assessment d diagnoses which included esity, edema and required fer. Further, R338 was el, had no problem with pattern tools or diarrhea or as functionally disabled and assessment indicated R338 ctional incontinence. The s blank regarding R338's 3 day d for the 3 day bowel pattern. assessment with letting ded to be changed and was to change program, upon arising, eals, before bed, with night	F 315			

		& MEDICAID SERVICES				. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245242	B. WING		08/	/24/2017
NAME OF I	PROVIDER OR SUPPLIER	• •	STREET ADDRESS, CITY, STATE, ZIP C		CODE	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 315	Continued From pa	ige 52	F 3	15		
	Assessment dated short term memory to urge to void/defe use call light, able t assessment indicat bladder, unknown h incontinent of bladd urine, had no incon coughing, changing exercise. The asses continent of bowel, constipation problet symptoms affecting Further, the assess assistance with am adaptive equipmen elimination patterns assistance, residen patterns of urinary of hours, was able to u shifts and had prob assessment indicat incontinence (decreas unwillingness). R33 scheduled toileting impaired, functiona dependent. The elin and change due to retraining to return to feel sensation, al inhibit urge, toilets i assist and prompt v toilet (however a re continence was nev included for R338 to	nitial Bowel and Bladder 4/28/17, indicated R338 had loss, able to identify the need ecate all of the time, able to to ask to go to the toilet. The ted R338 was incontinent of now long resident has been der, no problem with leaking tinent episodes with laughing, positions, sneezing or ssment indicated R338 was utilized a bedside commode, ms sometimes, and no g eliminations patterns. sment indicated R338 required bulation, transfers and used t. R338 has pain that effected s, required weight bearing it somewhat involved, showed continence greater than 2 use toilet majority of time on all lems with constipation. R338's ted R338 had functional eased mental sed or loss mobility or personal 88's elimination plan was due to being cognitively I disabilities and care giver mination plan included: Check cognitive impairment, to previous pattern due to able ble to understand and learn to independently or with minimal voiding due to able to request etraining program to improve ver implemented). The plan o utilize the bedpan or ng and to use the commode				

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	OF DEFICIENCIES	<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	IPLE CONSTRUCTION		). 0938-039 TE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED		
		245242	B. WING _			08/24/2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE	
F 315	Continued From pa	age 53	F 31	5			
	for bowel moveme	nts and wore a brief.					
	Review of R338's Bowel and Bladder Quarterly Assessment, reviewed on 5/4/17, indicated the bladder and bowel management programs were effective and no changes were needed to the current plan of care.						
	Assessment, revie R338 was incontin current bowel and	Bowel and Bladder Quarterly wed on 7/13/17, indicated ent of bladder and bowel, the bladder plan was effective and y changes to the current plan of					
	Center physician p dated 4/18/17, from indicated "nursing continent of bowel	Hennepin County Medical rogress notes revealed a note in the nurse practitioner which assistants report the patient is and bladder and is utilizing a ponally utilizing commode."					
	stated in the past w facility to visit R338 stated he was awa void or have a bow left on the bedpan FM-A indicated he R338's elimination had been told the s R338. FM-A indica	B p.m. family member (FM)-A when family have come to B, she had been crying. FM-A re R338 had attempted to not rel movement, to avoid being for extended periods of time. had reported the concerns with needs, to nursing staff and staff do not have time to assist ted he had posted a note on ff to utilize to call him to help 338.					
	difficult to commur language barrier a	I a.m. RN-D indicated it was licate with R338 due to the nd indicated she only knew a medication, pain in R338's					

D PLAN O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	FIPLE CONSTRUCTION	· · /	E SURVEY	
	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	CON	IPLETED	
		245242	B. WING		08/	08/24/2017	
AME OF F	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZI	P CODE		
UGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 315	Continued From pa	age 54	F 3	15			
	primary language.	RN-D indicated she had on when she was not sure					
	the interpreter and not communicate w with that sometime had been left on the the past, she had tr so she could avoid R338 indicated she incontinent product bedpan and stated sometimes made h if she was able to c care would be bette welcome staff help then they just leave and indicated she f	20 p.m. during interview with R338, R338 stated she could with staff and her son helps s. R338 indicated because she e bedpan without assistance in ried not to go to the bathroom that from happening again. a had bowel movements in her due to avoiding use of the it made her feel bad, her cry. R338 indicated she felt communicate with staff, her er. R338 indicated she would , but staff comes in her room, a without providing assistance elt regret not getting the e was younger and stated she					

DEPARTMENT OF HEALTH				FORM	02/02/2018 APPROVED
CENTERS FOR MEDICAR STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG	COM	IPLETED
	245242	B. WING			24/2017
NAME OF PROVIDER OR SUPPLIEF	1		STREET ADDRESS, CITY, STAT 1007 EAST 14TH STREET	E, ZIP CODE	
AUGUSTANA HEALTH CARE	CENTER OF MINNEAPOLIS		MINNEAPOLIS, MN 5540	4	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
indicated the usual something, she was son would call the R338 wanted or ne confirmed the inter posted in R338's r now. RN-G indicat assistance in time incontinent of urine always continent of not aware of any of R338 and stated, communication." On 8/24/17, at 9:4 interview, FM-A in- continent of bowel sick and was only when she was sicl not respond to R3 the bed and stated holds it, and holds called for assistan incontinence issue On 8/24/17, at 9:0 able to speak the R338. She indicat her hip when she stated other staff t but R338 used the to go to the bathro assistance with to utilized the call ligf indicated she was incontinence with staff who do not utiline the staff who do not utiline the staff who do not utiline the staff who	d to translate for her. RN-G al practice if R338 needed build call her son and then her desk to let staff know what eeded assistance with. She rpreter hot line information oom had not in her room until ted of R338 did not receive or had urgency she would be e and stated she felt R338 was of bowel. RN-G denied she was communication concerns with "I don't think the problem is 3 a.m. during a follow up dicated R338 had been and bladder before she got incontinent and wore a brief k. FM-A indicated when staff did 38, she would be incontinent on d," happens quite a bit, she it." He indicated when she ce she would have		15		

## PRINTED: 02/02/2018 FORM APPROVED

STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED	
		245242	B. WING		0	08/24/2017	
NAME OF	PROVIDER OR SUPPLIER		1 1	STREET ADDRESS, CITY, STATE, ZIP CO		0/24/2017	
		CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 315	R338, she was con but when staff who communicate with H R338 wore a brief. reported she was a incontinence episod aware the interprete when R338 had sch appointments. NA- staff many times of language barrier. On 8/24/17, at 9:07 able to speak the si R338. NA-K verified with toileting, used use the call light. N continent of bowel a R338 will have inco assisting her with to what R338 needed of the staff did not H verified R338 has h not understanding v and stated, "she ha NA-K indicated R33 her needs, was pre cares and did not re On 8/24/17, at 12:3 (DON) confirmed R stated she expected plan, staff to assist needs consistently. expect staff to assist continent, help the call lights. DON ind	tinent and did not wear a brief, could not properly ner provided cares for R338, She indicated R338 had fraid she would have des. NA-J indicated she was er only came to the facility neduled medical J stated she had told nursing her concerns with R338's a.m. NA-K stated she was ame language (Somali) as d R338 needed assistance the bedpan and was able to A-K confirmed R338 was and bladder. NA-K indicated ntinence if staff were late bileting and not understanding NA-K indicated she felt a lot know what R338 wanted and ad incontinence due to staff what she is trying to tell them s not had accidents for me." 88 was able to communicate tty pleasant, cooperative with efuse cares. 3 p.m. director of nursing 338's current care plan and d staff to follow R338's care as needed, and meet her DON indicated she would st the resident to stay resident with cares, answer icated R338 had a language peaking English and would	F 3				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/02/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245242	B. WING	i		08/:	24/2017
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE (	CENTER OF MINNEAPOLIS			1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315 F 323 SS=D	available, or use pic She stated all staff interpreter services utilize the resources with R338. The DC aware of any conce barrier. Review of facility po Programming/Toilet indicated the facility admission, and at o (EX: removal of cat retraining/toileting p FREE OF ACCIDEN HAZARDS/SUPER CFR(s): 483.25(d)(1 (d) Accidents. The facility must en (1) The resident ent from accident haza (2) Each resident re and assistance dev (n) - Bed Rails. The appropriate alternat bed rail. If a bed or must ensure correct maintenance of bed to the following eler (1) Assess the reside from bed rails prior	cture cards or online service. had access to the online and she would expect staff to savailable to communicate DN indicated she was not irns with R338's language olicy titled, Bladder ing revised on 1/2016, would assess residents upon ther appropriate clinical times heter) for bladder orograms. NT VISION/DEVICES 1)(2)(n)(1)-(3) sure that - vironment remains as free rds as is possible; and eceives adequate supervision ices to prevent accidents. e facility must attempt to use tives prior to installing a side or side rail is used, the facility t installation, use, and d rails, including but not limited nents.		315			10/12/17

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				<u> </u>			
		245242	B. WING _		08/2	24/2017	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE	
F 323	the resident or resid informed consent p (3) Ensure that the appropriate for the This REQUIREMEN by: Based on observat review, the facility fi individualized equip the appropriate tran during transfers for who had a history of a mechanical lift. In follow manufacture use of a wheeled w hazards for 1 of 1 r walker for ambulati Findings include: R123's face sheet of current diagnoses of bilateral leg weakned disorder with seizur depression, pain in and repeated falls p R123's Care Area A 1/9/17, indicated R required extensive was at risk for falls deconditioning, pse	dent representative and obtain rior to installation. bed's dimensions are resident's size and weight. NT is not met as evidenced tion, interview and document ailed to implement oment requirements to ensure hafer equipment was utilized 2 of 2 residents (R123, R228) of fall during a transfer utilizing addition, the facility failed to r's guidelines for the proper valker to prevent accident esident (R224) who utilized a on.	F 32	<ul> <li>F323</li> <li>F323</li> <li>It is the policy of Augustana Health Center that the environment remai free from accident hazards as pose and that each resident receives ad supervision and assistance devices prevent accidents.</li> <li>Corrective Action:</li> <li>Staff were immediately re-educated proper use of the EZ stand, with co sling size for identified resident R1. 8-23-17</li> <li>Staff were immediately re-educated necessity to use the proper transfe equipment per resident's plan of ca identified resident R228</li> <li>8-24-17</li> <li>Staff were immediately re-educated proper method of transporting resid and care sheet was updated with the proper method of transporting resid identified resident R224</li> <li>8-21-17</li> <li>EZ stand policy was updated to inclinformation regarding appropriate as size use.</li> <li>9-29-17</li> <li>Identification of Other Residents: All residents were audited for appro- transfer equipment and sling size p weight, transfer ability and care pla- care plans and care sheets were residents</li> </ul>	ns as sible equate s to d on orrect 23 d on r are for d on dent, he dent for clude sling opriate per un. all		

Facility ID: 00164

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	TH AND HUMAN SERVICES RE & MEDICAID SERVICES			PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245242	B. WING		08/24/2017	
NAME OF PROVIDER OR SUPPL	ER		STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS			1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
<ul> <li>pain, and use of R123's care plat required extensis transfers, staff th transfers, R123 resident reports plan dated 8/14/ for sling related EZ stand strap/s</li> <li>R123's undated fall risk, required stand pivot trans protective boot, sling when resid following words underlined in real sling with all EZ</li> <li>During observat was observed ly (NA)-A present is she was ready th yes, NA-A proce At 7:55 a.m. NA mechanical lift at lift had a sling w over the top of the lift into place. N R123's calves. and utilized the</li> </ul>	activities of daily living (ADL's), medications. In dated 8/22/17, indicated R123 we assistance of one staff with o cue resident before and during may use the EZ stand when feeling weak. R123's fall care 17, indicated R123 was resized to a fall, appropriate large fitting			er seated Do not seated seated seated a gents and ng staff nd, EZ protocols rting of be 10-17 ed for all nsfer poment ts weekly oper	

Facility ID: 00164

If continuation sheet Page 60 of 81

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 E SURVEY PLETED	
		245242	B. WING	B. WING			08/24/2017	
NAME OF	PROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	00,1		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			007 EAST 14TH STREET INNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE	
F 323	proceeded to unlow widened the legs of in front of her wheel in place once R123 wheelchair, and us R123 into her wheel seated in the wheel really good about p unlocked the EZ st from the platform, H released, loops unl beige colored bindi confirmed the sling size medium, as sh attached to the sling size medium, as sh attached to the sling Review of Event Re p.m. indicated R12 during an EZ stand report, the EZ stand R123 or nursing as remember what ha the sling was out of land on her buttock straight out. R123 of the fall. At the til pain, hitting her heal extremities without were no signs of in indicated R123 was three, communicated time, but was unab Interventions identited checking on function	addes of the lift. NA-A ck the EZ stand lift brakes, f the lift and transferred R123 elchair, she then locked the lift 8 was in front of her ed the remote control to lower elchair. Once R123 was lchair, she stated NA-A was outting all the belts on. NA-A and lift, R123 removed her feet booked, and the sling with ng was removed. NA-A used to transfer R123 was a the visualized the white tag g with a letter M on the tag. eport dated 8/5/17, at 5:45 3 suffered a witnessed fall transfer. According to the d suddenly stopped moving, sistant was unable to ppened next, then one side of f place which caused R123 to is, on the floor, with legs was wearing shoes at the time me of the fall R123 denied ad, range of motion in all pain or limitations, and there jury. The Event Report is alert and oriented times ed the situation well at the le to describe what happened. fied on the Event Report, and staff the importance of on of the equipment before ucated on proper use of EZ	F3	23	Random skill checks will be conduresidents on all units monthly for the 60 days to ensure proper equipment sling size is used. 12-4-17 1-4-18 Responsible Person/s Director of Nursing Clinical Manage Staff Development Staff Quality Improvement Director	he next ent and		

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SL		(X2) MULT	FIPLE CONSTRUCTION	OMB N (X3) D	ATE SURVEY	
	OF CORRECTION	IDENTIFICATIO			NG		COMPLETED	
		245	242	B. WING		_ 0	08/24/2017	
IAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STA			
UGUST	ANA HEALTH CARE	CENTER OF MIN	INEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 554	04		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICI Y MUST BE PRECED .SC IDENTIFYING INF	ED BY FULL	ID PREFI) TAG	( (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE	
F 323	Continued From pa	age 61		F 3	23			
	transferring R123 f	rom her chair to	bed, the					
	EZ(stand) stanc [si	c] sling popped	out of place					
	causing resident to							
	injuries observed, r oriented. Staff re-e							
	stand and to ensur							
	used.							
	Review of R123's Incident Review Form dated 8/7/17, indicated R123 had a fall on 8/5/17, with							
	no injury. The inter							
	and documented th		inteviewed					
	-no medication con		nental					
	concerns or change	e of condition no	oted. Plan of					
	Care Changes/Nev							
	re-educated on pro ensure the proper s							
	sling.	sing used, obtai	neulaige					
	-							
	Review of the print							
	8/7/17, indicated st							
	related to the incorr causing resident to							
	procedures and sta							
	reviewed with NA-L							
	-All assigned tasks							
	meticulous attentio		uality of life of					
	our resident depen -Correct use of EZ		cafaty of					
	residents and staff		Saicly UI					
	-Correct size of slin		pertinent for					
	providing safe trans	sfers; all slings i	used should be					
	the appropriate size							
	will involve the judg							
	-Nursing assistants both machine, batte							
	ensure safety.	ery and sing De						
	-The sling must be	secured to the i	machine on					
	both sides; the foot							

		& MEDICAID SERVICES	0.00			D. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED	
		245242	B. WING _			8/24/2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIOI DATE	
F 323	to resident and place Review of nursing p 8/22/17, revealed th -On 8/7/17, at 1:45 rib pain, no bruises R123's nurse pract rule out fracture. -8/7/17, at 4:02 p.m with negative result R123 continued to side, medication an relief noted, also no 2 cm bruise to R12 -On 8/8/17, at 2:46 of left side and rib of Results of x-ray we nurse practitioner, n -On 8/13/17, at 6:5 indicated while tran to bed, the EZ(stan of place causing re No injuries observe oriented. Staff re-e stand and to ensure used.	Ary lift. VAY harness sizing chart given ced on machine. Drogress notes dated 8/5/17 to he following: p.m. R123 complained of left noted. A call was placed to itioner to request an x-ray to h., R123 returned to the facility, t from x-ray. At 11:32 p.m. complain of pain to the left nd a cold pack given with some bete was a 2 centimeter (cm) x 3's inner right arm. p.m. R123 complained of pain cage area, and rated 8/10. The sent to R123's primary no new orders received. 1 a.m. resolution of fall noted, usferring R123 from her chair id) stanc [sic] sling popped out sident to land on her buttocks. ed, resident remains alert and educated on proper use of EZ e correct size sling was being ints of pain or injuries	F 32	23			
	R123 had mild biba however, no acute	port dated 8/7/17, indicated asilar infiltrates or atelectasis, fracture was found.					
	6/21/17, indicated F	all risk assessment dated R123 did not have any falls nonths, and was a low fall risk					

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		AND HUMAN SERVICES & MEDICAID SERVICES	1		FORM	02/02/2018 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245242	B. WING		08/:	24/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUGUST	ANA HEALTH CARE (	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 63	F 323			
	reported she fell fro weeks ago. R123 r member hooked he member did not hoo abdomen, and had the hooks of the lift. from the lift all staff the belts, and she h R123 reported after her ribs all the way stated she still gets picture in her mind transferred. R123 s gloves to make sure the handles of the lift reported prior to he not always attaching abdomen, then statt information to any r from the EZ stand I admission. When i R123 reported after her ribs all the way verified she did rece no fractures, she st in that location of he still continues to hat back and hip area. During interview on confirmed R123 reco one staff member fo of eating which she reported staff carry indicate what each NA-A reported R123	8/23/17, at 8:07 a.m. R123 on the EZ stand lift a few reported when the staff or up to the lift, the staff ob the safety belt around her only attached the loops on to . R123 reported since she fell had been hooking up all of has not had any further falls. r she fell she had pain from down to her bottom. R123 scared, and repeats the of falling when she gets stated she now wears gripper e she has a secure hold on ift during transfers. R123 r fall from the lift, staff were g the safety belt around her ed she had not reported that hurses. R123 stated the fall ift has been her only fall since nterviewed at 12:49 a.m., r she fell she had pain from down to her bottom. R123 eive an x-ray and there were ated she did not have the pain er body prior to the fall, and ve discomfort in her lower 8/23/17, at 8:17 a.m. NA-A quired extensive assistance of or all ADL's, with the exception was independent. NA-A care guide sheets that resident needs for assistance. 3 did have one fall only that stated R123 fell from the lift				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 02/02/2018 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY IPLETED
		245242	B. WING		08/	/24/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	because the lift was staff decide and chi- for each resident, a use it." NA-A confir sized sling to transf marked with a M or color guide attache transfer which indic colored binding wer indicated the sling s NA-A reported whe safety belts were to and behind legs. N education regarding lifts when she starte During interview on confirmed R123 fel transfer. RN-C si she believed the str thought the size of RN-C stated re-edu member involved re sizes. RN-C verifie specific assessmen correct sling size to the color coded slim lifts, and when aske the size of sling to t size, she did not an During follow up int a.m. RN-C stated s staff discretion and then staff documen care sheet. RN-C verifie sling, RN-C stated	a not working. NA-A verified bose which size sling to use and stated if the sling fits, "we med she used a medium er R123, and verified the tag in it. NA-A also indicated a d to the lift used for R123's ated slings with a beige re size medium. NA-A also size was on R123's care plan. In staff use the EZ stand lift, all be attached, on the abdomen A-A verified she had received g the safe use of the EZ stand ed working at the facility. 8/23/17, at 11:43 a.m. RN-C I from the EZ stand lift during a tated after talking with staff rap snapped off or open, and the sling was maybe incorrect. Incation was given to the staff egarding the lift use and sling d the staff did not complete a at when determining the use. RN-C was not aware of g size sticker attached to the ed how the staff determines use, if they go by weight or	F 323			

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		AND HUMAN SERVICES				FOR	D: 02/02/2018 M APPROVED O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONST		(X3) D.	ATE SURVEY OMPLETED
		245242	B. WING			0	8/24/2017
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP	CODE	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			T 14TH STREET POLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CC EACH CORRECTIVE ACTIOI OSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 323	sling size, but report medium sized sling she visited with R12 not injured from the complain of pain, a out fractures, and v atelactisis. RN-C v investigations or do fall on 8/5/17. When interviewed of licensed practical m were measured arc sling sizes were de like a girdle. LPN-F used was documer and confirmed R12 sling with all transfe When interviewed of reported the staff h slings for the EZ sta not have the correct laundry to obtain th NA-B believed R12 sling. When interviewed of verified R123 used transfers and exter NA-C stated R123 sized sling for all tra- information was als verified she was giv the mechanical lifts When interviewed of indicated R123 req	rted the resident stated the felt comfortable for her when 23. RN-C reported R123 was e fall, confirmed R123 did n x-ray was completed to rule vas found to have some rerified there were no further boumentation regarding R123's on 8/23/17, at 11:50 a.m. furse (LPN)-B stated residents bound their abdomen, then the termined by the measurement, B stated the sling size to be need in the resident's care plan, 3 should use a large sized ers. on 8/23/17, at 12:14 p.m. NA-B ad access to several sizes of and lift, and stated if they do at size, staff would notify the correct size. 3 required an extra large sized on 8/24/17, at 9:30 a.m. NA-C an EZ stand lift for all nsive assistance of one staff. required the use of a large ansfers, and indicated this so on the care sheets. NA-C ven education on the use of	F	323			

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUT	TIPLE CONSTRUCTION		). 0938-039 TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		NG	· · /	MPLETED
		245242	B. WING		08	/24/2017
NAME OF P	ROVIDER OR SUPPLIER	• •		STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 323	Continued From pa	ige 66	F 3	23		
	a large sized sling.					
	for all transfers, and always transferred. completed the asse appropriate sling siz correct size was do and care plan. When interviewed of director of nursing ( had the fall from the analysis was compl R123 let go of the h felt the harness was investigated, the wo incident report, due "popped off." The I involved was imme ensure the sling fit The DON stated aff believed a different The DON confirmer a medium sized slin determining the pro- weight, but weights according the manu She stated we take resident's comfort le width, and what loo sling size assessme was more of a judg factors, then the siz	R123 required the EZ stand lift d indicated that is how she had LPN-C confirmed RN-C essments to determine the zes for each resident, an the ocumented on the care sheet on 8/24/17, at 11:30 a.m. the (DON) reported after R123 e EZ stand lift, a root cause leted. The DON reported nandles on the lift because she s a little tight, as staff further ording "popped off" was in the to being too tight or the loop DON stated the staff member diately given education to properly and was comfortable. ter the investigation, staff size sling should be used. d prior to the fall R123 utilized ng. The DON stated when oper size sling, staff look at were pretty fluid and variable ufacture's chart and guidelines. in to consideration the evel of sling, generalized ks safe. The DON verified the ent was not documented, as it ement based on clinical ze was documented on the e plan. The DON verified staff sized sling for all EZ stand lift				
	transfers with R123	B, unless there was some ed to be a change, the change Obsolete Event ID:M4PX		Facility ID: 00164	If continuation shee	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			` '	MPLETED
		245242	B. WING _		08	/24/2017
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 323	Continued From pa	ige 67	F 32	23		
	DON stated staff do sling size changes, indicated on the ca size. The DON sta manager re-assess sling size, and base did, the sling should all staff should be p the care sheets and indicates a large siz confirmed there we assessments regar stand lift, other than stated the interdisc of a discussion, talk picture of what hap new interventions s all done "off the rec DON reported the r expected to visualiz of sling and lift prior maintenance routin slings. When interviewed of director of maintenance completed monthly	by the clinical manager. The o not routinely document if the then stated it would be re sheet as being a different ted she had the clinical s R123 on 8/23/17 for proper ed on the assessment that she d be a large size, and verified providing care as directed by d care plan which also ze sling to be used. The DON re no other documents or rding R123's fall from the EZ n the event report. The DON iplinary team (IDT) had more ks with people to get more of a pened, so we know what the should be, and verified this is cord" as the IDT talked. The nursing assistants were ze the lifts for obvious damage r to each use, and stated rely inspects the lifts and on 8/24/17, at 3:52 p.m. the audits and inspections on all ed in the facility. The DOM				
	and replaced them ensure the lifts wer DOM stated he was ever falling from a r then stated if staff v of event, he would	r broken, loose or worn parts, as needed, and looked to e functioning safely. The s not aware of any residents mechanical lift or EZ stand lift, would update him in that type want to go look at the lift or ect the lift for safety and proper				

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		AND HUMAN SERVICES			FORM	: 02/02/2018 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245242	B. WING _		08/	24/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AUGUS	TANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	ILD BE	(X5) COMPLETION DATE
F 323	Review of the unda manufacturer's sizi included a color co- different sizes by di harnesses. Beige medium for use of of circumference of is applied. The cha designations were	tted, EZ way, Inc. smart stand ng guidelines document ding system, separating ifferent colored binding on the colored represent a size 90-220 pounds, 34-46 inches f patient's torso where harness art indicates the size/weight of merely estimates and basic er fit would involve the	F 3			

Facility ID: 00164

CENTER		I AND HUMAN SERVICES <u>&amp; MEDICAID SERVICES</u>				APPROVED
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		245242	B. WING		08	/24/2017
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 1007 EAST 14TH STREET		
				MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 323	Continued From pa	age 69	F 3	23		
	7/28/17, indicated I impairment and rec transferring.	nimum Data Set(MDS) dated R228 had severe cognitive quired assist of two for				
	dementia with Lew	dicated diagnoses included y Bodies, Parkinson disease, orthostatic hypotension, and lisorder.				
	R228 required assi impaired mobility re	rision dated 8/19/17, indicated st with transfers due to elated to Parkinson disease. acted staff "transfers with assis	t	•		
		ed nursing assistant care /17, indicated for R228 "				
	6:44 p.m. indicated EZ stand lift, R228 hold on to the bar of lowered R228 to th staff assisted R228 mechanical lift. The	brogress note dated 8/19/17, at while transferring R228 with became weak and unable to of the lift and nursing staff e ground by his arms. Three to bed utilizing a (EZ lift) full e note indicated the EZ lift or R228 and an order obtained e lift for R228.				
	nurses aide (NA)-C	tion on 8/24/17, at 1:14 p.m. ) and nurses aide (NA)-P rolled the hallway and entered R228				

Facility ID: 00164

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		AND HUMAN SERVICES			FORM	02/02/2018 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		245242	B. WING		08/2	24/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET		
AUGUS	TANA HEALTH CARE	CENTER OF MINNEAPOLIS		MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	EZ stand handles v feet onto stand to tr wheelchair to his be with transfer from v was lowered to on o minute." R228 lear removed from the E lifted R228 legs up him in bed. During an interview clinical manager (C recent accident with R228 legs and arm him to safely be tra CM-A stated R228 been changed to us transfer. CM-A state care plan changes careplan review and the NA-O and NA-F EZ lift with R228. D , NA-O approached R228 was hollering strap between his lo CM-A stated to NA- transferred with the During an interview director of nursing of had been updated used as R228 had and was not safe to	with his arms. NA-O placed his ransfer R228 from his ed. NA-O and NA-P continued wheelchair to the bed. As R228 edge of bed he said "wait a ned to right side as legs EZ stand. NA-O and NA-P onto the bed and positioned on 8/24/17, at 1:30 p.m. with M)-A stated R228 had a n the EZ stand. CM-A stated s were not strong enough for nsferred with an EZ stand. careplan interventions had se of a EZ lift to ensure a safe ed staff were made aware of through shift communication, d aid care sheets. CM-A stated P should have been using the uring the interview with CM-A d the desk area and stated and said he didn't want a egs so she used an EZ stand. O, he was supposed to be EZ lift. NA-O did not respond.	F 323			

Facility ID: 00164

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		& MEDICAID SERVICES				. 0938-039 E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION		IPLETED
		245242	B. WING		08	/24/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 323	Continued From pa	ge 71	F 323	3		
	7/15/17, identified F and had diagnoses disease, schizophre MDS identified R22 activities of daily liv staff assistance wit personal hygiene. T ambulated indepen for mobility. R224's care plan re- identified R224 aml of a walker. The ca fatigue with distanc staff and visitors to walker and was not plan directed staff t self performance v indicated R224 was and did not use a w plan further instruct total assist to prope depending on weak R224 was at risk fo disease effects, use use of a devise and behavior related to directed staff to end ambulate with his 4 The untitled, undate sheet indicated R22 4 wheeled walker a The sheet further in independent with tr	ed nursing assistant care 24 was ambulatory and used a and wheelchair as needed. Indicated R224 was ansfers. The care sheet ffer use of wheelchair for				

		AND HUMAN SERVICES				FORM APP	ROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SUF COMPLET	RVEY
		245242	B. WING _			08/24/2	017
NAME OF F	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE,	ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	TION SHOULD	BE CON	(X5) MPLETION DATE
F 323	seated on the bench the hallway near the assistant (NA)-F pu- hall. NA-F pushed the walker while he approximately 50 fe desk to the table in the common sitting seated himself in a On 8/21/17 at 7:39 transported R224 u wheeled walker. N requested her to pu- because he felt we transported R224 u wheeled walker eve and verified the nur indicated R224 utili had a wheel chair t On 8/21/17, at 7:44 verified she was pri- when she observed the nursing station verified NA-F pushe bench of his 4 whe she told NA-F not to on his walker, but of indicated she had in residents while the walkers. CM-A ind would use a wheeled On 8/23/17, at 8:17 able to ambulate in	<ul> <li>p.m. R224 was observed</li> <li>ch of his 4 wheeled walker in</li> <li>e nurses station, while nursing ushed R224's walker down the R224, seated on the bench of</li> <li>e faced backwards,</li> <li>e tfrom the nursing station</li> <li>the dining room located past area. R224 stood up and</li> <li>chair at the dining room table.</li> <li>p.m. NA-F confirmed she had</li> <li>utilizing the bench of his</li> <li>A-F indicated R224 had</li> <li>ush him to the dining room</li> <li>ak. NA-F indicated she</li> <li>utilizing the bench of his</li> <li>ery 2-3 weeks. NA-F visualized</li> <li>rsing assistant care sheet that</li> <li>zed a 4 wheeled walker and</li> <li>o be used as needed.</li> <li>p.m., clinical manager (CM)-A</li> <li>esent at the nursing station</li> <li>d NA-F transport R224 from</li> <li>to the dining room. CM-A</li> <li>ed R224 while he sat on the</li> <li>eled walker. CM-A indicated</li> <li>o transport R224 while he sat</li> <li>did not intervene. CM-A</li> <li>nstructed staff not to transport</li> <li>y sat on the bench of their</li> <li>icated R224 at times the staff</li> <li>chair to transport R224.</li> <li>a.m. R224 indicated he was</li> <li>dependently with his 4</li> </ul>	F 32				
FORM CMS-25	67(02-99) Previous Versions	S Obsolete Event ID: M4PX1	1	Facility ID: 00164	If continuation	on sheet Page	73 of 81

PRINTED: 02/02/2018

		AND HUMAN SERVICES			PRINTED: 02/02 FORM APPR OMB NO. 0938	ROVED
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURV COMPLETEI	
		245242	B. WING		08/24/20	17
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT		
AUGUST		CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET		
A00001				MINNEAPOLIS, MN 5540	4	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMP TO THE APPROPRIATE DA	X5) PLETION ATE
F 323	had used the Rollat while he sat on the On 8/23/17, at 9:00 indicated she would walker to be used for resident sat on the she witnessed a sta while they sat on th she would intervend indicated she would would be educated as a wheelchair for On 8/23/17, at 9:10 (DON) confirmed sl had utilized R224's facility. DON indicated would not push residuench of their 4 who Review of undated attached to R224's Medical Rollator revise be used as a wheel to tip-over, resulting The facility's EZ-st directed staff to che damaged parts and	224 confirmed in the past staff tor walker to transport him bench of the walker. D a.m. director of rehab (DR)-A d not recommend a 4 wheeled or transportation while a bench. DR-A indicated that if aff member pushing a resident e bench of a 4 wheeled walker e and stop them. DR-A d expect staff and residents to not use 4 wheeled walkers transportation. a.m. director of nursing he had been made aware staff walker to transport him in the ated she would expect staff idents while they sat on the eeled walkers. manufacturer's guidelines, Rollator walker titled Roscoe vealed Rollators are NOT to lchair. Doing so may cause it g in injury. tand policy dated 04/08, eck for loose nuts and bolts, it o check the sling to ensure it rayed. The policy did not	F 3		ENCY)	
	policy, dated 4/201 committed to provid residents, and woul	ent Prevention and Reduction 7 indicated the facility was ding a safe environment for Id use a systematic approach tification, evaluation and				
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID:M4PX1	1	Facility ID: 00164	If continuation sheet Page 7	74 of 81

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	· · ·	
ID PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	0	MPLETED
		245242	B. WING		08	8/24/2017
IAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
UGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 323	Continued From pa	age 74	F 32	3		
F 431 SS=D	need for supervisio or individual reside resident's environm and hazards as pos receives adequate devices to prevent DRUG RECORDS BIOLOGICALS CFR(s): 483.45(b)( The facility must pr drugs and biologica them under an agre §483.70(g) of this p unlicensed personn	ABEL/STORE DRUGS & 2)(3)(g)(h) ovide routine and emergency als to its residents, or obtain eement described in part. The facility may permit nel to administer drugs if State ly under the general	F 43	1		10/12/17
	pharmaceutical ser that assure the acc dispensing, and ad biologicals) to mee	facility must provide vices (including procedures surate acquiring, receiving, ministering of all drugs and t the needs of each resident. tation. The facility must				
		e services of a licensed				
	disposition of all co	ystem of records of receipt and ntrolled drugs in sufficient accurate reconciliation; and	1			
	that an account of a	t drug records are in order and all controlled drugs is riodically reconciled.				

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		& MEDICAID SERVICES				. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY
		245242	B. WING			/24/2017
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
UGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 431	Continued From pa	ge 75	F 4	31		
	labeled in accordar professional princip appropriate access instructions, and the applicable. (h) Storage of Drug (1) In accordance w the facility must sto locked compartmer controls, and permi have access to the (2) The facility must permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distri quantity stored is m be readily detected This REQUIREMEN by: Based on observat review, the facility fi was labeled with ac of 1 resident (R323 to be mislabeled du administration. Findings include:	e expiration date when s and Biologicals. vith State and Federal laws, re all drugs and biologicals in nts under proper temperature t only authorized personnel to keys. t provide separately locked, d compartments for storage of red in Schedule II of the ug Abuse Prevention and and other drugs subject to n the facility uses single unit bution systems in which the inimal and a missing dose can NT is not met as evidenced ion, interview, and document ailed to ensure medication courate directions for use for 1 ) whose insulin was observed		F431: It is the policy of the Augus Care Center that drugs an used in the facility must be accordance with currently professional principles, an appropriate accessory and instructions, and the expire applicable. Corrective Action:	d biologicals abeled in accepted d include the cautionary	
	included diabetes n and kidney failure.	R323 had diagnoses which nellitus, Alzheimer's disease The report included an order n) solution 100 unit/ml		Clinical Manager immedia medication change labels pharmacy and placed on t upon identification by the s	from the he insulin bottle	

Facility ID: 00164

If continuation sheet Page 76 of 81

TATEMEN	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
	of Connection	IDENTIFICATION NUMBER.	A. BUILDING	ä	COM	
		245242	B. WING		08/2	24/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET		
AUGUSI	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 431	before breakfast, 14 units before dinner. Humalog to be give included to give 12 400. On 8/21/17, at 6:40 was observed to pre R323's insulin. RN Humalog insulin intr 10 units for R323's because the physic want to give more t scale dose of 12 un R323's Humalog via medication containe with administration subcutaneous 3 tim sliding scale param blood sugar 130-15 blood sugar 151-20 blood sugar 201-25 blood sugar 351-40 blood sugar 351-40 blood sugar greater doctor) On 8/21/17, at 6:43 Humalog order had indicated the order always be relied on directions/dose. RI practice was to com	U) injected subcutaneously 4 units before lunch, and 10 R323 had an order for m with a sliding scale that units if blood sugar was 351 to p.m. registered nurse (RN)-E epare for administration of I-E had drawn 22 units of o the syringe. RN-E explained dinner dose and 12 units ian was called and did not han the current highest sliding nits. al was kept in a amber er. The container was labeled directions to inject 10 units nes daily before meals with eters as follows: i0=0 0=2U i0=4U i0=6U i0=8U 0=10U r than 400 call MD (medical p.m. RN-E verified R323's changed on 7/20/17. RN-E labels on medications can not	F 431		abeling. ee will e weekly ext 30 ee will for the y the o	

Facility ID: 00164

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		& MEDICAID SERVICES				). 0938-039 <sup>-</sup>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · /	TE SURVEY MPLETED
		245242	B. WING		08	8/24/2017
NAME OF I	PROVIDER OR SUPPLIER	• •		STREET ADDRESS, CITY, STATE,	ZIP CODE	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETION DATE
F 431	Continued From pa	-	F 4	31		
	Medication Adminis	stration Record (MAR).				
	(LPN)-D prepared 2 R323. LPN- explain morning dose of ins sliding scale dose. On 8/23/17, at 8:09	a.m. licensed practical nurse 24 units of Humalog insulin fo ned 12 units for R323's sulin and 12 units for the 5 a.m. LPN-D verified R323's				
insulin medica than the direct		oottle container was different in the MAR and did not have a cker on it.	a			
	(CM)-B verified R3: were changed 8/22 called to provide a place on the insulin the clinical record C scale order had als from 10 units to 12 reading of 351 to 4 order had changed placed to alert staff should have.	a.m. the clinical manager 23's Humalog insulin orders /2017, and the pharmacy was change of order sticker to bottle. With further review of CM-B verified the insulin sliding o changed in July, increasing units for a blood sugar 00. CM-B verified when the in July a sticker had not been of the order change, and	g			
	(DON) verified med based on the the M The DON indicated noted staff were ex orders and if there the pharmacy shou change of order stic change of order stic staff to a dosage ch	4 a.m the director of nursing dications were administered IAR and the medication label. I when a discrepancy was pected to check the original was a dosage change found, Id have been contacted for a cker. The DON verified a cker would be used to alert nange and aid in prevention of ion error. The DON verified				

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 02/02/2018 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		245242	B. WING		08/	24/2017
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE. DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 431	Continued From pa recent order change change.	ge 78 e and prior sliding scale order	F 4	31		
F 465 SS=D		ity policy was not provided. L/SANITARY/COMFORTABL	F 4	65		10/12/17
	(i) Other Environme					
		ovide a safe, functional, ortable environment for the public.				
	applicable Federal, regulations, regardi	es, in accordance with State, and local laws and ng smoking, smoking areas, that also take into account ents.				
	by:	NT is not met as evidenced				
	review, the facility fa services necessary sanitary condition in bathrooms for 2 of 2	ion, interview and document ailed to provide housekeeping to maintain a clean and resident rooms and 2 resident rooms and shared		F465: It is the policy of the Augusta Care Center to provide a sa sanitary, and comfortable er residents, staff and the publ	fe, functional, nvironment for	
	Findings include:	09, 111, East 252) reviewed.		Corrective Action: The three identified rooms of have been deep cleaned an	d checked	
	were noted:	ur on 8/22/17, the following		numerous times to ensure s conditions have been mainta 9-29-17	ained	
		109 and 111 on the first floor nd to have a strong urine odor nared bath room.		Identification of Other Resid Every resident room was au sanitary conditions and deep indicated.	dited for	
		252 on the second floor East ave a strong urine odor		9-29-17 Measures Put in Place:		

Facility ID: 00164

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TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
			A. BUILD	ING			
		245242	B. WING				24/2017
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			7 EAST 14TH STREET INEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 465	Continued From pa	ae 79	F 4	65			
	through out the roo On 8/24/17, at 11:1 environmental tour environmental serv environmental serv environmental cond On 8/24/17, at 11:1 responsibility of ma staff. The DES expl and duties to includ - one staff person w total of seven hours -staff were provided and weekly cleaning - identified smells w The DES verified th odorous and difficu clientele living on th East unit room 252 an ongoing concerr the floor. The DES cleaning procedure however, agreed th control. On 8/24/17, at 11:4 improvement direct of environmental se services to resident up checks to ensur- cleaning services. On 8/24/17, at 12:2	m and bathroom. 4 p.m. during the with the director of ices (DES) the above cerns were verified. 14 a.m. the DES verified the naging the house keeping lained housekeeping staffing le the following: vas assigned to each unit for a s per day. d schedules to follow for daily g tasks. vere managed promptly. he first floor main unit was lt to manage due to the hat unit. The DES agreed the 2 was odorous and had been in due to residents urinating on identified numerous additional s to manage the odors, at the problem was not under 49 a.m. the quality or (QID) indicated the director ervices provided deep cleaning t rooms and completed follow e staff were providing the 3 p.m. in the administrators			Mandatory all staff education w conducted on the importance o maintaining a sanitary, clean ar comfortable environment for re staff and the public. 10-11-17 Monitoring Mechanisms: All resident rooms will be audite weekly for the next 30 days to o sanitary, clean and comfortable environment is maintained. 10-10-17 10-24-17 10-31-17 All resident rooms will be audite monthly for the next 60 days to sanitary, clean and comfortable environment is maintained. 11-30-17 12-31-17 Resident Room audits will be re the Quality Improvement comm compliance with providing a sa clean and comfortable environm before 10-31-17 11-30-17 12-31-18 Responsible Person/s Director of Environmental Serv Quality Improvement Director	f nd sidents, ed one time ensure a ed 2 times ensure a eviewed by nittee for nitary, nent on or	
	office with the admi director of maintena rooms and shared I	3 p.m. in the administrators nistrator, DON, QID, and ance, the DES verified the two bathroom had a strong odor. he personally stripped, waxed					

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		AND HUMAN SERVICES			FORM	APPROVED
		& MEDICAID SERVICES	1			0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		E SURVEY IPLETED
		245242	B. WING _		08/	24/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUS	TANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 465	and went thorough 252 on the East un only so much time	ge 80 clothing and etcetera in room it. The DES stated, "There is we can spend in there." ity policy was not provided.	F 46			

Facility ID: 00164

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PRINTED: 02/02/2018

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

## **CENTERS FOR MEDICARE & MEDICAID SERVICES**

ID: M4PX Facility ID: 00164 N: <u>7 (</u>L8)

	CARE/MEDICAID CERTIFICATION AND TRANSMITTAL - TO BE COMPLETED BY THE STATE SURVEY AGENCY	ID: Fac
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245242	3. NAME AND ADDRESS OF FACILITY (L3) AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	<ol> <li>TYPE OF ACTION:</li> <li>Initial</li> </ol>

(L1)       245242         2.STATE VENDOR OR MEDICAID NO.       (L2)         159540700       159540700         5.       EFFECTIVE DATE CHANGE OF OW (L9)         6.       DATE OF SURVEY       10/18/         8.       ACCREDITATION STATUS:         0       Unaccredited       1 TJC         2 AOA       3 Other         11.       LTC PERIOD OF CERTIFICATION		<ul> <li>(L3) AUGUSTAN</li> <li>(L4) 1007 EAST 1</li> <li>(L5) MINNEAPO</li> <li>7. PROVIDER/SUI</li> <li>01 Hospital</li> <li>02 SNF/NF/Dual</li> <li>03 SNF/NF/Distinct</li> <li>04 SNF</li> <li>10.THE FACILITY</li> </ul>	4TH STREET LIS, MN PPLIER CATEGOR 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	Y 09 ESRD 10 NF 11 ICF/IID 12 RHC		(L6) <b>55404</b> (L7) 22 CLIA	1. Initial       2. Recertification         3. Termination       4. CHOW         5. Validation       6. Complaint         7. On-Site Visit       9. Other         8. Full Survey After Complaint         FISCAL YEAR ENDING DATE:       (L35)         09/30	
From (a):		X A. In Complian	nce With		And/Or A	Approved Waivers Of The	e Following Requirements:	
To (b):		Complianc	equirements the Based On:		3	<ul><li>Technical Personnel</li><li>24 Hour RN</li></ul>	<ul> <li>6. Scope of Services Limit</li> <li>7. Medical Director</li> </ul>	
12.Total Facility Beds	250 (L18)	1. A	Acceptable POC			7-Day RN (Rural SNF)		
13.Total Certified Beds	<b>250</b> (L17)		npliance with Progra and/or Applied Waiv		<u>x</u> 5. * Code:	Life Safety Code	9. Beds/Room (L12)	
14. LTC CERTIFIED BED BREAKDOW	'N				15. FACI	LITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e)	(1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMAR								
See Attached Remarks	IKS (II AITEICADE		LEATION DATE).					
17. SURVEYOR SIGNATURE		Date :			18. STAT	E SURVEY AGENCY A	APPROVAL Date:	
							11/20/2017	
<u>Tammy Williams, HFE - N</u>	NE II	1	1/29/2017	(L19)	Joanne	Simon, Enforcer	ment Specialist 11/29/2017	20)
•						Simon. Enforcer	ment Specialist (L2	20)
•	<b>ART II - TO BH</b> Y	E COMPLETED 20. COM		GIONAL	OFFICE	2 OR SINGLE STA 1. Statement of Finan	ment Specialist (L: ATE AGENCY acial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513)	20)
PA 19. DETERMINATION OF ELIGIBILITY	<b>ART II - TO BH</b> Y	E COMPLETED 20. COM	<b>BY HCFA RE</b> IPLIANCE WITH C	GIONAL	OFFICE	<ol> <li>C OR SINGLE STA</li> <li>1. Statement of Finan</li> <li>2. Ownership/Control</li> </ol>	ment Specialist (L: ATE AGENCY acial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513)	20)
PA 19. DETERMINATION OF ELIGIBILITY _X_ 1. Facility is Eligible to Pa	<b>ART II - TO BH</b> Y rticipate	E COMPLETED	<b>BY HCFA RE</b> IPLIANCE WITH C	GIONAL	21.	<ol> <li>C OR SINGLE STA</li> <li>1. Statement of Finan</li> <li>2. Ownership/Control</li> </ol>	ment Specialist (L: ATE AGENCY acial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513)	20)
PA 19. DETERMINATION OF ELIGIBILITY _X1. Facility is Eligible to Pa2. Facility is not Eligible	ART II - TO BE Y rticipate (L21)	E COMPLETED	BY HCFA RE IPLIANCE WITH C GHTS ACT:	GIONAL IVIL	21.	C OR SINGLE STA  1. Statement of Finan 2. Ownership/Control 3. Both of the Above  MINATION ACTION:	(L30)	20)
PA 19. DETERMINATION OF ELIGIBILITY _X1. Facility is Eligible to Pa2. Facility is not Eligible 22. ORIGINAL DATE	ART II - TO BE Y rticipate (L21) 23. LTC AGREEM	E COMPLETED	BY HCFA RE IPLIANCE WITH C 3HTS ACT: 4. LTC AGREEMI	GIONAL IVIL	26. TERI VOLUNTA	C OR SINGLE STA  1. Statement of Finan  2. Ownership/Control  3. Both of the Above  MINATION ACTION:  ARY00  Closure	(L20)	20)
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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

ID: M4PX

Facility ID: 00164

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

### CCN: 24 5242

On August 24, 2017, a standard survey was completed at this facility by the Minnesota Departments of Health and Public Safety to determine if the facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567.

The facility met one or more criterion and remedies were imposed immediately. Therefore, this Department imposed the following remedy:

• State Monitoring effective September 25, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedies listed below to the CMS Region V Office for imposition:

• Civil money penalty for the deficiency cited at F310. (42 CFR 488.430 through 488.444)

• Civil money penalty for the deficiency cited at F315. (42 CFR 488.430 through 488.444)

Further, Submitted documentation supporting the facility's request for a continuing waiver involving life safety code deficiency cited at K521 has been forwarded to CMS. Approval of the waiver request was recommended.



Protecting, Maintaining and Improvingthe Health of All Minnesotans

CMS Certification Number (CCN): 245242

November 29, 2017

Ms. Jean Cole, Administrator Augustana Health Care Center Of Minneapolis 1007 East 14th Street Minneapolis, MN 55404

Dear Ms. Cole:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective October 12, 2017 the above facility is recommended for:

250 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 250 skilled nursing facility beds.

We have recommended CMS approve the waiver that you requested for the following Life Safety Code Requirement: K521.

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 or renew your request for waiver in order to continue your participation in the Medicare 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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Augustana Health Care Center Of Minneapolis November 29, 2017 Page 2

 $\sim$ 5 6

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically delivered

November 29, 2017

Ms. Jean Cole, Administrator Augustana Health Care Center Of Minneapolis 1007 East 14th Street Minneapolis, MN 55404

Re: Reinspection Results - Project Number S5242027

Dear Ms. Cole:

On October 18, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 24, 2017, with orders received by you on September 21, 2017. At this time these correction orders were found corrected.

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,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically delivered

November 20, 2017

Ms. Jean Cole, Administrator Augustana Health Care Center Of Minneapolis 1007 East 14th Street Minneapolis, MN 55404

Re: Reinspection Results - Project Number S5242027

Dear Ms. Cole:

On October 18, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 24, 2017, with orders received by you on September 21, 2017. At this time these correction orders were found corrected.

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Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			<b>CENTERS FOR MED</b>	ICARE &	MEDICAID SI	ERVICES
	MEDICA	ARE/MEDICAI	D CERTIFIC	CATION A	AND TRANSMITTAL		ID: M4P	Х
	PART I -	TO BE COMPI	LETED BY T	THE STAT	<b>FE SURVEY AGENCY</b>		Facility II	D: 00164
MEDICARE/MEDICAID PROVIDI     (L1) 245242     2.STATE VENDOR OR MEDICAID N		3. NAME AND AL (L3) AUGUSTAN (L4) 1007 EAST	A HEALTH C	CARE CEN	TER OF MINNEAPOLIS	1. Initia		certification
(L2) <b>159540700</b>	NO.	(L5) MINNEAPO		•	(L6) <b>55404</b>	3. Term 5. Valid 7. On-S		mplaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	IPPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA		Survey After Complain	
	<b>4/2017</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL Y	EAR ENDING DATE	: (L35)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID			)9/30	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	· · ·	17/50	
11LTC PERIOD OF CERTIFICATION	N	10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complia			And/Or Approved Waivers Of		-	
To (b) :			equirements e Based On:		2. Technical Personnel		Scope of Services Li	nit
					3. 24 Hour RN 4. 7-Day RN (Rural SN		Medical Director	
12.Total Facility Beds	250 (L18)	1. A	cceptable POC			<u> </u>	Patient Room Size	
13.Total Certified Beds	250 (L17)	X B. Not in Con		-	X 5. Life Safety Code	9.	Beds/Room	
		Requirements	and/or Applied V	Waivers:	* Code: <b>B, 5</b>	(L12)		
14. LTC CERTIFIED BED BREAKDO					15. FACILITY MEETS		(1.1.5)	
18 SNF 18/19 SNF 250	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):		(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
<ol> <li>STATE SURVEY AGENCY REM</li> <li>SURVEYOR SIGNATURE</li> </ol>		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date	2:
_Denise Erickson, HFE N	Ell	1	0/08/2017	(L19)	Mark Meath, E	nforcemer	nt Specialist	0/25/2017 (L20)
PAI	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	OFFICE OR SINGLE S	FATE AGI	ENCY	(*)
19. DETERMINATION OF ELIGIBIL	JTY	20. COM	IPLIANCE WITH	H CIVIL	21. 1. Statement of Finan	cial Solvency	(HCFA-2572)	
X 1. Facility is Eligible to F	Participate	RIGH	ITS ACT:		<ol> <li>Ownership/Contro</li> <li>Both of the Above</li> </ol>		losure Stmt (HCFA-1:	513)
2. Facility is not Eligible					5. Both of the floore	·		
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	/IENT	26. TERMINATION ACTION:		(L30)	
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	ГЕ	VOLUNTARY 00	_	INVOLUNTARY	
01/01/1982					01-Merger, Closure		05-Fail to Meet Heal	th/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse		06-Fail to Meet Agree	ement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	n	<u>OTHER</u>	
	A. Suspension	n of Admissions:	<i></i>		04-Other Reason for Withdrawal		07-Provider Status (	Change
(L27)	B. Rescind St	uspension Date:	(L44)				00-Active	
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)	AW LSC K521 Emaile	ed ROCHI	10/25/2017 Co.	
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE	Posted 10/25/2017 Co.			
	(L32)			(L33)	DETERMINATION APPE	ROVAL		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: M4PX PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

#### **C&T REMARKS - CMS 1539 FORM** STATE AGENCY REMARKS

## CCN: 24 5242

On August 24, 2017, a standard survey was completed at this facility by the Minnesota Departments of Health and Public Safety to determine if the facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567.

The facility met one or more criterion and remedies were imposed immediately. Therefore, this Department imposed the following remedy:

• State Monitoring effective September 25, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedies listed below to the CMS Region V Office for imposition:

• Civil money penalty for the deficiency cited at F310. (42 CFR 488.430 through 488.444)

• Civil money penalty for the deficiency cited at F315. (42 CFR 488.430 through 488.444)

Further, Submitted documentation supporting the facility's request for a continuing waiver involving life safety code deficiency cited at K521 has been forwarded to CMS. Approval of the waiver request was recommended.

# DEPARTMENT OF HEALTH

Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically delivered

September 20, 2017

Ms. Jean Cole, Administrator Augustana Health Care Center Of Minneapolis 1007 East 14th Street Minneapolis, MN 55404

RE: Project Number S5242027

Dear Ms. Cole:

On August 24, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567.

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

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

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

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

Augustana Health Care Center Of Minneapolis September 20, 2017 Page 2

## DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor Fergus Falls Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1505 Pebble Lake Road, Suite 300 Fergus Falls, Minnesota 56537-3858 Email: gail.anderson@state.mn.us Phone: (218) 332-5140 Fax: (218) 332-5196

# NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; <u>OR</u>
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; <u>OR</u>
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) <u>AND</u> has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

• State Monitoring effective September 25, 2017. (42 CFR 488.422)

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

Augustana Health Care Center Of Minneapolis September 20, 2017 Page 3

- Civil money penalty for the deficiency cited at F310. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F315. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

## ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

# PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

# VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the 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 November 24, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 24, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

# INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process.

Augustana Health Care Center Of Minneapolis September 20, 2017 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Email: <u>mark.meath@state.mn.us</u> Phone: (651) 201-4118 Fax: (651) 215-9697

DEPART	IMENT OF HEALTH	AND HUMAN SERVICES		· ·		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		0	MB NO.	0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED
		245242	B. WING		08/:	24/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET		
	[			MINNEAPOLIS, MN 55404		T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 000	D		
	survey was comple Minnesota Departm your facility was in o of 42 CFR Part 483	bugh 8/24/2017, a standard ted at your facility by the nent of Health to determine if compliance with requirements a, Subpart B, and ong Term Care Facilities.				
	The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance.					
F 225 SS=D	revisit of your facilit validate that substa regulations has bee your verification.	acceptable POC, an on-site y may be conducted to initial compliance with the en attained in accordance with 1)-(4) INVESTIGATE/REPORT DIVIDUALS	F 22	5		10/12/17
	483.12(a) The facili	ty must-				
	(3) Not employ or o who-	therwise engage individuals				
		d guilty of abuse, neglect, propriation of property, or court of law;				
	nurse aide registry	ing entered into the State concerning abuse, neglect, atment of residents or their property; or				
	or her professional body as a result of	ary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or				
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE
Electron	ically Signed					09/29/2017

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

PRINTED: 10/09/2017

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/09/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
		245242	B. WING _			08/	24/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			007 EAST 14TH STREET IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 225	Continued From par misappropriation of (4) Report to the St licensing authorities actions by a court of which would indicat nurse aide or other (c) In response to a exploitation, or mist (1) Ensure that all a abuse, neglect, exp including injuries of misappropriation of reported immediate after the allegation cause the allegation serious bodily injury the events that cau abuse and do not re the administrator of officials (including t adult protective ser for jurisdiction in lon accordance with St procedures. (2) Have evidence for thoroughly investigat (3) Prevent further	ge 1 resident property. ate nurse aide registry or s any knowledge it has of f law against an employee, e unfitness for service as a facility staff. Illegations of abuse, neglect, treatment, the facility must: alleged violations involving ploitation or mistreatment, unknown source and resident property, are ely, but not later than 2 hours is made, if the events that n involve abuse or result in 4, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to the facility and to other o the State Survey Agency and vices where state law provides ng-term care facilities) in ate law through established that all alleged violations are ated.	F 2	25			
	administrator or his	rogress. Its of all investigations to the					

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TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY
	of Connection	IDENTIFICATION NOMBER.	A. BUILDI	NG	CON	
		245242	B. WING		08/	24/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 225	Continued From pa	ae 2	F 2	25		
	with State law, inclu Agency, within 5 wo if the alleged violati corrective action m This REQUIREMEN by: Based on interview facility failed to imm agency (SA) and th incident of potentia residents (R123) w the facility. Findings include: R123's face sheet of current diagnoses of bilateral leg weakned disorder with seizur depression, pain in and repeated falls p R123's admission N dated 1/5/17, identia and required extern Review of Event Re p.m. indicated R122 her chair to bed, E place causing resid Staff re-educated of to ensure correct si Further, the report suddenly stopped m assistant did not re	dated 12/29/16, identified of chronic pain, muscle and point of admission. dated 12/29/16, identified of chronic pain, muscle and ess, lymphedema, conversion res or convulsions, anxiety, left ankle and joints of left foot prior to admission. Minimum Date Set (MDS) fied R123 had intact cognition nsive assistance for transfers. eport dated 8/5/17, at 6:45 3 had been transferred from Z stand sling popped out of lent to land on her buttocks. on proper use of EZ stand and ize sling is being used. listed the EZ stand had noving, resident and nursing member what happened next,		Augustana Health Care Center of Minneapolis' Plan of correction is credible assertion of substantial compliance with the Federal and requirements of Nursing facilities skilled nursing facilities participat Federal Medicare or State Medic Assistance programs. Please no nothing set forth in this documen or should be construed to be an admission by Augustana Health Center of Minneapolis, or the val accuracy of any of the deficiencie by the Minnesota Department of relative to the survey, certification enforcement effort at issue. Furt please note that any and all docu transmitted or otherwise provided Augustana Health Care Center of Minneapolis in relation to the Pla correction, as well as any and all communications in writing or otho or on behalf of Augustana Health Center of Minneapolis, at law and equity, all of which are not waived of which are reserved and retaine and on behalf of Augustana Health Center of Minneapolis F225	a written State and/or ing in the al te that t is to be Care dity or es cited Health her ments d by f o of other erwise by Care d/or in d and all ed by, for th Care	
	one side of the sline resident landed on was helped off the	g was out of place and the floor on buttocks. Resident floor utilizing a hoyer lift, and were evident at that time.		It is the policy of Augustana Heal Center to ensure that all alleged involving mistreatment, neglect, including injuries of unknown sou	violations or abuse	

Facility ID: 00164

If continuation sheet Page 3 of 80

	-	AND HUMAN SERVICES			F OME	FORM A	10/09/201 APPROVEI 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X		SURVEY
		245242	B. WING _			08/2	4/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			007 EAST 14TH STREET IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From pa	age 3	F 22	25			
	<ul> <li>8/7/17, indicated R no injury. The inter and documented the concerns, environm condition noted. The intervention of staff EZ stand and to en- obtained large sling.</li> <li>During interview on reported a few weet the EZ stand lift use reported when the staff me safety belt around he attached the loops R123 reported since hooking up all of the any further falls.</li> <li>During interview on registered nurse (R the EZ stand lift dur talking with staff sh off or open, and the maybe incorrect. F given to the staff me lift use and sling siz no further investiga regarding R123's fat</li> <li>When interviewed of director of nursing of had the fall from the analysis was comp R123 let go of the head staff the fall</li> </ul>	a 8/23/17, at 8:07 a.m. R123 eks ago she had fallen from ed during a transfer. R123 staff member hooked her up to ember had not hooked the her abdomen, and had only on to the hooks of the lift. the that fall, all staff had been e belts, and she had not had a 8/23/17, at 11:43 a.m. RN)-C confirmed R123 fell from ring a transfer, and stated after the believed the strap snapped ought the size of the sling was RN-C stated re-education was ember involved regarding the zes. RN-C verified there were tions or documentation			misappropriation of resident property immediately reported to the administr and other state officials in accordance with state law and to have evidence th all violations are thoroughly investigat Corrective Action: Staff person was educated at time of original incident on proper use of the stand, and using the correct sling size identified resident R123 8-7-17 All care sheets were updated with slir size for all residents to ensure safe transfers 10-3-17 Identification of Other Residents: All current (August 1 - September 30) incident reports were reviewed to ens appropriate and immediate Vulnerable Adult reporting of abuse and/or negle reported if indicated. 10-4-17 Measures Put In Place: Incident review summary form was revised to add an additional review measure related to any possible indic of Abuse or Neglect to ensure a full investigation has been completed Mandatory all staff education was completed to review Vulnerable Adult reporting, investigation, and definition abuse and neglect Mandatory all staff education was completed to review appropriate sling and size, and use of transfer equipme 10-11-17 Monitoring Mechanisms: Per facility policy all incident reports a reviewed by the Administrator, Director	rator e that tted. i the EZ e for ng ) sure le ect is cation t ns of g use ent. are	

Facility ID: 00164

If continuation sheet Page 4 of 80

STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
				3		
		245242	B. WING		08/2	24/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIC DATE
F 225	further investigated in the incident repo loop "popped off." T not complete a repo not feel this was a r no negative outcom During group interv with the administration the current facility p confirmed she expe suspected neglect of needed to be report administrator and th feel R123's fall from was reportable due negative outcome, negative intent. Th stated they expected of care possible, and be followed. Review of the facility and Investigation P indicated incidents immediately to MDI Health) included net the Administrator and person to investigation - the residnets' med events leading up to - interview the wither - interview the resid members , interview	, the wording "popped off" was rt, due to being too tight or the The DON stated the facility did ort to the SA as the facility did reportable event as there was ne for R123. iew on 8/24/17, at 3:41 p.m. tor and DON, they confirmed policy, and the administrator ected all neglect of care and or not providing care as ted to the SA. The ne DON stated they did not in the EZ stand mechanical lift to the fact there was no no harm, no abuse or no e administrator and DON ed staff to give the highest level and expected the care plan to ty's Vulnerable Adult Reporting rocedure policy dated, 8/2016 that must be reported H (Minnesota Department of eglect. The policy indicated and DON would appoint a te the alleged incident,	F 22	5 Nursing, and Medical Director for p completion and appropriate interver This review now includes the addit measure to review for any possible indication of abuse or neglect. Incident report patterns/trends are reviewed at the quarterly QAA/QAI meetings for maintaining an accep standard of practice in regards to investigation of all incidents. We w review on-going for the next year a track and incident review that indic abuse or neglect on or before: 10-19-17 11-30-17 12-31-17 1-31-18 2-27-18 3-31-18 4-30-18 5-31-18 6-30-18 7-31-18 8-31-18 9-30-18 Responsible Person/s Administrator Director of Nursing Clinical Managers Quality Improvement Director	entions. ional Pl table ill ind	

Facility ID: 00164

If continuation sheet Page 5 of 80

	TMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391							
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245242	B. WING _			08/;	24/2017	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION		
F 225 F 225 SS=D	Continued From pa - interview other res employee provides Review of the facili Vulnerable Adults P indicated all allegati abuse must be repo- immediately. The p is unexplainable, or reported or witness neglect a report mu the Minnesota Depa call the administrator also indicated an in reports will be comp 483.12(b)(1)-(3), 48 DEVELOP/IMPLME POLICIES 483.12 (b) The facility must written policies and (1) Prohibit and pre exploitation of resid resident property, (2) Establish policie investigate any suct (3) Include training §483.95	age 5 sidents to whom the accused care or services. ity's Maltreatment of Policy, dated 10/2016, ions and/or suspicious of orted to the administrator policy further indicated if injury allegation of abuse is ed, if there is caregiver ast immediately be reported to artment of Health (MDH) and or immediately. The policy ternal, facility investigation of pleted. 33.95(c)(1)-(3) ENT ABUSE/NEGLECT, ETC t develop and implement procedures that:	F 2:				10/12/17	
	the freedom from a requirements in § 4	buse, neglect, and exploitation 83.12, facilities must also heir staff that at a minimum						

If continuation sheet Page 6 of 80

PRINTED: 10/09/2017

		AND HUMAN SERVICES		F	NTED: 10/09/2017 ORM APPROVED 3 NO. 0938-0391			
STATEMENT OF DEFICIENCIES (X1) PROVID		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
245242			B. WING		08/24/2017			
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	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)				
F 226	Continued From pa educates staff on-	ge 6	F 226					
		constitute abuse, neglect, isappropriation of resident n at § 483.12.						
		or reporting incidents of abuse, n, or the misappropriation of						
	prevention.	nagement and resident abuse						
	Based on interview facility failed to imp policy to immediate (SA) and thorough	and document review, the lement their abuse prevention ly report to the State agency y investigate potential 1 of 1 resident (R123) who cal lift in the facility.		F226 It is the policy of Augustana Health C. Center to develop and implement wri- policies and procedures that prohibit prevent abuse, neglect, and exploitat residents and misappropriation of res property. To establish policies and	tten and ion of			
	Findings include:			procedures to investigate such allega and include the required abuse, negle				
	and Investigation P indicated incidents immediately to MDI Health) included ne the Administrator an person to investigat	ty's Vulnerable Adult Reporting rocedure policy dated, 8/2016 that must be reported H (Minnesota Department of glect. The policy indicated nd DON would appoint a te the alleged incident,		and exploitation staff training. Corrective Action: Staff person was educated at time of original incident on proper use of the stand, and using the correct sling size identified resident R123 8-7-17	EZ e for			
	events leading up to - interview the pers - interview the withe	lical record to determine		All care sheets were updated with slir size for all residents to ensure safe transfers 10-3-17 Identification of Other Residents: All current (August 1 - September 30) incidents reports were reviewed to en	) isure			
		the the resident's physician, nember, and visitors as		appropriate and immediate Vulnerabl Adult reporting of abuse and/or negle				

Facility ID: 00164

If continuation sheet Page 7 of 80

TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED	
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER.	A. BUILDIN	IG	COM	PLETED	
		245242	B. WING			24/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	PCODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
F 226			F 22	reported if indicated. 10-4-17 Measures Put in Place: Incident review summary revised to add an addition measure related to any p of Abuse or Neglect to er investigation has been co Mandatory all staff educa completed to review Vuln reporting, investigation, a abuse and neglect. Mandatory all staff educa completed to review appl and size and use of trans 10-11-17 Monitoring Mechanisms: Per facility policy all incid reviewed by the Administ Nursing, and Medical Dir completion and appropria	nal review ossible indication nsure a full ompleted. tion was herable Adult and definitions of ation was ropriate sling use offer equipment. ent reports are rator, Director of ector for proper ate interventions. the additional		
	assistant did not rei one side of the sling resident landed on was helped off the t no pain or injuries v Review of R123's Ir 8/7/17, indicated R no injury. The inter	noving, resident and nursing member what happened next, g was out of place and the floor on buttocks. Resident floor utilizing a hoyer lift, and vere evident at that time. Incident Review Form, dated 123 had a fall on 8/5/17, with disciplinary team reviewed ere were no medication		measure to review for an indication of abuse or neu- lncident report patterns/tr reviewed at the quarterly, QAA/QAPI meetings for acceptable standard of p to investigation of all incid review on-going for the n track any incident review abuse or neglect on or be 10-19-17	glect. rends are /monthly maintaining an ractice in regards dents. We will ext year and that indicated		
	concerns, environm condition noted. Th intervention of staff	nental concerns or change of ne form listed the new re-educated on proper use of sure the proper sling used,		11-30-17 12-31-17 1-31-18 2-27-18 3-31-18 4-30-18			

Facility ID: 00164

If continuation sheet Page 8 of 80

TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED	
		245242	B. WING				
	PROVIDER OR SUPPLIER	243242	D. WING	STREET ADDRESS, CITY, STATE, ZI		8/24/2017	
		CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	OODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 226	Continued From pa	age 8 n 8/23/17, at 8:07 a.m. R123	F 22	5-31-18			
	reported a few wee the EZ stand lift us reported when the the lift, the staff me safety belt around I attached the loops	eks ago she had fallen from ed during a transfer. R123 staff member hooked her up to ember had not hooked the her abdomen, and had only on to the hooks of the lift.		6-30-18 7-31-18 8-31-18 9-30-18 Responsible Person/S Administrator			
	hooking up all of th any further falls. During interview on registered nurse (F	e that fall, all staff had been e belts, and she had not had n 8/23/17, at 11:43 a.m. RN)-C confirmed R123 fell from		Director of Nursing Clinical Managers Quality Improvement Dire	ector		
	talking with staff sh off or open, and the maybe incorrect. F given to the staff m lift use and sling size	ring a transfer, and stated after the believed the strap snapped bught the size of the sling was RN-C stated re-education was tember involved regarding the zes. RN-C verified there were titions or documentation all on 8/5/17.					
	director of nursing had the fall from the analysis was comp R123 let go of the H felt the harness was further investigated in the incident repo loop "popped off." not complete a repo	on 8/24/17, at 11:30 a.m. the (DON) reported after R123 e EZ stand lift, a root cause leted. The DON reported handles on the lift because she s a little tight, and as staff I, the wording "popped off" was int, due to being too tight or the The DON stated the facility did ort to the SA as the facility did reportable event as there was he for R123.					
	with the administrative the current faciilty p	view on 8/24/17, at 3:41 p.m. tor and DON, they confirmed policy, and the administrator ected all neglect of care and					

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					OMB NO. 0938-0 (X3) DATE SURVE		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	COMPLETED		
		245242	B. WING		08/24/201		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	E		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLE		
F 226	Continued From pa	age 9	F 22	6			
	needed to be report administrator and to feel R123's fall from was reportable due negative outcome, negative intent. The stated they expected	or not providing care as rted to the SA. The the DON stated they did not in the EZ stand mechanical lift to the fact there was no no harm, no abuse or no ne administrator and DON ed staff to give the highest level nd expected the care plan to					
F 280 SS=D	PARTICIPATE PLA 483.10 (c)(2) The right to p	(3),483.21(b)(2) RIGHT TO NNING CARE-REVISE CP	F 28	0	10/12/		
	<ul> <li>plan of care, includ</li> <li>(i) The right to part including the right to be included in the prequest meetings a</li> </ul>	n of his or her person-centered ling but not limited to: icipate in the planning process, to identify individuals or roles to planning process, the right to and the right to request rson-centered plan of care.					
	expected goals and amount, frequency other factors relate plan of care.	ticipate in establishing the d outcomes of care, the type, , and duration of care, and any ed to the effectiveness of the					
	(iv) The right to rec included in the plar	eive the services and/or items n of care.					
		e the care plan, including the ignificant changes to the plan					

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		AND HUMAN SERVICES	I OTMINT THOVED					
		& MEDICAID SERVICES					0938-0391	
	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				( - )	E SURVEY PLETED	
		245242	B. WING _			08/2	24/2017	
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
AUGUS	ANA HEALTH CARE (	CENTER OF MINNEAPOLIS		-	107 EAST 14TH STREET INNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 280	right to participate in shall support the re- planning process m (i) Facilitate the incl resident representa (ii) Include an asses strengths and need (iii) Incorporate the cultural preferences 483.21 (b) Comprehensive (2) A comprehensive (2) A comprehensive (2) A comprehensive (i) Developed within the comprehensive (ii) Prepared by an i includes but is not li (A) The attending p (B) A registered nur resident. (C) A nurse aide wit resident. (D) A member of for (E) To the extent pro- the resident and the An explanation mus	h his or her treatment and sident in this right. The ust usion of the resident and/or tive. ssment of the resident's s. resident's personal and s in developing goals of care. Care Plans e care plan must be- 7 days after completion of assessment. Interdisciplinary team, that imited to	F 28	80				

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COMF	PLETED
		245242	B. WING		08/2	24/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE
F 280	not practicable for t	epresentative is determined the development of the	F 28	0		
	disciplines as deter or as requested by (iii) Reviewed and r team after each as comprehensive and assessments.	tte staff or professionals in mined by the resident's needs the resident. revised by the interdisciplinary sessment, including both the				
	by: Based on observative review, the facility finclude individualized communicate with language barrier. Findings include: R338's admission Mated 2/5/17, identive which included arthand unspecified unive indicated R338 had memory problems,	tion, interview and document ailed to revise the care plan to ed interventions to effectively 1 of 1 resident (R338) with a Minimum Data Set (MDS) fied R338 had diagnoses iritis, chronic pain syndrome, inary incontinence. The MDS I both short and long term had moderately impaired		F280 It is the policy of Augustana Health Center that residents have the righ participate in the development and implementation of his or her person-centered plan of care. Corrective Action: Communication audit was done wit identified resident R338 to ensure communication needs were address Resident's electronic care plan, an Care Card were updated with individualized communication interventions.	t to th all ssed.	
	preferred language wanted an interpret or health care staff. R338 required exte mobility, dressing, t did not ambulate. F R338 was frequent bowel and was not	daily decision making, her was Somali and needed or ter to communicate with doctor . The MDS also indicated onsive assistance for bed toileting, personal hygiene and further, the MDS indicated ly incontinent of urine and on a toileting program.		<ul> <li>9-27-17</li> <li>Identification of Other Residents: Communication Section was added TCU Care Card to ensure communinterventions will be identified for a admits with a Language barrier.</li> <li>9-27-17</li> <li>Communication audits were compliant residents with an identified lang communication barrier to ensure communication needs are address</li> </ul>	nication Il new eted on uage or	

Facility ID: 00164

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STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATI	0938-039 E SURVEY PLETED
		245242	B. WING		08/	24/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 280	Somali and family r times R338 though listed various caus which included cult recognizing caregiv risk factors included decreased progres therapies. Also, the bowel and bladder control, history of s was not consistent needs to be change communication did addressed on the C R338's quarterly M R338 had severely preferred language wanted an interpret or health care staff. required extensive daily living (ADL). T was occasionally in incontinent of bowe program. R338's current care listed the problem of adequate, and indio understood through directed staff to rep communicate, under hear and to refer for R338's care plan id language was Som weakness, dement assistance with beo	338's primary language was reported confusion and at t she was in Africa. The CAA ses and contributing factors ural/language barrier, not vers or medical equipment and d social isolation, confusion, s and participation in rehab e CAA indicated R338 had incontinence with some tress incontinence and R338 with letting staff know she ed. The CAA for not trigger and was not	F 28	0 Resident's electronic care plans a care sheets were updated as nee individualized communication interventions. 10-6-17 Measures Put in Place: Mandatory all staff education was completed on the importance of communication interventions as a developing a resident-centered pl care. 10-11-17 Monitoring Mechanisms: 20% random audits will be done of Care Cards, LTC resident care sh and electronic care plans on all u monthly for the next 60 days. 10-10-17 11-10-17 12-10-17 Audits will be reviewed by the Qu Improvement Committee for com with providing a resident-centered care on or before 10-19-17 11-30-17 12-31-17 Responsible Person/s: Director of Nursing Clinical Managers Quality Improvement Director	ded with a part of an of of TCU neets, nits ality pliance	

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED	
		245242	B. WING		08	/24/2017	
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	=		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 280	simply and clearly a environmental cues communicate at ey explain cares/treatu needed and consis cares. The care pla opportunity for pati- social services as r talk through anger schedule an interpu- practitioner/physici- upon request. No fi- were listed to effec or assistive devices R338. Review of R338's u listed various interva- barrier. During observation R338 wore a hospi of her bed with her (NA)-G entered R3 light and asked R3 proceeded to repea- repeatedly tapped NA-G stated she w R338 was trying to repeat the foreign v of her hands out in R338 extended her front of her groin w sound repeatedly.	e plan directed staff to speak and repeat as needed, utilize s as calendars, clocks, notes, re level and establish calm, ments before beginning, as itent routine when providing an directed to provide ent to express feelings, involve needed, encourage resident to and frustration, and to reter for rehab therapies, nurse an visits, care conferences and urther care plan interventions tively communicate with R338, s to use to communicate with undated Transitional Care Card ventions which included Ls, however, the care card ntions for R338's language s on 8/23/17, at 8:56 a.m. tal gown, seated on the edge r call light on. Nursing assistant i38's room, deactivated the call 38 what she needed. R338 at foreign words, and her thigh with her left hand. vas unable to understand what tell her. R338 continued to words, proceeded to place both front her, and spread her legs. r fingers open and arms out in hile making a "sheeeew" R338 continued make the and gestures for NA-G until					

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DEPAR	IMENT OF HEALTH	AND HUMAN SERVICES			P		APPROVED
		& MEDICAID SERVICES					0938-0391
	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY IPLETED
		245242	B. WING			08/:	24/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			007 EAST 14TH STREET /INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 280	Continued From pa	ge 14	F 2	280			
	At 8:59 a.m. NA-G R338 wanted, but th She stated, "No one it's very hard, I don' indicated she was r facility who spoke F hard to communica gestures or movem gestures and move to communicate wit when working with At 9:02 a.m. R338 v bed, and R338's ca began to speak fore fast to registered nu entered her room a left hand on the left continued to repeat angry, frustrated vo hands out in front h extended her finger of her groin while m repeatedly. R338 o the "sheeeew" sour repeatedly if she wa appeared to get mo in her foreign langu her uneaten food ite waved her left arm her head. NA-G sta she wants."	stated she did not know what hought she was having pain. here speaks this language, t understand her." NA-G not aware of anyone in the R338's language and felt it was te with R338 utilizing hand ents. NA-G indicated the hand ments staff utilized to attempt h R338 were not effective					

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PRINTED: 10/09/2017

		AND HUMAN SERVICES				FORM	10/09/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245242	B. WING	i		08/:	24/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			007 EAST 14TH STREET /INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 280	bedpan to the bed. to place the bedpar she removed R338 repeatedly moaned rapid, frustrated voi place the bedpan b out of the way of the placed under her bu void on the bedpan During interview on stated staff had a h wanted when she c staff have to guess resident got frustrat On 8/21/17, at 7:53 stated in the past w facility to visit R338 stated he was awar void or have a bowe left on the bedpan f FM-A indicated he f R338's elimination had been told the s R338. FM-A indicat R338's wall for staff communicate with f On 8/23/17, at 9:21 difficult to communi language barrier an few words such as primary language. F contacted R338's s what R338 needed On 8/23/17, at 9:41	RN-D proceeded to attempt n under R338's buttocks, while 's disposable brief. R338 l, "uhhh, uhhh, uhhh" in a ice and frantically assisted to by moving her hospital gown e bedpan. With the bedpan uttocks, R338 proceeded to a large amount of urine. 8/23/17, at 9:11 a.m. RN-D hard time knowing what R338 called for assistance and stated a lot of the time and the ted during that time. 8 p.m. family member (FM)-A when family have come to 6, she had been crying. FM-A re R338 had attempted to not el movement, to avoid being for extended periods of time. had reported the concerns with needs, to nursing staff and staff do not have time to assist ted he had posted a note on f to utilize to call him to help R338. a.m. RN-D indicated it was icate with R338 due to the nd indicated she only knew a medication, pain in R338's RN-D indicated she had on when she was not sure	F	280			

		AND HUMAN SERVICES				FORM	10/09/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245242	B. WING			08/:	24/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			007 EAST 14TH STREET /INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 280	gestures to attempt and stated she was interventions to utili R338. NA-G indicat the family member R338 needed assis had not utilized an i not aware how to re- interpreter services On 8/23/17, at 9:50 communication was she pointed at obje- when he was availar routine was to stand point until she figure wanted. NA-H indic interpreter services On 8/23/17, at 12:1 present in the build services were utilized appointments with ro of any other time in in the facility. The ir (8/23/17), was the f a schedule medical today. On 8/23/17, at 12:2 the interpreter and not communicate w with that sometimes had been left on the the past, she had tr so she could avoid R338 indicated she incontinent product	t to communicate with R338 a not aware of any other ze while communicating with ted in the past she had called to attempt to figure out what tance with. NA-G stated she interpreter in the past and was equest for or use needed a.m. NA-H indicated s difficult with R338 and stated cts or had her son translate able. NA-H indicated her usual d in her room, have R338 ed out what R338 needed or tated she had not utilized	F 2	280			

STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA	). 0938-039 TE SURVEY MPLETED	
				â			
		245242	B. WING		08	8/24/2017	
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	SHOULD BE COMPLET		
F 280	sometimes made h if she was able to o care would be bette welcome staff help then they just leave and indicated she f education when sh blamed herself and learning the langua isolated, could not because staff could they were unable to the interpreter, R33 receive assistance and bursting. R338 her room in the pas communication, ho longer in her room pictures were. On 8/23/17 at 12:24 interview, FM-A ind telephone numbers help with R338's la staff did not use the had been told by th cares and did not us R338 would call hir facility to get R338 stated he felt if R33 were offering, she w indicated he felt the care had been corr language barrier.	ther cry. R338 indicated she felt communicate with staff, her er. R338 indicated she would , but staff comes in her room, e without providing assistance elt regret not getting the e was younger and stated she d people before her for not ige. R338 indicated she felt get up on her own, and stated d not communicate with her, o help her. Through the use of 88 stated when she did not at times she felt like exploding 6 indicated she had pictures in st for assistance with wever, the pictures were no and was not aware where the 5 p.m. during second licated he posted a note with s to the wall in R338's room to nguage barrier, but the facility e telephone numbers. FM-A te facility staff R338 refused use her call light. FM-A stated m on telephone, he called the assistance with toileting. FM-A 88 understood what the staff would not refuse. FM-A e number one issue with her imunication with R338's	F 280				

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STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DAT	0938-039 E SURVEY PLETED
		245242	B. WING			08/24/2017	
NAME OF	PROVIDER OR SUPPLIER		·		REET ADDRESS, CITY, STATE, ZIP CODE 7 EAST 14TH STREET		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE
F 280	been incontinent of had reported that si longer. FM-A indica concerns with the la facility staff many ti he had suggested u utilize pictures of va the Internet to use f R338. FM-A stated "maybe once" and I R338's room since. not utilized an interp communication for On 8/24/17, at 8:37 edge of her bed, wi left, and was observ telephone. Above th to R338's bed, a wh approximately 8 inc the wall. On the pap instructions for com service. On 8/24/17 at 8:56 R338's room and in communication car R338 was not able "so did not really we was easier to have communication and indicated the usual something, she wo son would call the o R338 wanted or ne confirmed the interp posted in R338's ro now. RN-G indicated	urine all over the bed and she he could not hold her urine any ated he had discussed his anguage barrier for R338 with mes in the past. He indicated use of an interpreter or staff to arious items or objects from to assist communication with he had seen pictures used had not seen the pictures in FM-A stated the facility had oreter to assist in cares for R338. Ta.m. R338 was seated on the th a cellular telephone in her ved to dial the cellular ne night stand, which was next hite piece of paper, thes (in) by 11 in. was taped to per, typed in black ink, were tacting an online interpreter	F 2	280			

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245242	B. WING _		08/	24/2017
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AUGUSI	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 280	incontinent of urine always continent of not aware of any co R338 and stated, " communication." On 8/24/17 at 9:43 interview, FM-A indorespond to her, she bed and stated "ha and holds it." He in assistance she wor FM-A stated the intr room was not there last night. On 8/24/17, at 9:00 able to speak the s R338. She indicate her hip when she h stated other staff th but R338 used thes to go to the bathroo assistance with toil utilized the call ligh indicated she was a incontinence with b staff who do not un cared for her. NA- R338, she was cor but when staff who communicate with R338 wore a brief. reported she was a incontinence episo aware the interpret when R338 had sc appointments. NA-	and stated she felt R338 was fowel. RN-G denied she was ommunication concerns with I don't think the problem is a.m. during a follow up licated when staff did not e would be incontinent on the ppens quite a bit, she holds it, dicated when she called for uld have incontinence issues. terpreter information in R338's e until they came to visit her 0 a.m. NA-J stated she was tame language (Somali) as ed R338 would point or slap had to go to the bathroom. She nink this gesture was for pain se gestures to indicate she has om. NA-J verified R338 needed eting, used the bedpan and t for assistance. NA-J aware R338 has had powel and bladder when other derstand what she wants J indicated when she cared for ntinent and did not wear a brief, could not properly her provided cares for R338, She indicated R338 had afraid she would have des. NA-J indicated she was er only came to the facility	F 2			

Facility ID: 00164

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		AND HUMAN SERVICES			FORM	10/09/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245242	B. WING		08/:	24/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	language barrier, and confirmed the interpreter		F 280	ט		
		338's room was not present stated, "She did not have that pefore."				
	able to speak the sa R338. NA-K verified with toileting, used use the call light. Na continent of bowel a R338 will have inco assisting her with to	a.m. NA-K stated she was ame language (Somali) as d R338 needed assistance the bedpan and was able to A-K confirmed R338 was and bladder. NA-K indicated ontinence if staff were late bileting and not understanding . NA-K indicated she felt a lot				
	of the staff did not k verified R338 has h not understanding v and stated "she has NA-K indicated R33	know what R338 wanted and had incontinence due to staff what she is trying to tell them s not had accidents for me." 38 was able to communicate tty pleasant, cooperative with				
	confirmed R338 pri and indicated he we for R338 or use the had medical appoin his portion of the M facility practice was son to translate, oth be patient and expla- indicated staff were plan and to utilize th having trouble com indicated he was no communicating with other interventions	8 p.m. social worker (SW)-A mary language was Somali ould schedule an interpreter online service when R338 ntments or when he completed DS. SW-A indicated the usual to encourage R338 to use the her staff members, and staff to ain cares to her. The SW-A e expected to follow the care he online interpreter services if municating with R338. He of aware of any problems in R338. SW-A confirmed no had been put in place to assist				
	R338 to effectively	communicate with staff.				

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTIF	LE CONSTRUCTION		). 0938-039 TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		à	( )	MPLETED
		245242	B. WING		08	/24/2017
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
F 280	(DON) confirmed F stated she expected plan, staff to assist needs consistently. expect staff to assist continent, help the call lights. DON inco barrier due to not s expect staff to call available, or use pi She stated all staff interpreter services utilize the resource with R338. The DO aware of any conce barrier. The DON in	age 21 33 p.m. director of nursing 338's current care plan and ed staff to follow R338's care as needed, and meet her . DON indicated she would st the resident to stay resident with cares, answer licated R338 had a language peaking English and would an interpreter, family if cture cards or online service. had access to the online and she would expect staff to s available to communicate DN indicated she was not erns with R338's language ndicated when residents were language barriers, the usual	F 280			
	to all staff to notify resident's primary I available to assist. we have family to a The DON indicated an interpreter for the medical appointme not schedule any fu the communication indicated 338's sort and stated she had with communication Review of the facilit revised on 11/2016 developed after con assessment or as d	s to send an email notification them of the individual anguage and if the family was She stated "90%" of the time accommodate for their needs. I the facility routinely scheduled herapy appointments and onts, and stated the facility did urther services unless they felt was unclear. The DON a came to the facility quite a lot I not heard of any concerns in that impacted 338's care. Ty policy titled Care Plans, d, indicated care plans are mpletion of the comprehensive changes occur. The care plan least quarterly and revised as				

If continuation sheet Page 22 of 80

		AND HUMAN SERVICES			FORM	10/09/201 APPROVEI 0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245242	B. WING _		08/2	24/2017
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	BE	(X5) COMPLETION DATE
F 280 F 282 SS=D	plan goals. The pol provide written guid the resident to mee care and psychoso person-centered de plan of care. This p sheets and /or prof changes to ensure plan of care." 483.21 (b)(3)(ii) SEI PERSONS/PER C/ (b)(3) Comprehens The services provide as outlined by the of must- (ii) Be provided by the of must- (iii) Be provided by the of accordance with ea care. This REQUIREMEI by: Based on observar review, the facility f interventions for us of 2 residents (R12 mechanical equipm transfers. Findings include: R123's care plan da required extensive transfers, staff to out transfers, R123 ma resident reports fee	the development of the care icy further indicated care plans des for intervention, assisting et their needs for ADL's, health cial needs and to provide for evelopment of the resident's policy also indicated "NAR Care iles are updated per care plan the practice of following the RVICES BY QUALIFIED ARE PLAN	F 28		y the nsive ified I on rrect 23 I on	10/12/17

Facility ID: 00164

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						. 0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED		
		245242	B. WING _			/24/2017		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE			
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ST BE PRECEDED BY FULL PREFIX (EACH CORREC			(X5) COMPLETIO DATE		
F 282	Continued From pa	ige 23	F 28	32				
	for sling related to a EZ stand strap/sling	a fall, appropriate large fitting g obtained.		identified resident F 8-24-17 Identification of Oth	-			
	R123's undated care sheet, indicated R123 was a fall risk, required extensive assist of one staff for stand pivot transfer with four wheeled walker and protective boot, OR required EZ stand with large sling when resident report feeling weak. The			All residents were a transfer equipment weight, transfer abi care plans and care	audited for appropriate and sling size per lity and care plan. All e sheets were reviewed	1		
	following words were underlined and in r	re typed on the care sheet and ed ink wer " be sure to use all EZ stand transfers."		sling size and appr equipment for each 9-30-17 Measures Put in Pl	resident.			
	was observed lying (NA)-A present in the she was ready to get	on 8/23/17, at 7:29 a.m. R123 in bed, nursing assistant ne room. NA-A asked R123 if et up for the day, R123 stated ed to provide morning cares.		was conducted on	on for al nursing staff use of EZ stand, EZ lift nd safety protocols for	,		
	At 7:55 a.m. NA-A mechanical lift and lift had a sling with over the top of the l	retrieved an EZ stand brought into R123's room, the beige colored binding draped lift. NA-A brought the EZ stand		Monitoring Mechan Staff skill checks w residents requiring equipment to ensur	ill be conducted for all the use of transfer re proper equipment			
	her feet on the lift's lift into place. NA-A R123's back, attach the hooks of the EZ	f the bed, R123 placed both of foot platform and locked the A then placed the sling behind hed all loops of the sling on to Z stand lift, and attached the		for the next 30 days	checks will be lents on all units weekly s to ensure proper	/		
	R123's calves. NA and utilized the hyd while R123 wore bl held on to both han	R123's abdomen and behind -A used the remote control, Iraulic lift to stand R123 upright ack grippy type gloves and dles. NA-A proceeded to		equipment and slin 10-17-17 10-24-17 10-31-17 11-4-17	-			
	and transferred R12 she then locked the front of her wheelch	d lift brakes, widened the legs 23 in front of her wheelchair, a lift in place once R123 was in hair, and used the remote 23 into her wheelchair. Once		proper equipment a				
	R123 was seated ir NA-A was really go	23 into her wheelchair. Once In the wheelchair, she stated od about putting all the belts I the EZ stand lift, R123			l be reviewed at the eetings for compliance			

Facility ID: 00164

STATEMENT	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DAT	0938-039 E SURVEY
		245242	B. WING _			08/	24/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRES	S, CITY, STATE, ZIP CODE		, _ •
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH MINNEAPOLIS			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO EFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 282	removed her feet fr belts were released sling with beige colo NA-A confirmed the was a size medium tag attached to the During interview on reported she fell fro weeks ago. R123 member hooked he member did not hoo abdomen, and had the hooks of the lift from the lift all staff the belts, and she h R123 reported after her ribs all the way stated she still gets picture in her mind transferred. R123 g gloves to make sur the handles of the I reported prior to he not always attachin abdomen, then stati information to any r from the EZ stand I admission. During interview on confirmed R123 rec one staff member f of eating which she reported R122 she was aware of, s	ge 24 om the platform, both safety d, loops unhooked, and the ored binding was removed. e sling used to transfer R123 , as she visualized the white sling with a letter M on the tag. 8/23/17, at 8:07 a.m. R123 om the EZ stand lift a few reported when the staff ok the safety belt around her only attached the loops on to . R123 reported since she fell had been hooking up all of has not had any further falls. r she fell she had pain from down to her bottom. R123 scared, and repeats the of falling when she gets stated she now wears gripper e she has a secure hold on ift during transfers. R123 r fall from the lift, staff were g the safety belt around her red she had not reported that hurses. R123 stated the fall ift has been her only fall since 8/23/17, at 8:17 a.m. NA-A quired extensive assistance of or all ADL's, with the exception was independent. NA-A care guide sheets that resident needs for assistance. 3 did have one fall only that stated R123 fell from the lift s not working. NA-A verified	F 2	with standa on or befor 10-31-17 11-30-17 12-31-17 1-31-18 Responsibl Director of Clinical Ma Staff Devel	le Person/s Nursing	xt 90 days	

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED
		245242	B. WING		08	/24/2017
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	MINNEAPOLIS, MN 55404 PROVIDER'S PLAN OF CORREC <sup>®</sup> (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 282	staff decide and cha for each resident, a use it. NA-A confirm sling to transfer R11 marked with a M or color guide attache transfer which indic colored binding wer indicated the sling s During interview or stated sling size wa discretion and to th staff document the sheet. RN-C was r be transferred with stated R123's ident plan and care shee but reported the res sling felt comfortab R123. When interviewed of licensed practical n were measured arc sling sizes were de like a girdle. LPN-E used was documen and confirmed R12 sling with all transfe When interviewed of reported the staff h slings for the EZ sta not have the correct laundry to obtain th	oose which size sling to use and stated if the sling fits, we med she used a medium sized 23, and verified the tag in it. NA-A also indicated a d to the lift used for R123's stated slings with a beige re size medium. NA-A also size was on R123's care plan. In 8/24/17, at 9:44 a.m. RN-C as determined by staff e resident's comfort level, then size on the care plan and care notified R123 was observed to a medium sized sling, RN-C ified sling size on her care t indicated a large size sling, sident stated the medium sized le for her when she visited with on 8/23/17, at 11:50 a.m. urse (LPN)-B stated residents bund their abdomen, then the termined by the measurement, 3 stated the sling size to be ited in the resident's care plan, 3 should use a large sized ers. on 8/23/17, at 12:14 p.m. NA-B ad access to several sizes of and lift, and stated if they do it size, staff would notify				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY IPLETED	
		245242	B. WING	i		08/	24/2017	
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		-	STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETIC DATE	
F 282	When interviewed of verified R123 used transfers and extern NA-C stated R123 sized sling for all tra- information was als verified she was give the mechanical lifts When interviewed of indicated R123 req one staff and the E a large sized sling. When interviewed of LPN-C confirmed F for all transfers, and always transferred. completed the asset appropriate sling si correct size was do and care plan. When interviewed of director of nursing had the fall from the analysis was comp R123 let go of the F felt the harness wa investigated, the we incident report, due popped off. The Do involved was imme ensure the sling fit The DON stated af believed a different The DON confirme a medium sized sling	on 8/24/17, at 9:30 a.m. NA-C an EZ stand lift for all sive assistance of one staff. required the use of a large ansfers, and indicated this so on the care sheets. NA-C ven education on the use of	F2	282	2			

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	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · /	E SURVEY	
		245242	B. WING			04/0047	
	PROVIDER OR SUPPLIER	243242	D. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	08/	24/2017	
		CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 282	( (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 28	32			

Facility ID: 00164

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			F		APPROVED	
		& MEDICAID SERVICES					0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	· · ·	E SURVEY PLETED	
		245242	B. WING			08/:	24/2017	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
AUGUST	ANA HEALTH CARE (	CENTER OF MINNEAPOLIS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 282	Continued From pa	ge 28	F 2	:82				
	R228 required assis impaired mobility re R228 careplan direct of two via an EZ lift. The untitled, undate sheet updated 8/21. "Transfers: EZ-Lift."	ed nursing assistant care /17, indicated for R228 '						
	During an observation on 8/24/17, at 1:14 p.m. nurses aide (NA)-O and nurses aide (NA)-P rolled an EZ stand down the hallway and entered R228 room. NA-O verbally cued R228 she was going to use the EZ stand to transfer him from his wheel chair to his bed. NA-O and NA-P placed an EZ sling under R228 back and cued R228 "lean forward so can get sling behind you, your weaker arm is on right." NA-O cued R228 to hold onto EZ stand handles with his arms. NA-O placed his feet onto stand to transfer R228 from his wheelchair to his bed. NA-O and NA-P continued with transfer from wheelchair to the bed. As R228 was lowered to on edge of bed he said "wait a minute." R228 leaned to right side as legs removed from the EZ stand. NA-O and NA-P lifted R228 legs up onto the bed and positioned him in bed. During an interview on 8/24/17, at 1:30 p.m. with clinical manager (CM)-A stated R228 had a recent accident with the EZ stand. CM-A stated R228 legs and arms were not strong enough for him to safely be transferred with an EZ stand.							

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PRINTED: 10/09/2017

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED		
		245242	B. WING _		08/	24/2017		
NAME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE	00/	24/2011		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE		
F 282	transfer. CM-A stat care plan changes careplan review an the NA-O and NA-F EZ lift with R228. D , NA-O approached R228 was hollering strap between his le CM-A stated to NA- transferred with the During an interview director of nursing had been updated used as R228 had and was not safe to stated staff had bee and were provided The facility's Care F indicated care plan written guides for ir resident to meet the	se of a EZ lift to ensure a safe ed staff were made aware of through shift communication, d aid care sheets. CM-A stated P should have been using the puring the interview with CM-A d the desk area and stated and said he didn't want a egs so she used an EZ stand. -O, he was supposed to be e EZ lift. NA-O did not respond. on 8/24/17, at 3:59 p.m. with (DON) stated R228 care plan on 8/19/17 for an EZ lift to be weakness in arms and legs o use on a EZ stand. DON also en informed of the changes education. Plan policy dated 11/2016, s are developed to provide ntervention, assisting the eir needs for ADL's, health	F 28	32				
F 310 SS=G	person-centered de plan of care.	cial needs and to provide for evelopment of the resident's DO NOT DECLINE UNLESS	F 31	0		10/12/17		
	resident and consis and choices, the fa necessary care and resident's abilities i diminish unless circ clinical condition de	omprehensive assessment of a stent with the resident's needs cility must provide the d services to ensure that a n activities of daily living do not cumstances of the individual's emonstrate that such woidable. This includes the						

Facility ID: 00164

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	IMENT OF HEALTH						FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU IDENTIFICATIO	JPPLIER/CLIA		PLE CONSTRUCTION	N	(X3) DATE	E SURVEY PLETED
		245	242	B. WING _			08/2	24/2017
NAME OF F	PROVIDER OR SUPPLIER					CITY, STATE, ZIP CODE	-	
AUGUST	ANA HEALTH CARE	CENTER OF MIN	INEAPOLIS		1007 EAST 14TH S	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICI Y MUST BE PRECED SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	(EACH CC	DER'S PLAN OF CORRECTIO DRRECTIVE ACTION SHOULD FERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 310	<ul> <li>Continued From page 30 facility ensuring that:</li> <li>(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section,</li> <li>(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:</li> </ul>		F 31	0				
	(1) Hygiene -bathin oral care,	g, dressing, gro	oming, and					
	(2) Mobility-transfer walking,	r and ambulation	n, including					
	(3) Elimination-toile	ting,						
	(4) Dining-eating, ir	ncluding meals a	and snacks,					
	(5) Communication	, including						
	(i) Speech,							
	(ii) Language,							
	(iii) Other functiona This REQUIREMEI by:							
	Based on observa- review, the facility f communication ser living to ensure bas resident (R338) wit deficient practice re for R338, who expe	ailed to provide vices for activiti sic needs were r h a language ba esulted in psych	sufficient es of daily net for 1 of 1 arrier. This osocial harm		Care Center care and ser resident's ab living do not	y of the Augustana He to provide the necess vices to ensure that a ilities in activities of da diminish unless es of the individual's cl	ary aily	
FORM CMS-25	567(02-99) Previous Versions	Obsolete	Event ID:M4PX1	1	Facility ID: 00164	If continuat	ion sheet l	Page 31 of 80

PRINTED: 10/09/2017

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO. (X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
		245242	B. WING		08/2	24/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	=	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 310	Continued From pa	age 31	F 31	0		
		related to incontinence when		condition demonstrates that su	ich	
		ere unable to be met due to		diminution was unavoidable. corrective Action:		
	madequate commu	inication with facility staff.		Identified resident R338 was a	ssessed for	
	Findings include:			incontinence and communicati		
	D220'a admission	Minimum Data Sat (MDS)		areas and appropriate change	s were	
		Minimum Data Set (MDS) ified R338 had diagnoses		made to the care plan. Resident was supplied with wa	ll mounted	
		iritis, chronic pain syndrome,		communication cards that can		
		inary incontinence. The MDS		staff to speak her language an		
		both short and long term had moderately impaired		resident to point to when comr her needs.	nunicating	
		daily decision making, her		9-28-17		
	preferred language	was Somali and needed or		Identification of Other Residen		
		ter to communicate with doctor		Communication Section was a		
		. The MDS also indicated ensive assistance for bed		TCU Care Card to ensure com interventions will be identified to		
		toileting, personal hygiene and		admits with a language barrier		
	did not ambulate. F	urther, the MDS indicated		9-27-17		
		ly incontinent of urine and		Communication audits were co		
	bowel and was not	on a toileting program.		all residents with an identified communication barrier to ensu	0 0	
	R338's Care Area A	Assessment (CAA) dated		communication needs are add		
	2/9/17, indicated R	338's primary language was		Resident's electronic care plan		
		reported confusion and at		care sheets were updated as r individualized communication	needed with	
		t she was in Africa. The CAA		interventions.		
		ural/language barrier, not		10-6-17		
	recognizing caregiv	vers or medical equipment and		Measures Put in Place:		
		d social isolation, confusion, s and participation in rehab		Mandatory all staff education v completed to review communic		
		e CAA indicated R338 had		needs of residents, communic		
	bowel and bladder	incontinence with some		available to all residents, and t	he	
		tress incontinence and R338		importance of reporting any dif		
	was not consistent needs to be change	with letting staff know she		communicating with residents providing cares and services.	wnen	
		not trigger and was not		10-11-17		
	addressed on the C			Monitoring Mechanisms:		
				Staff communication skill chec	ks will be	

Facility ID: 00164

EFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION	(X3) DAT	E SURVEY	
RRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COM	PLETED	
	245242	B. WING _		08/2	24/2017	
IDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE	
38's quarterly M 38 had severely ferred language need an interpret nealth care staff uired extensive y living (ADL). T s occasionally in ontinent of bowe gram. 38's current care ed the problem of equate, and indi- lerstood through ected staff to rep nmunicate, under a and to refer for 38's care plan io guage was Som akness, dement istance with bee ist to lift legs in/ bed. R338's care ply and clearly a rironmental cues nmunicate at ey blain cares/treati eded and consis es. The care pla bortunity for patie ial services as r through anger edule an interpr	DS dated 8/5/17, indicated impaired cognition, her was Somali and needed or ter to communicate with doctor . The MDS indicated R338 assistance for all activities of The MDS also indicated R338 incontinent of urine, frequently and had no toileting e plan, revised on 8/22/17, of communication, hearing was icated R338 made herself in an interpreter. The care plan bort any changes in ability to erstand others, or in ability to or hearing exam as needed. Identified R338's primary rali, had frequent pain, ia, required extensive d mobility, boost up in bed, out of bed, and sitting position e plan directed staff to speak and repeat as needed, utilize is as calendars, clocks, notes, re level and establish calm, ments before beginning and as tent routine when providing an directed to provide ent to express feelings, involve needed, encourage resident to and frustration, and to reter for rehab therapies, nurse	F 31	0 done with all residents who language barrier. Skills ch include demonstrated staff with using communication and individualized interven each resident's compreher assessment. 10-10-17 Staff communication skill of done for all residents who language barrier weekly fo days and monthly for 6 mo 10-10-17 10-17-17 10-24-17 10-24-17 10-31-17 11-24-17 11-28-17 12-28-17 1-31-18 2-27-18 3-31-18 4-30-18 5-31-18 All communication skill che reviewed at the monthly Qu for compliance with staff co communication interventio 10-31-17 11-30-17 12-31-17 1-31-18	ecks will be proficiency devices/tools tions specific to nsive thecks will be have a r the next 60 nths.		
	IDER OR SUPPLIER HEALTH CARE SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L A HEALTH CARE A HEALTH CARE SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L A HEALTH CARE A HEALTH CARE SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L A HEALTH CARE SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L A HEALTH CARE A	IDENTIFICATION NUMBER: 245242 IDER OR SUPPLIER A HEALTH CARE CENTER OF MINNEAPOLIS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 32 38's quarterly MDS dated 8/5/17, indicated 38 had severely impaired cognition, her ferred language was Somali and needed or inted an interpreter to communicate with doctor health care staff. The MDS indicated R338 uired extensive assistance for all activities of ly living (ADL). The MDS also indicated R338 is occasionally incontinent of urine, frequently ontinent of bowel and had no toileting	DEFICIENCIES IRRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULT A. BUILDIN         245242       B. WING _         IDER OR SUPPLIER       245242         INTER OR SUPPLIER       IDENTIFICATION NUMBER:       IDENTIFICATION NUMBER:         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Intinued From page 32       S3's quarterly MDS dated 8/5/17, indicated 38 had severely impaired cognition, her ferred language was Somali and needed or neted an interpreter to communicate with doctor neealth care staff. The MDS indicated R338 s occasionally incontinent of urine, frequently ontinent of bowel and had no toileting gram.       F 31         38's current care plan, revised on 8/22/17, ed the problem of communication, hearing was equate, and indicated R338 made herself destood through an interpreter. The care plan ected staff to report any changes in ability to ar and to refer for hearing exam as needed. 38's care plan identified R338's primary guage was Somali, had frequent pain, akness, dementia, required extensive istance with bed mobility, boost up in bed, sist to lift legs in/out of bed, and stifting position ped. R338's care plan directed staff to speak uply and clearly and repeat as needed, utilize vironmental cues as calendars, clocks, notes, numicate at eye level and establish calm, plain cares/treatments before beginning and as eded and consistent routine when providing es. The care plan directed to provide portunity for patient to express feelings, involve isal services as needed, encourage resident to a through anger and frustration, and to redule an interpreter for rehab therapies, nurse cititoner/physician visits, car	IDEFICIENCIES       (X1) PROVIDERSUPPLIER       (X2) MULTIPLE CONSTRUCTION         IDER OR SUPPLIER       IDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP         IDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP         INNEAPOLISS       ID       PROVIDER'S PLAN OF CC         SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CC         INNEAPOLISS, MINSEAPOLISS       ID       PROVIDER'S PLAN OF CC         REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG       CROSS-REFERENCED OF Y FULL         REGULATORY OR LSC IDENTIFYING INFORMATION)       F 310       Cone with all residents who can interpreter to communicate with doctor readin care staff. The MDS indicated R338       F 310         as's quarterly MDS dated 8/5/17, indicated 38 had severely impaired cognition, her forred language was Somali and needed or niclade demonstrated staff to report any changes in ability to an to toileting gram.       F 310         38's current care plan, revised on 8/22/17, ad the problem of communication, hearing was aquate, and indicated R338 made herself learstod through an interpreter. The care plan identified R338's primary guage was Somali, and needed.       10-17-17         38's current care plan, revised on 8/22/17, adantor fer or hearing exam as needed.       10-17-17         38's care plan identified R338's primary guage was Somali, and needed.       11-24-17         39's care plan idertified R338's primary guage was Somali, and necold, and sitting position bead, and sitting	EFRCIENCIES       (X1) PROVIDERSUPPLIER/CLIA DENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION       (X3) DATA         A BUILDING       245242       B. WING       08/         IDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       1007 EAST 14TH STREET       08/         INMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRICEDED BY FULL REGULATORY OR LSC DEPTIFING INFORMATION)       ID       PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION INTERAPOLIS, MIN 55404       ID       PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION INTERAPOLIS, MIN 55404         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PROCEEDE BY FULL REGULATORY OR LSC DEPTIFIENTING INFORMATION)       ID       PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION INTERPLAN DESCORE BY FULL REGULATORY OR LSC DEPTIFIENTING INFORMATION       ID       PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVID	

Facility ID: 00164

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL1	TIPL	E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG _		COM	PLETED
		245242	B. WING _			08/;	24/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			007 EAST 14TH STREET IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 310	Continued From pa	ige 33	F 3	10			
	listed various interv assistance with ADI	Indated Transitional Care Card rentions which included Ls, however, the care card itions for R338's language					
	R338 wore a hospit of her bed with her (NA)-G entered R33 light and asked R33 proceeded to repeat repeatedly tapped h NA-G stated she wa R338 was trying to repeat the foreign w of her hands out in R338 extended her front of her groin wh sound repeatedly. F "sheeew" sounds a NA-G exited the root At 8:59 a.m. NA-G R338 wanted, but th She stated, "No one it's very hard, I don' indicated she was r	s on 8/23/17, at 8:56 a.m. tal gown, seated on the edge call light on. Nursing assistant 38's room, deactivated the call 38 what she needed. R338 at foreign words, and her thigh with her left hand. as unable to understand what tell her. R338 continued to words, proceeded to place both front her, and spread her legs. fingers open and arms out in hile making a "sheeeew" R338 continued make the and gestures for NA-G until om at 8:59 a.m. stated she did not know what hought she was having pain. e here speaks this language, 't understand her." NA-G not aware of anyone in the R338's language and felt it was					
	hard to communica gestures or movem gestures and move to communicate wit when working with At 9:02 a.m. R338 v bed, and R338's ca	te with R338 utilizing hand hents. NA-G indicated the hand ments staff utilized to attempt th R338 were not effective					

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PRINTED: 10/09/2017

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		DNSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED	
		245242	B. WING			08	/24/2017	
NAME OF	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		// <b>2 <del>4</del>/ 2011</b>	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			EAST 14TH STREET NEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	κ	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
F 310	fast to registered mentered her room a left hand on the left continued to repeat angry, frustrated vol- hands out in front h extended her finger of her groin while menter repeatedly. R338 of the "sheeew" sound repeatedly if she wa appeared to get menter in her foreign langu her uneaten food it waved her left arm her head. NA-G states she wants." R338 continued to rapid in a loud voice cry and stated, "hull indicated she was to need to go to the bo- bedpan to the bed. to place the bedpans her removed R338 repeatedly moaned rapid, frustrated vo place the bedpan b out of the way of th placed under her b void on the bedpan During interview on stated staff had a h wanted when she co	age 34 urse (RN)-D and NA-G as they at that time. R338 tapped her t side of her thigh area and t foreign words in a very fast, bice. She placed both of her her, spread her legs and rs open and arms out in front naking a "sheeeew" sound continued to gesture and make d while RN-D asked her as having pain. R338 ore frustrated, talking very fast uage. NA-G asked R338 about ems on her room tray, R338 towards the door and shook ated she was "not sure what appear upset, talking very e and proceeded to whimper, h, huh, huh" repeatedly. RN-D unsure, but felt R338 may athroom and brought a RN-D proceeded to attempt n under R338's buttocks, while t's disposable brief. R338 d, "uhhh, uhhh, uhhh" in a ice and frantically assisted to by moving her hospital gown e bedpan. With the bedpan uttocks, R338 proceeded to a large amount of urine.	F 3	10				

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	10/09/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION		(X3) DAT	E SURVEY IPLETED
		245242	B. WING	i			08/3	24/2017
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C	ODE	•	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD	BE	(X5) COMPLETION DATE
F 310	<ul> <li>8/21/17, revealed it</li> <li>-5/5/17, Somali interhad moderately improderate risk for moderately improderate risk for moderate risk for moderately improved translated social and assist as needer -5/7/17, alert and or interpreter, no Engli -6/6/17, care conferson will attend and interpreter service.</li> <li>-6/8/17, wound nurst translated for the visit questions.</li> <li>-7/14/17, social serring attent's family throod discuss room transpunderstand and agriculture.</li> </ul>	rogress notes from 5/1/17 to ne following: rpreter used for assessment, paired cognition and was at nood disturbance. R338 had ing asleep, feeling tired and ng because of pain and poor not have mental health eiving psychotropic ed psychiatric services referral. ial services would follow up ed. rientated to facility, needs ish. rence scheduled for that day, interpreter requested se visited with patient, her son sit and R338 had no vices met with patient and ugh phone interpreter to fer. Patient and family	F	310				
	-7/25/17, social ser indicated that he is requested that an ir assessments.	vice met with son and son present at most times but nterpreter be utilized for formal ssed concerns regarding						

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STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED	
		245242	B. WING _		08/	24/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE	
F 310	needs were not bei as she was not abl Facility staff sugger pictures as well as resident to use to o indicated he would implemented, and f flash cards and pro- -8/4/17, resident ur language barrier. F with communicating communication by cards. No further d implementation of f of the flash cards of communication aid -8/10/17, R338 hos service assessmen reported R338 had problems, had diffid daily decision maki symptoms of mood -8/20/17, on Hepar to language and ins On 8/21/17, at 7:53 stated in the past w facility to visit R338 stated he was awa void or have a bow left on the bedpan FM-A indicated he R338's elimination had been told the s	Son concerned resident's ing met when he was not there e to communicate to staff. sted making flash cards with English/Somali commands for communicate her needs. Son like the flash cards facility staff were to create the bound to the resident to use. The ble to communicate due to family and interpreter assist g with staff. Staff to assist with providing communication ocumentation of flash cards, the effectiveness or any alternative les were found in the chart. Spitalized at this time, social and done by staff interview. Staff no short or long term memory culty in new situations only with ing skills and minimal	F 31				

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		AND HUMAN SERVICES				FORM	10/09/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245242	B. WING			08/2	24/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			007 EAST 14TH STREET /INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 310	R338's wall for staff communicate with I On 8/23/17, at 9:21 difficult to communi language barrier an few words such as primary language. If contacted R338's s what R338 needed On 8/23/17, at 9:41 interview with NA-G gestures to attempt and stated she was interventions to utili R338. NA-G indicat the family member R338 needed assis had not utilized an in not aware how to re- interpreter services On 8/23/17, at 9:50 communication was she pointed at obje- when he was availar routine was to stand- point until she figure wanted. NA-H indic interpreter services On 8/23/17, at 12:1 present in the build services were utilized	f to utilize to call him to help R338. a.m. RN-D indicated it was icate with R338 due to the nd indicated she only knew a medication, pain in R338's RN-D indicated she had on when she was not sure or wanted. a.m. during a follow up G, she stated she used hand to communicate with R338 s not aware of any other ze while communicating with ted in the past she had called to attempt to figure out what tance with. NA-G stated she interpreter in the past and was equest for or use needed a.m. NA-H indicated s difficult with R338 and stated cts or had her son translate able. NA-H indicated her usual d in her room, have R338 ed out what R338 needed or tated she had not utilized	F3	310	DEFICIENCY)		
	in the facility. The ir	terpreter services were utilized nterpreter indicated that day first time he had met R338 for					

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED		
		245242	B. WING		08	8/24/2017		
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COL		<i>"</i>		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
F 310	today. On 8/23/17, at 12:2 the interpreter and not communicate w with that sometime had been left on the the past, she had th so she could avoid R338 indicated she incontinent product bedpan and stated sometimes made h if she was able to o care would be bette welcome staff help then they just leave and indicated she f education when she blamed herself and learning the langua isolated, could not because staff could they were unable to the interpreter, R33	age 38 I appointment with the doctor 20 p.m. during interview with R338, R338 stated she could <i>v</i> ith staff and her son helps s. R338 indicated because she e bedpan without assistance in ried not to go to the bathroom that from happening again. e had bowel movements in her due to avoiding use of the it made her feel bad, er cry. R338 indicated she felt communicate with staff, her er. R338 indicated she would , but staff comes in her room, e without providing assistance elt regret not getting the e was younger and stated she I people before her for not ge. R338 indicated she felt get up on her own, and stated a not communicate with her, o help her. Through the use of 88 stated when she did not at times she felt like exploding	F 3	310				
	her room in the pas communication, ho longer in her room pictures were.	indicated she had pictures in st for assistance with wever, the pictures were no and was not aware where the						
	interview, FM-A ind telephone numbers help with R338's la staff did not use the	5 p.m. during second icated he posted a note with s to the wall in R338's room to nguage barrier, but the facility e telephone numbers. FM-A e facility staff R338 refused						

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA	TE SURVEY MPLETED		
	245242	B. WING			8/24/2017		
	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	ODE	E		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	X (EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE		
cares and did not u R338 would call hin facility to get R338 stated he felt if R33 were offering, she v indicated he felt the care had been com language barrier. FM-A indicated he y assist R338 with to everything she nee ago, he had come to been incontinent of had reported that s longer. FM-A indica concerns with the la facility staff many ti he had suggested u utilize pictures of va the Internet to use f R338. FM-A stated "maybe once" and R338's room since. not utilized an inter communication for On 8/24/17, at 8:37 edge of her bed, wi left, and was obser telephone. Above th to R338's bed, a wf approximately 8 ind the wall. On the paj instructions for con service. On 8/24/17 at 8:56	se her call light. FM-A stated n on telephone, he called the assistance with toileting. FM-A 8 understood what the staff would not refuse. FM-A e number one issue with her imunication with R338's visited everyday and would ileting, dressing and ded. FM-A stated a few days to the facility and R338 had urine all over the bed and she he could not hold her urine any ated he had discussed his anguage barrier for R338 with mes in the past. He indicated use of an interpreter or staff to arious items or objects from to assist communication with he had seen pictures used had not seen the pictures in . FM-A stated the facility had rpreter to assist in cares for R338. Y a.m. R338 was seated on the th a cellular telephone in her ved to dial the cellular he night stand, which was next nite piece of paper, ches (in) by 11 in. was taped to per, typed in black ink, were tacting an online interpreter						
	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER TANA HEALTH CARE SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From patcares and did not u R338 would call hir facility to get R338 stated he felt if R33 were offering, she v indicated he felt the care had been com language barrier. FM-A indicated he fact assist R338 with to everything she nee ago, he had come f been incontinent of had reported that s longer. FM-A indic concerns with the la facility staff many ti he had suggested u utilize pictures of va the Internet to use R338. FM-A stated "maybe once" and R338's room since. not utilized an inter communication for On 8/24/17, at 8:37 edge of her bed, wi left, and was obser telephone. Above ti to R338's bed, a wi approximately 8 inc the wall. On the pat instructions for con service. On 8/24/17 at 8:56	DF CORRECTION       IDENTIFICATION NUMBER:         245242         PROVIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 39 cares and did not use her call light. FM-A stated R338 would call him on telephone, he called the facility to get R338 assistance with toileting. FM-A stated he felt if R338 understood what the staff were offering, she would not refuse. FM-A indicated he felt the number one issue with her care had been communication with R338's language barrier.         FM-A indicated he visited everyday and would assist R338 with toileting, dressing and everything she needed. FM-A stated a few days ago, he had come to the facility and R338 had been incontinent of urine all over the bed and she had reported that she could not hold her urine any longer. FM-A indicated he had discussed his concerns with the language barrier for R338 with facility staff many times in the past. He indicated he had suggested use of an interpreter or staff to utilize pictures of various items or objects from the Internet to use to assist communication with R338. FM-A stated he had seen pictures used "maybe once" and had not seen the pictures in R338's room since. FM-A stated the facility had not utilized an interpreter to assist in communication for cares for R338.         On 8/24/17, at 8:37 a.m. R338 was seated on the edge of her bed, with a cellular telephone in her left, and was observed to dial the cellular telephone. Above the night stand, which was next to R338's bed, a white piece of paper, approximately 8 inches (in) by 11 in. was taped to the wall. On the paper, typed in black ink, were instructions for contacting an online interpreter </td <td>RS FOR MEDICARE &amp; MEDICAID SERVICES         TOF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         245242         B. WING         245242         PROVIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 39 cares and did not use her call light. FM-A stated R338 would call him on telephone, he called the facility to get R338 assistance with toileting. FM-A stated he felt if R338 understood what the staff were offering, she would not refuse. FM-A indicated he felt the number one issue with her care had been communication with R338's language barrier.         FM-A indicated he visited everyday and would assist R338 with toileting, dressing and everything she needed. 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Above the night stand, which was next to R338's bed, a white piece of paper, approximately 8 inch</td> <td>RS FOR MEDICARE &amp; MEDICAID SERVICES         COP DEFICIENCIES         COP DEFICIENCIES         PCORRECTION         (X1) PROVIDERSUPPLIERCLA         DENTIFICATION NUMBER:         245242         B. WING    STREET ADDRESS, CITY, STATE, ZIP C          1007 EAST 14TH STREET         MAN HEALTH CARE CENTER OF MINNEAPOLIS    SIMMERY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST EF PRECEDED BY FULL REQUILATORY ON LSC IDENTIFYING INFORMATION)          Continued From page 39         cares and did not use her call light. FM-A stated         R338 would call him on telephone, he called the facility to get R338 asistance with toleting. FM-A stated he felt the number one issue with her care had been communication with R338's language barrier.         FM-A indicated he visited everyday and would assist R338 with toileting, dressing and everything she needed. FM-A stated a few days ago, he had come to the facility and R38 had been incontinent of urine all over the bed and she had reported that she could not hold her urine any longer. FM-A indicated he had discussed his concerns with the language barrier for R338 with facility staff many times in the past. He indicated he had suggested use of an interpreter or staff to utilize pictures of various items or objects from the Internet to use to assist communication with R338's room since. FM-A stated the facility and not utilized an interpreter to assist in communication for cares for R338.         On 8/24/17, at 8:37 a.m. R338 was seated on the edge of her bed, with a cellular telephone in her left, and was observed to d</td> <td>RS FOR MEDICARE &amp; MEDICAID SERVICES     OMB NC       COP DEFICIENCIES     (x1) PROVIDERSUPPLIENCUL IDENTIFICATION NUMBER: 245242     (x2) MULTIPLE CONSTRUCTION A BULDING     (x3) DA       PROVIDER OR SUPPLIER     245242     B. WING     (g3) DA       ANA HEALTH CARE CENTER OF MINNEAPOLIS     STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET     (g4) DA       SUMMARY STATEMENT OF DEFICIENCIES     DOP EAST 14TH STREET     (g5) DA       SUMMARY STATEMENT OF DEFICIENCIES     DOP EAST 14TH STREET     (g6) PROVIDERS NAME OF DATE DATE ON SHOULD BE (recht OPRECISC) MIST DE PRECEDENCIES       Continued From page 39 cares and did not use her call light. FM-A stated R388 would call him on telephone, he called the facility to get R328 assistance with holieting. FM-A stated he felt If R388 understood what the staff were offering, she would not refuse. FM-A indicated he felt the number one issue with her care had been communication with R338's language barrier.     F 310       FM-A indicated he wisited everyday and would assist R338 with toileting, dressing and everything she needed. FM-A stated the facility and R338 had been incontinent of urine all over the bed and she had reported that she could not hold her urine any longer. FM-A indicated he had discussed his concerns with the language barrier or R338 with facility staff many times in the past. He indicated he had suggested use of an interpreter or staff to utilize pictures of various items or objects from the Internet to use to assist communication with R338's room since. FM-A stated the facility had not utilize pictures of various items or objects from the Internet to use to assist communication with R338's room since. FM-A stated the facility had not utilize pictures</td>	RS FOR MEDICARE & MEDICAID SERVICES         TOF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         245242         B. WING         245242         PROVIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 39 cares and did not use her call light. FM-A stated R338 would call him on telephone, he called the facility to get R338 assistance with toileting. FM-A stated he felt if R338 understood what the staff were offering, she would not refuse. FM-A indicated he felt the number one issue with her care had been communication with R338's language barrier.         FM-A indicated he visited everyday and would assist R338 with toileting, dressing and everything she needed. FM-A stated a few days ago, he had come to the facility and R338 had been incontinent of urine all over the bed and she had reported that she could not hold her urine any longer. FM-A indicated he had discussed his concerns with the language barrier for R338 with facility staff many times in the past. He indicated he had suggested use of an interpreter or staff to utilize pictures of various items or objects from the Internet to use to assist communication with R338. FM-A stated he had seen pictures used "maybe once" and had not seen the pictures in R338's room since. FM-A stated the facility had not utilized an interpreter to assist in communication for cares for R338.         On 8/24/17, at 8:37 a.m. R338 was seated on the edge of her bed, with a cellular telephone in her left, and was observed to dial the cellular telephone. Above the night stand, which was next to R338's bed, a white piece of paper, approximately 8 inch	RS FOR MEDICARE & MEDICAID SERVICES         COP DEFICIENCIES         COP DEFICIENCIES         PCORRECTION         (X1) PROVIDERSUPPLIERCLA         DENTIFICATION NUMBER:         245242         B. WING    STREET ADDRESS, CITY, STATE, ZIP C          1007 EAST 14TH STREET         MAN HEALTH CARE CENTER OF MINNEAPOLIS    SIMMERY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST EF PRECEDED BY FULL REQUILATORY ON LSC IDENTIFYING INFORMATION)          Continued From page 39         cares and did not use her call light. FM-A stated         R338 would call him on telephone, he called the facility to get R338 asistance with toleting. FM-A stated he felt the number one issue with her care had been communication with R338's language barrier.         FM-A indicated he visited everyday and would assist R338 with toileting, dressing and everything she needed. FM-A stated a few days ago, he had come to the facility and R38 had been incontinent of urine all over the bed and she had reported that she could not hold her urine any longer. FM-A indicated he had discussed his concerns with the language barrier for R338 with facility staff many times in the past. 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WING     (g3) DA       ANA HEALTH CARE CENTER OF MINNEAPOLIS     STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET     (g4) DA       SUMMARY STATEMENT OF DEFICIENCIES     DOP EAST 14TH STREET     (g5) DA       SUMMARY STATEMENT OF DEFICIENCIES     DOP EAST 14TH STREET     (g6) PROVIDERS NAME OF DATE DATE ON SHOULD BE (recht OPRECISC) MIST DE PRECEDENCIES       Continued From page 39 cares and did not use her call light. FM-A stated R388 would call him on telephone, he called the facility to get R328 assistance with holieting. FM-A stated he felt If R388 understood what the staff were offering, she would not refuse. FM-A indicated he felt the number one issue with her care had been communication with R338's language barrier.     F 310       FM-A indicated he wisited everyday and would assist R338 with toileting, dressing and everything she needed. 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Facility ID: 00164

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		AND HUMAN SERVICES				FORM	10/09/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY IPLETED
		245242	B. WING	i		08/:	24/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 310	communication car R338 was not able "so did not really we was easier to have communication and indicated the usual something, she wou son would call the of R338 wanted or ne confirmed the interp posted in R338's ro now. RN-G indicate assistance in time of incontinent of urine always continent of not aware of any co R338 and stated, "I communication." On 8/24/17 at 9:43 interview, FM-A ind respond to her, she bed and stated "haj and holds it." He ind assistance she wou FM-A stated the inter incom was not there last night. On 8/24/17, at 9:00 able to speak the si R338. She indicate her hip when she h stated other staff th but R338 used thesit to go to the bathroo assistance with toile utilized the call light	ds with words on them, but to read the cards and stated, ork that well." RN-G stated it	F	310			

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	<mark>). 0938-039</mark> TE SURVEY MPLETED	
		045040	B. WING				
	PROVIDER OR SUPPLIER	245242	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CO		8/24/2017	
		CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 310	incontinence with b staff who do not un cared for her. NA- R338, she was com but when staff who communicate with I R338 wore a brief. reported she was a incontinence episod aware the interpret when R338 had scl appointments. NA- staff many times of language barrier, a hotline posted in R3 until recently. She s paper in her room b On 8/24/17, at 9:07 able to speak the s R338. NA-K verified with toileting, used use the call light. N continent of bowel R338 will have inco assisting her with to what R338 needed of the staff did not I verified R338 has h not understanding and stated "she has NA-K indicated R33 her needs, was pre cares and did not room On 8/24/17, at 12:00 confirmed R338 priot	owel and bladder when other derstand what she wants J indicated when she cared for the provided cares for R338, She indicated R338 had fraid she would have des. NA-J indicated she was er only came to the facility heduled medical J stated she had told nursing ther concerns with R338's nd confirmed the interpreter 338's room was not present stated, "She did not have that before." Y a.m. NA-K stated she was ame language (Somali) as d R338 needed assistance the bedpan and was able to A-K confirmed R338 was and bladder. NA-K indicated ontinence if staff were late bileting and not understanding . NA-K indicated she felt a lot know what R338 wanted and had incontinence due to staff what she is trying to tell them s not had accidents for me." 38 was able to communicate bity pleasant, cooperative with	F 31				

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STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY IPLETED	
		245242	B. WING		08	/24/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/	24/2017	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 310	had medical appoir his portion of the M facility practice was son to translate, oth be patient and expl indicated staff were plan and to utilize th having trouble com indicated he was no communicating with other interventions R338 to effectively On 8/24/17, at 12:3 (DON) confirmed F stated she expected plan, staff to assist needs consistently. expect staff to assist needs consistently. expect staff to assist continent, help the call lights. DON ind barrier due to not s expect staff to call a available, or use pin She stated all staff interpreter services utilize the resource with R338. The DO aware of any conce barrier. The DON in admitted who have facility practice was to all staff to notify the resident's primary fa available to assist. we have family to a The DON indicated	attments or when he completed IDS. SW-A indicated the usual is to encourage R338 to use the her staff members, and staff to ain cares to her. The SW-A expected to follow the care he online interpreter services if municating with R338. He of aware of any problems in R338. SW-A confirmed no had been put in place to assist communicate with staff. B p.m. director of nursing R338's current care plan and ed staff to follow R338's care as needed, and meet her DON indicated she would st the resident to stay resident with cares, answer licated R338 had a language peaking English and would an interpreter, family if cture cards or online service. had access to the online and she would expect staff to s available to communicate DN indicated she was not erns with R338's language indicated when residents were language barriers, the usual at o send an email notification them of the individual anguage and if the family was She stated "90%" of the time accommodate for their needs. I the facility routinely scheduled arrapy appointments and	F 31	0			

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		AND HUMAN SERVICES				FORM	: 10/09/2017 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION		E SURVEY IPLETED
		245242	B. WING			08/24/2017	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 310 F 312 SS=D	not schedule any fu the communication indicated 338's son and stated she had with communication On 8/24/17, at 4:18 medical director (M if the facility had ac hours a day. The M all residents would care to meet their m felt it was difficult fo because families do concerns. Review of facility po Interpreter/Translat English Proficiency the interdisciplinary communication nee pre-admission, adm residents stay at the worker will arrange needs for resident. Center will be respon worker will write a p communication nee policy listed various used such as: unive communication boa need they will be or 483.24(a)(2) ADL C DEPENDENT RES (a)(2) A resident wh activities of daily live	The services unless they felt was unclear. The DON came to the facility quite a lot not heard of any concerns in that impacted 338's care. p.m. during a phone interview D) indicated he was not aware ccess to an interpreter 24 D indicated he would expect have ongoing assessment and needs and also indicated he or foreign speaking resident o not always tell staff the Dicy titled, Communication: ion Services for limited revised on 1/2016, indicated team will assess residents eds/deficits upon hission and throughout the e care center. the social for any on-going interpreter Augustana Health Care onsible for the charges. Social progress note describing eds and arrangements. The auxiliary aids to be available ersal communication cards, ards and if additions aids are dered in a prompt manner. CARE PROVIDED FOR		310			10/12/17

Facility ID: 00164

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		AND HUMAN SERVICES				RINTED: 10/09/2017 FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED
		245242	B. WING			08/24/2017
NAME OF I	PROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			007 EAST 14TH STREET IINNEAPOLIS, MN 55404	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 312	Continued From pa personal and oral h	•	FЗ	312		
	This REQUIREMEN by: Based on observat review the facility fa shaving for 1 of 3 re required staff assis daily living. Findings include: R162's quarterly Mi 7/14/17, indicated F included Alzheimer and chronic pain. T severely impaired of extensive assistand indicated R162 required hands on a Alzheimer disease to encourage and a Review of R162's n undated, identified her shower on Mon On 8/22/17, at 8:37 wheelchair at dining independently eatin several other reside room. R162 was no coarse, white hairs On 8/23/17, at 7:14	NT is not met as evidenced tion, interview, and document tield to provide assistance with esidents (R162) reviewed who tance to complete activities of nimum Data Set (MDS) dated R162 had diagnoses which 's disease, psychotic disorder he MDS indicated R162 had cognition and required ce for dressing. The MDS uired set up help for al hygiene including shaving h bathing. ated 7/23/17, indicated R162 assistance at times due to for grooming and directed staff issist as needed for grooming. ursing assistance care sheet, R162 received assistance with day mornings. 'a.m. R162 was seated in her g room table. She was ig the breakfast meal, with ents present in the dining oted to have many long,			F312: It is the policy of the Augustana Hea Care Center to provide the necessa services to maintain good nutrition, grooming, personal, and oral hygier Corrective Action: Identified resident R162 received th immediate services required for fac removal. The staff person responsi- the grooming of identified resident received a written work performance education 8-24-17 Identification of Other Residents: A facility wide shaving audit was conducted to ensure appropriate sh services were completed and/or offer all residents. 9-29-17 Measures Put in Place: Mandatory education for all nursing was conducted to ensure appropria shaving services are completed and offered to all residents. Noting reside will continue to have the right to refu- shaving. 10-11-17 Monitoring Mechanism: Random shaving audits will be done units weekly for the next 30 days. 10-10-17 10-17-17 10-24-17 10-31-17 Random shaving audits will be done units monthly for the next 60 days.	e e e e e e e e e e e e e e e e e e e

Facility ID: 00164

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## PRINTED: 10/09/2017

TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED		
		245242	B. WING			04/0017		
	PROVIDER OR SUPPLIER	243242	D: WING _	STREET ADDRESS, CITY, STATE, ZI		/24/2017		
		CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE		
F 312	room. R162 was ob white coarse hairs	uge 45 oserved to have the same long, under her chin. At 8:58 a.m., he dining room with the same	F 31	2 11-30-17 12-31-17 Audits will be reviewed b	v the Quality			
long, coarse, white chin During an interview on nursing assistant (NA)- many coarse, white chi stated the usual facility facial hair as part of ba R162's chin hair should Monday with her bath. hair was noticed on a r to be taken care of righ			Improvement committee with providing and/or offe services for residents on 10-19-17 11-30-17 12-31-17 1-31-18 Responsible Person's Director of Nursing or de Clinical Managers Quality Improvement Dire	for compliance ering shaving or before.				
	licensed practical n always liked to look in the past. LPN-A	on 8/23/17, at 11:49 a.m. with Jurse (LPN)-A stated R162 had a nice. but had resisted cares stated R162 typically allowed approached her later.						
	indicated a body au R162. The form inc were completed su bruises, rashes and	Skin-Body Visual ation form, dated 8/21/17, udit had been completed for licated various inspections ch as visualizing for new d indicated "resident emoved-No, not needed."						
	clinical manager (C was for all resident shower/bath, and e facial hair is remov	on 8/24/17, at 8:24 a.m. with M)-A stated the expectation s to be checked with veryday with cares to ensure ed. CM-A also stated she t the nurse know if a resident						

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		AND HUMAN SERVICES				FORM	10/09/2017 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245242	B. WING _			08/	24/2017
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	•	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			07 EAST 14TH STREET INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From pa	ge 46	F 3 <sup>.</sup>	12			
	Facility policy on gr was not provided.	ooming was requested but					
F 315 SS=G	•	D CATHETER, PREVENT UTI, ER	F 3 <sup>-</sup>	15			10/12/17
	continent of bladde receives services a continence unless h	t ensure that resident who is r and bowel on admission nd assistance to maintain his or her clinical condition is nat continence is not possible					
		ith urinary incontinence, based omprehensive assessment, the that-					
	indwelling catheter	enters the facility without an is not catheterized unless the ondition demonstrates that necessary;					
	indwelling catheter is assessed for rem as possible unless	enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary					
	receives appropriat	is incontinent of bladder te treatment and services to t infections and to restore xtent possible.					
	on the resident's co facility must ensure	with fecal incontinence, based comprehensive assessment, the e that a resident who is el receives appropriate					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · /	E SURVEY PLETED	
	CONTRECTION	DENTIFICATION NOMBER.	A. BUILDIN	IG	CON		
		245242	B. WING _			24/2017	
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE	
F 315	Continued From pa	age 47	F 31	5			
	•	ices to restore as much normal					
		NT is not met as evidenced					
	by: Based on observer	tion, interview, and document		F315:			
		ailed to accurately assess		It is the policy of the Augus	tana Health		
	bowel and bladder	patterns and implement a		Care Center to accurately	assess bowel		
		restore continence of bowel		and bladder patterns and i			
		extent possible for 1 of 1 ho was not being provided		toileting schedule/plan to re continence of bowel and b			
		eting routinely due to a		extent possible.			
	language barrier. R	338 sustained harm due to		Corrective Action:			
		ase in bowel and bladder		Upon review of resident's of			
	function.			patterns related to eliminat interventions including the			
	Findings include:			for bathroom and gestures			
	-			identified and care planned	to indicate		
		Minimum Data Set (MDS)		need for toileting. Upon re			
		fied R338 had diagnoses ritis, chronic pain syndrome,		60 days of bowel and blade care documentation improv			
		inary incontinence. The MDS		was demonstrated for iden			
	indicated R338 had	both short and long term		R338. R338 Bowel and Bl			
		had moderately impaired		assessment has been revi	ewed and		
		daily decision making, her was Somali and needed or		remains current. 9-28-17			
	1 0 0	ter to communicate with doctor		Identification of Other Resi	dents:		
	or health care staff.	. The MDS also indicated		Communication section wa			
		nsive assistance for bed		TCU Care Cards to ensure			
		toileting, personal hygiene and Further, the MDS indicated		communication interventio identified for all new admits			
		ly incontinent of urine and		language barrier.	, with a		
		on a toileting program.		9-27-17			
	Raadie Care Aree /	Accoccmont (CAA) datad		Communication audits wer			
		Assessment (CAA) dated 338 had bowel and bladder		all residents with an identif			
		ome control and history of		communication needs are			
	stress incontinence	e. Contributing factors included		Residents electronic care			
	mornings with conf	usion, obesity, impaired		care sheets were updated	as needed with		

Facility ID: 00164

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPL		(X3) DATE	0938-039
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _		COMF	PLETED
		245242	B. WING _			08/2	24/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			007 EAST 14TH STREET IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 315	use of narcotics, ar barrier. Staff were t rising, before and a rounds and as need was not consistent needed to be chang with peri care with i R338's quarterly MI R338 was moderat extensive assistant transfers and exten dressing, toileting a MDS also indicated incontinent of urine and had no toileting R338's quarterly MI R338 had severely extensive assistant activities of daily liv R338 was occasion frequently incontine toileting program. Review of R338's c 8/22/17, indicated F bowel and bladder of stress incontiner included: dementia related to weaknes	vith wound vac, pain, anemia, ntidepressants, and language to check and change upon after meals, bedtime, night ded related to confusion. R338 with letting staff know she ged and staff were to assist ncontinence. DS dated 5/8/17, indicated ely impaired, needed ce of two staff for bed mobility, isive assistance of one staff for and personal hygiene. The d R338 was frequently and always continent of bowel g program. DS dated 8/5/17, indicated impaired cognition, needed ce of one staff for all of her ing. The MDS also indicated hally incontinent of urine and ent of bowel and had no surrent care plan revised on R338 had incontinence of with some control and history nce. Contributing factors , obesity, impaired mobility s, right lower extremity	F 31	15	interventions. 10-6-17 All bowel and bladder assessments residents with a language barrier we reviewed for decline. 10-9-17 Measures Put in Place: Mandatory all staff education was completed on the importance of identifying communication needs of residents and use of communication interventions to ensure standard of maintained. 10-11-17 Monitoring Mechanisms: Clinical Managers are notified by R/ of any decline in bowel and bladder time of their quarterly assessment, we triggers a review of the current assessments, and any additional assessments for residents with lang barriers will be done for the next 6 m to ensure all bowel and bladder care needs of residents with language ba are being met. 10-31-17 11-30-17 12-31-17 1-31-18 2-27-18	ere Al staff at the which eted. er guage nonths e	
	anti-depressants ar confusion she is no know she needs to the bedpan. The ca interventions such	nia, use of narcotics, nd language barrier. Related to ot consistent with letting staff be changed or when to use are plan listed various as: check and change upon after meals, before bed, night			3-31-18 Staff communication skill checks wi done with all residents who have a language barrier. Skill checks will ir demonstrated staff proficiency with communication devices/tools and	nclude	

Facility ID: 00164

If continuation sheet Page 49 of 80

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION		0938-039 E SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:	( )	G		IPLETED	
		245242	B. WING		08/	24/2017	
NAME OF F	PROVIDER OR SUPPLIER	1	1	STREET ADDRESS, CITY, STATE,		• · · ·	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLETIC DATE	
F 315	Continued From pa	age 49	F 31	5			
	rounds and as nee confused, peri care and needed extens depending on cogn listed on how to co- regarding the langu incontinence or toil Review of R338's T NA (nursing assista- was max for toiletin calls for assistance was continent of bo- occasional incontin- incontinent brief. N how to communica- language barrier an needs. During observation R338 wore a hospi of her bed with her (NA)-G entered R3 light and asked R3 proceeded to repea- repeatedly tapped NA-G stated she w R338 was trying to repeat the foreign v of her hands out in R338 extended her front of her groin w sound repeatedly.	ded, offer bed pan when not es with incontinence episodes, sive assist of one or two staff ition. No interventions were mmunicate with R338 uage barrier and her eting needs. Transitional Care Plan for the ant) undated, indicated R338 big assistance and resident as The sheet indicated R338 owel and bladder with ence of bladder and wore a o interventions were listed on te with R338 regarding the nd her incontinence or toileting s on 8/23/17, at 8:56 a.m. tal gown, seated on the edge call light on. Nursing assistant 38's room, deactivated the call 38 what she needed. R338 at foreign words, and her thigh with her left hand. as unable to understand what tell her. R338 continued to words, proceeded to place both front her, and spread her legs. r fingers open and arms out in hile making a "sheeeew" R338 continued make the and gestures for NA-G until		individualized interventi each resident's compre- assessment 10-10-17 Staff communication sk done for all residents w language barrier weekly days and monthly for the 10-10-17 10-17-17 10-24-17 10-24-17 10-31-17 11-24-17 11-24-17 11-24-17 11-28-17 12-28-17 1-31-18 2-27-18 3-31-18 4-30-18 5-31-18 All communication skill reviewed at the monthly for compliance with stat communication interver 10-31-17 12-31-17 12-31-17 12-31-17 12-31-18 2-27-18 3-31-18 2-27-18 3-31-18 4-30-18 5-31-18	hensive ill checks will be ho have a y for the next 60 he next 6 months. checks will be y QI/QAA meetings ff competency in		
	R338 wanted, but t	om at 8:59 a.m stated she did not know what hought she was having pain. e here speaks this language,		Responsible Person/s Director of Nursing Clinical Managers Quality Improvement D	irector		

Facility ID: 00164

STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY
		IDENTIFICATION NUMBER.	A. BUILDIN	IG	COM	
		245242	B. WING		08/	24/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETIC DATE
F 315	it's very hard, I don indicated she was facility who spoke I hard to communica gestures or mover gestures and move to communicate wi when working with At 9:02 a.m. R338 bed, and R338's ca began to speak for fast to registered n entered her room a left hand on the left continued to repea angry, frustrated vo hands out in front h extended her finge of her groin while n repeatedly. R338 of the "sheeeew" sou repeatedly if she w appeared to get m in her foreign langu her uneaten food it waved her left arm her head. NA-G sta she wants." R338 continued to rapid in a loud voic cry and stated, "hu indicated she was need to go to the b bedpan to the bed, to place the bedpa she removed R338	't understand her." NA-G not aware of anyone in the R338's language and felt it was ate with R338 utilizing hand nents. NA-G indicated the hand ements staff utilized to attempt th R338 were not effective	F 31	5		

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED		
		245242	B. WING		08	8/24/2017		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI				
AUGUSI	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE		
F 315	rapid, frustrated vo place the bedpan b out of the way of th the bedpan placed proceeded to void o of urine. R338's dis Review of R338's a Assessment, dated short term memory need or urge to voie was able to use the toilet sometimes, a incontinence. The a had incontinence o episodes with posit indicated R338 had recent surgery, obe assistance to trans incontinent of bowe irregularity, loose s constipation and wa had urgency. The a had stress and fund documentation was voiding pattern and The analysis of the had confusion, was staff know she nee be on a check and before and after me rounds and as need Review of R338's in Assessment dated short term memory to urge to void/defe	ice and frantically assisted to y moving her hospital gown e bedpan. At 9:05 a.m., with under her buttocks, R338 on the bedpan a large amount posable brief was dry. dmission Bowel and Bladder 2/9/17, indicated R338 had loss, was able to identify the d/defecate some of the time, e call light, ask to go to the nd had been admitted with assessment indicated R338 f bladder, had incontinence ion changes. The assessment I diagnoses which included esity, edema and required fer. Further, R338 was el, had no problem with pattern	F 3	15				

Facility ID: 00164

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OTATE:			()(0)			0.0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · /	TE SURVEY MPLETED	
		245242	B. WING		08	/24/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 315		-	F3	15			
	Continued From page 52 bladder, unknown how long resident has been incontinent of bladder, no problem with leaking urine, had no incontinent episodes with laughing, coughing, changing positions, sneezing or exercise. The assessment indicated R338 was continent of bowel, utilized a bedside commode, constipation problems sometimes, and no symptoms affecting eliminations patterns. Further, the assessment indicated R338 required assistance with ambulation, transfers and used adaptive equipment. R338 has pain that effected elimination patterns, required weight bearing assistance, resident somewhat involved, showed patterns of urinary continence greater than 2 hours,was able to use toilet majority of time on all shifts and had problems with constipation. R338's assessment indicated R338 had functional incontinence (decreased mental awareness/decreased or loss mobility or personal unwillingness). R338's elimination plan was scheduled toileting due to being cognitively impaired, functional disabilities and care giver dependent. The elimination plan included: Check and change due to cognitive impairment, retraining to return to previous pattern due to able to feel sensation, able to understand and learn to inhibit urge, toilets independently or with minimal assist and prompt voiding due to able to request						
	continence was new included for R338 t commode for voidir for bowel movemen Review of R338's E Assessment, review bladder and bowel	etraining program to improve ver implemented). The plan o utilize the bedpan or ng and to use the commode nts and wore a brief. Bowel and Bladder Quarterly wed on 5/4/17, indicated the management programs were anges were needed to the					

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		AND HUMAN SERVICES				FORM	10/09/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245242	B. WING	i		08/2	24/2017
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 315	Continued From pa	ige 53	F:	315			
	Assessment, review R338 was incontine current bowel and b	Bowel and Bladder Quarterly wed on 7/13/17, indicated ent of bladder and bowel, the bladder plan was effective and changes to the current plan of					
	Center physician pr dated 4/18/17, from indicated "nursing a continent of bowel a	tennepin County Medical rogress notes revealed a note in the nurse practitioner which assistants report the patient is and bladder and is utilizing a onally utilizing commode."					
	stated in the past w facility to visit R338 stated he was awar void or have a bowe left on the bedpan f FM-A indicated he h R338's elimination had been told the s R338. FM-A indicat	p.m. family member (FM)-A when family have come to a, she had been crying. FM-A re R338 had attempted to not el movement, to avoid being for extended periods of time. had reported the concerns with needs, to nursing staff and taff do not have time to assist red he had posted a note on f to utilize to call him to help 338.					
	difficult to communi language barrier an few words such as primary language. F	a.m. RN-D indicated it was icate with R338 due to the ind indicated she only knew a medication, pain in R338's RN-D indicated she had on when she was not sure or wanted.					
	the interpreter and	20 p.m. during interview with R338, R338 stated she could <i>v</i> ith staff and her son helps					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
	O CONTECTION	IDENTIFICATION NUMBER.	A. BUILDIN	IG		
		245242	B. WING _		08/	24/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETIC DATE
F 315	with that sometime had been left on the the past, she had tr so she could avoid R338 indicated she incontinent product bedpan and stated sometimes made h if she was able to o care would be bette welcome staff help, then they just leave and indicated she f education when she blamed herself and learning the langua isolated, could not because staff could they were unable to the interpreter, R33 receive assistance and bursting. R338 her room in the pas communication, ho	age 54 s. R338 indicated because she e bedpan without assistance in ried not to go to the bathroom that from happening again. had bowel movements in her due to avoiding use of the it made her feel bad, her cry. R338 indicated she felt communicate with staff, her er. R338 indicated she would but staff comes in her room, without providing assistance elt regret not getting the e was younger and stated she people before her for not ge. R338 indicated she felt get up on her own, and stated a not communicate with her, belp her. Through the use of as tated when she did not at times she felt like exploding indicated she had pictures in st for assistance with wever, the pictures were no and was not aware where the	F 31	5		
	used communication but R338 was not a stated, "So did not stated it was easer communication and indicated the usual something, she wo son would call the o R338 wanted or ne confirmed the inter	a.m. RN-G indicated staff had on cards with words on them, able to read the cards and really work that well." RN-G to have staff to assist with d to translate for her. RN-G practice if R338 needed uld call her son and then her desk to let staff know what eded assistance with. She preter hot line information bom had not in her room until				

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STATEMENT	OF DEFICIENCIES	KEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
				NG		
		245242	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	08/	24/2017
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	MINNEAPOLIS, MN 55404 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 315	now. RN-G indicate assistance in time of incontinent of urine always continent of not aware of any co R338 and stated, "I communication." On 8/24/17, at 9:43 interview, FM-A ind continent of bowel sick and was only i when she was sick not respond to R33 the bed and stated holds it, and holds called for assistance incontinence issues On 8/24/17, at 9:00 able to speak the s R338. She indicate her hip when she h stated other staff th but R338 used thes to go to the bathroo assistance with toil utilized the call ligh indicated she was a incontinence with b staff who do not un cared for her. NA- R338, she was con but when staff who communicate with R338 wore a brief. reported she was a incontinence episo	a of R338 did not receive or had urgency she would be and stated she felt R338 was bowel. RN-G denied she was ommunication concerns with I don't think the problem is a.m. during a follow up licated R338 had been and bladder before she got ncontinent and wore a brief . FM-A indicated when staff did 88, she would be incontinent on ," happens quite a bit, she it." He indicated when she se she would have s. 0 a.m. NA-J stated she was ame language (Somali) as ed R338 would point or slap ad to go to the bathroom. She nink this gesture was for pain se gestures to indicate she has om. NA-J verified R338 needed eting, used the bedpan and t for assistance. NA-J aware R338 has had owel and bladder when other derstand what she wants J indicated when she cared for tinent and did not wear a brief,	F 31			

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		AND HUMAN SERVICES			FORM	10/09/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245242	B. WING		08/:	24/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 315	when R338 had sch appointments. NA-, staff many times of language barrier. On 8/24/17, at 9:07 able to speak the si R338. NA-K verified with toileting, used use the call light. N continent of bowel a R338 will have inco assisting her with to what R338 needed of the staff did not k verified R338 has h not understanding v and stated, "she ha NA-K indicated R33 her needs, was pre cares and did not re On 8/24/17, at 12:3 (DON) confirmed R stated she expected plan, staff to assist needs consistently. expect staff to call a available, or use pio She stated all staff interpreter services utilize the resources with R338. The DC	heduled medical J stated she had told nursing her concerns with R338's Y a.m. NA-K stated she was ame language (Somali) as d R338 needed assistance the bedpan and was able to A-K confirmed R338 was and bladder. NA-K indicated ontinence if staff were late bileting and not understanding . NA-K indicated she felt a lot know what R338 wanted and had incontinence due to staff what she is trying to tell them as not had accidents for me." 38 was able to communicate tty pleasant, cooperative with	F 315			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/09/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245242	B. WING _			08/	24/2017
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			07 EAST 14TH STREET INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	Continued From pa	ge 57	F 3 <sup>-</sup>	15			
F 323 SS=D	indicated the facility admission, and at c (EX: removal of cat retraining/toileting p	ting revised on 1/2016, would assess residents upon other appropriate clinical times heter) for bladder programs. 1)-(3) FREE OF ACCIDENT	F 32	23			10/12/17
	(d) Accidents. The facility must en	sure that -					
		vironment remains as free rds as is possible; and					
		eceives adequate supervision ices to prevent accidents.					
	appropriate alternat bed rail. If a bed or must ensure correc	e facility must attempt to use tives prior to installing a side or side rail is used, the facility it installation, use, and rails, including but not limited ments.					
	(1) Assess the resid from bed rails prior	dent for risk of entrapment to installation.					
		s and benefits of bed rails with dent representative and obtain rior to installation.					
	appropriate for the This REQUIREMEN by:	bed's dimensions are resident's size and weight. NT is not met as evidenced					
		ion, interview and document			F323		

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	0938-039	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COM	PLETED	
		245242	B. WING			08/2	24/2017	
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 323	Continued From pa	ae 58	E 2	323				
	review, the facility f individualized equip the appropriate tran during transfers for who had a history of a mechanical lift. In follow manufacture use of a wheeled w hazards for 1 of 1 r walker for ambulati Findings include: R123's face sheet of current diagnoses of bilateral leg weakned disorder with seizur depression, pain in and repeated falls p R123's admission N dated 1/5/17, identi assistance for trans prior to admission a R123's Care Area A 1/9/17, indicated R required extensive was at risk for falls deconditioning, pse obesity, impaired b assistance with act pain, and use of me R123's care plan da	ailed to implement oment requirements to ensure asfer equipment was utilized 2 of 2 residents (R123, R228) of fall during a transfer utilizing addition, the facility failed to r's guidelines for the proper talker to prevent accident esident (R224) who utilized a on.		323	It is the policy of Augustana Health Center that the environment remain free from accident hazards as poss and that each resident receives ad supervision and assistance devices prevent accidents. Corrective Action: Staff were immediately re-educated proper use of the EZ stand, with co sling size for identified resident R12 8-23-17 Staff were immediately re-educated necessity to use the proper transfe equipment per resident's plan of ca identified resident R228 8-24-17 Staff were immediately re-educated proper method of transporting resid and care sheet was updated with th proper method of transporting resid identified resident R224 8-21-17 EZ stand policy was updated to inc information regarding appropriate size use. 9-29-17 Identification of Other Residents: All residents were audited for appro- transfer equipment and sling size p weight, transfer ability and care plans and care sheets were re and revised if needed stating the co sling size and appropriate transfer equipment for each resident. 9-29-17	ns as sible equate s to d on prrect 23 d on r r for d on dent, ne dent for lude sling opriate per n. all eviewed prrect		
	required extensive transfers, staff to cu transfers, R123 ma	assistance of one staff with ue resident before and during y use the EZ stand when ling weak. R123's fall care			All care sheets of residents with se walkers were updated to state, "Do transport residents at any time in s walker."	not		

Facility ID: 00164

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL		X3) DATE	0938-039 SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .		COMF	LETED
		245242	B. WING			08/2	4/2017
NAME OF I	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 323	Continued From pa	ge 59	F 3	23			
		indicated R123 was resized			9-29-17		
		a fall, appropriate large fitting			Measures Put in Place:		
	EZ stand strap/sling				Mandatory all staff education was		
					conducted on prevention of accidents	s and	
		re sheet, indicated R123 was a			resident safety. Mandatory education for all nursing s	stoff	
		tensive assist of one staff for with four wheeled walker and			was conducted on use of EZ stand, E		
		required EZ stand with large			Lift, proper sling size and safety prote		
		reports feeling weak. The			for resident transfers		
	following words wer	re typed on the care sheet and			10-11-17		
		k "be sure to use LG [large]			Monitoring Mechanisms:		
	sling with all EZ sta	nd transfers."			Safety rounds specific to transporting	g of	
	During observation	on 8/23/17, at 7:29 a.m. R123			residents with seated walker will be conducted for al residents by 10-10-1	17	
		in bed, nursing assistant			and monthly for the next 90 days.	17	
		ne room. NA-A asked R123 if			11-10-17		
		et up for the day, R123 stated			12-10-17		
		ed to provide morning cares.			1-10-18		
		retrieved an EZ stand			Staff skill checks will be conducted for		
		brought into R123's room, the			residents requiring the use of transfe		
		beige colored binding draped ift. NA-A brought the EZ stand			equipment to ensure proper equipme and sling size is used.	ent	
		f the bed, R123 placed both of			10-10-17		
		foot platform and locked the			Random staff skill checks will be		
		A then placed the sling behind			conducted for residents on all units w	veekly	
		ned all loops of the sling on to			for the next 30 days to ensure proper	r	
		stand lift, and attached the			equipment and sling size is used.		
		R123's abdomen and behind -A used the remote control,			10-17-17 10-24-17		
		raulic lift to stand R123 upright			10-24-17		
		ack, grippy type gloves and			11-4-17		
	held on to both han	dles of the lift. NA-A			Random skill checks will be conducted		
		ck the EZ stand lift brakes,			residents on all units monthly for the		
		the lift and transferred R123			60 days to ensure proper equipment	and	
		Ichair, she then locked the lift			sling size is used. 12-4-17		
	in place once R123	ed the remote control to lower			12-4-17		
		chair. Once R123 was			Responsible Person/s		
		chair, she stated NA-A was			Director of Nursing Clinical Managers	-	

Facility ID: 00164

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE	0938-039 E SURVEY PLETED
		245242	B. WING		08/2	24/2017
NAME OF	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIC DATE
F 323	unlocked the EZ sta from the platform, b released, loops unl beige colored bindi confirmed the sling size medium, as sh attached to the slin Review of Event Re p.m. indicated R12 during an EZ stand report, the EZ stand R123 or nursing as remember what ha the sling was out of land on her buttock straight out. R123 v of the fall. At the tip pain, hitting her hea extremities without were no signs of in indicated R123 was three, communicate time, but was unab Interventions identi educated resident a checking on function using it, staff re-edu stand and to ensurn Evaluation note of the transferring R123 function EZ(stand) stanc [si causing resident to injuries observed, re-	age 60 putting all the belts on. NA-A and lift, R123 removed her feet both safety belts were hooked, and the sling with ng was removed. NA-A used to transfer R123 was a he visualized the white tag g with a letter M on the tag. eport dated 8/5/17, at 5:45 3 suffered a witnessed fall transfer. According to the d suddenly stopped moving, sistant was unable to ppened next, then one side of f place which caused R123 to is, on the floor, with legs was wearing shoes at the time me of the fall R123 denied ad, range of motion in all pain or limitations, and there jury. The Event Report is alert and oriented times ed the situation well at the le to describe what happened. fied on the Event Report, and staff the importance of on of the equipment before ucated on proper use of EZ e correct size sling is used. the event, indicated while rom her chair to bed, the c] sling popped out of place land on her buttocks. No resident remains alert and educated on proper use of EZ e correct size sling was being	F 32	3 Staff Development Staff Quality Improvement Director		

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			(X3) DAT	0938-039 E SURVEY PLETED
		245242	B. WING			08/	24/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIC DATE
F 323	<ul> <li>8/7/17, indicated R no injury. The inter and documented th -no medication con concerns or change Care Changes/New re-educated on pro ensure the proper s sling.</li> <li>Review of the printe 8/7/17, indicated st related to the incorr causing resident to procedures and star reviewed with NA-L -All assigned tasks meticulous attentio our resident depend -Correct use of EZ residents and staff -Correct size of slin providing safe trans the appropriate size will involve the judg -Nursing assistants both machine, battle ensure safety.</li> <li>The sling must be both sides; the foot latched prior to eve -A copy of the EZ V to resident and place</li> <li>Review of nursing p 8/22/17, revealed th -On 8/7/17, at 1:45</li> </ul>	ncident Review Form dated 123 had a fall on 8/5/17, with rdisciplinary team reviewed be following: cerns, Environmental e of condition noted. Plan of v Interventions: staff per use of EZ stand and to sling used, obtained large ed education for NA-L dated aff had performance issues rect use of EZ stand sling fall on 8/5/17. Policy, undards of practice were ., which included the following: should be performed with n to detail, the quality of life of d on it. stand is vital to safety of members. Ig is extremely pertinent for sfers; all slings used should be e at all times. The proper fit ment of the caregiver. a has the task of inspecting ery and sling before every lift to secured to the machine on a and waist buckle must be rry lift. VAY harness sizing chart given ced on machine.	F 3	323			

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			()(0) 1 11			. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · /	E SURVEY IPLETED	
		245242	B. WING		08/	/24/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET			
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
F 323	R123's nurse pract rule out fracture. -8/7/17, at 4:02 p.m with negative result R123 continued to side, medication ar relief noted, also no 2 cm bruise to R12 -On 8/8/17, at 2:46 of left side and rib of Results of x-ray we nurse practitioner, n -On 8/13/17, at 6:5 indicated while tran to bed, the EZ(stan of place causing re No injuries observe oriented. Staff re-e stand and to ensure used. -No further complai documented after 8 Review of X-ray rep R123 had mild biba however, no acute Review of R123's fa 6/21/17, indicated F within the past six r for falls. During interview on reported she fell fro weeks ago. R123 n member hooked her member did not hom	itioner to request an x-ray to h., R123 returned to the facility, from x-ray. At 11:32 p.m. complain of pain to the left ad a cold pack given with some ote was a 2 centimeter (cm) x 3's inner right arm. p.m. R123 complained of pain cage area, and rated 8/10. re sent to R123's primary no new orders received. 1 a.m. resolution of fall noted, isferring R123 from her chair (d) stanc [sic] sling popped out sident to land on her buttocks. ed, resident remains alert and educated on proper use of EZ e correct size sling was being ints of pain or injuries 8/8/17. port dated 8/7/17, indicated asilar infiltrates or atelectasis,	F 32:	3			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	KANDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED	
		245242	B. WING		08/	24/2017	
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	D BE	(X5) COMPLETIO DATE	
F 323	the belts, and she I R123 reported afte her ribs all the way stated she still gets picture in her mind transferred. R123 gloves to make sur the handles of the I reported prior to he not always attachin abdomen, then stat information to any f from the EZ stand I admission. When R123 reported afte her ribs all the way verified she did rec no fractures, she st in that location of h still continues to ha back and hip area. During interview or confirmed R123 ref one staff member f of eating which she reported staff carry indicate what each NA-A reported R12 she was aware of, because the lift was staff decide and ch for each resident, a use it." NA-A confii sized sling to transf marked with a M of color guide attache	age 63 had been hooking up all of has not had any further falls. r she fell she had pain from down to her bottom. R123 s scared, and repeats the of falling when she gets stated she now wears gripper e she has a secure hold on lift during transfers. R123 er fall from the lift, staff were ing the safety belt around her ted she had not reported that nurses. R123 stated the fall lift has been her only fall since interviewed at 12:49 a.m., r she fell she had pain from down to her bottom. R123 eive an x-ray and there were tated she did not have the pain er body prior to the fall, and we discomfort in her lower a 8/23/17, at 8:17 a.m. NA-A quired extensive assistance of or all ADL's, with the exception was independent. NA-A care guide sheets that resident needs for assistance. 3 did have one fall only that stated R123 fell from the lift s not working. NA-A verified oose which size sling to use and stated if the sling fits, "we rmed she used a medium fer R123, and verified the tag n it. NA-A also indicated a ad to the lift used for R123's cated slings with a beige	F3				

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		AND HUMAN SERVICES			FORM	10/09/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245242	B. WING		08/;	24/2017
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	;	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	indicated the sling s NA-A reported when safety belts were to and behind legs. N education regarding lifts when she started During interview on confirmed R123 fell transfer. RN-C sta she believed the star thought the size of f RN-C stated re-edu member involved re- sizes. RN-C verifie specific assessmen correct sling size to the color coded slim lifts, and when aske the size of sling to u size, she did not an During follow up int a.m. RN-C stated s staff discretion and then staff documen care sheet. RN-C v observed to be trans sling, RN-C stated l her care plan and c sling size, but repor medium sized sling she visited with R12 not injured from the complain of pain, an out fractures, and w atelactisis. RN-C v	re size medium. NA-A also size was on R123's care plan. In staff use the EZ stand lift, all be attached, on the abdomen IA-A verified she had received g the safe use of the EZ stand ed working at the facility. If working at the facility. 8/23/17, at 11:43 a.m. RN-C I from the EZ stand lift during a tated after talking with staff rap snapped off or open, and the sling was maybe incorrect. Ucation was given to the staff egarding the lift use and sling ed the staff did not complete a nt when determining the o use. RN-C was not aware of ng size sticker attached to the ed how the staff determines use, if they go by weight or	F 323	3		

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	1				. 0938-0391
	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245242	B. WING		·····	08/	/24/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			007 EAST 14TH STREET //INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 323	<ul><li>23 Continued From page 65 fall on 8/5/17.</li><li>When interviewed on 8/23/17, at 11:50 a.m.</li></ul>		F3	323			
	licensed practical n were measured aro sling sizes were det like a girdle. LPN-E used was documen	urse (LPN)-B stated residents bund their abdomen, then the termined by the measurement, 3 stated the sling size to be the in the resident's care plan, 3 should use a large sized					
	reported the staff has slings for the EZ stanot have the correc laundry to obtain the	on 8/23/17, at 12:14 p.m. NA-B ad access to several sizes of and lift, and stated if they do et size, staff would notify e correct size. 3 required an extra large sized					
	verified R123 used transfers and exten NA-C stated R123 r sized sling for all tra information was als	on 8/24/17, at 9:30 a.m. NA-C an EZ stand lift for all sive assistance of one staff. required the use of a large ansfers, and indicated this so on the care sheets. NA-C ven education on the use of upon hire.					
	indicated R123 requ	on 8/24/17, at 9:20 a.m. NA-D uired extensive assistance of Z stand lift for all transfers with					
	LPN-C confirmed R for all transfers, and always transferred. completed the asse	on 8/24/17, at 9:36 a.m. R123 required the EZ stand lift d indicated that is how she had LPN-C confirmed RN-C essments to determine the zes for each resident, an the					

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED
		245242	B. WING			
	PROVIDER OR SUPPLIER	243242	D. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	08	/24/2017
		CENTER OF MINNEAPOLIS				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 323	and care plan. When interviewed of director of nursing ( had the fall from the analysis was comple R123 let go of the h felt the harness was investigated, the wo incident report, due "popped off." The I involved was imme ensure the sling fit The DON stated affi believed a different The DON confirmer a medium sized slin determining the pro- weight, but weights according the manu She stated we take resident's comfort le width, and what loo sling size assessme was more of a judg factors, then the siz care sheet and care should use a large transfers with R123 reason there neede would be reviewed DON stated staff do sling size changes, indicated on the car size. The DON sta	age 66 acumented on the care sheet on 8/24/17, at 11:30 a.m. the (DON) reported after R123 a EZ stand lift, a root cause leted. The DON reported handles on the lift because she is a little tight, as staff further ording "popped off" was in the to being too tight or the loop DON stated the staff member diately given education to properly and was comfortable. ter the investigation, staff size sling should be used. d prior to the fall R123 utilized ng. The DON stated when oper size sling, staff look at were pretty fluid and variable ufacture's chart and guidelines. in to consideration the evel of sling, generalized ks safe. The DON verified the ent was not documented, as it ement based on clinical ze was documented on the e plan. The DON verified staff sized sling for all EZ stand lift s, unless there was some ed to be a change, the change by the clinical manager. The o not routinely document if the then stated it would be re sheet as being a different ted she had the clinical a R123 on 8/23/17 for proper ed on the assessment that she d be a large size, and verified	F 3	23		

Facility ID: 00164

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						) <u>. 0938-039</u>
	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	` '	TE SURVEY MPLETED
		245242	B. WING		08	/24/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 323	all staff should be p the care sheets and indicates a large siz confirmed there we assessments regar stand lift, other than stated the interdisc of a discussion, talk picture of what hap new interventions s all done "off the red DON reported the r expected to visualiz of sling and lift prior maintenance routin slings. When interviewed of director of maintenance completed monthly mechanical lifts use stated he looked fo and replaced them ensure the lifts wer DOM stated he was ever falling from a r then stated if staff v of event, he would s standing lift to inspe functioning. Review of the undar manufacturer's sizio included a color coo different sizes by di harnesses. Beige of medium for use of of circumference of	age 67 providing care as directed by d care plan which also ze sling to be used. The DON ere no other documents or rding R123's fall from the EZ in the event report. The DON iplinary team (IDT) had more ks with people to get more of a pened, so we know what the should be, and verified this is cord" as the IDT talked. The nursing assistants were ze the lifts for obvious damage r to each use, and stated hely inspects the lifts and on 8/24/17, at 3:52 p.m. the ance (DOM) indicated he audits and inspections on all ed in the facility. The DOM ir broken, loose or worn parts, as needed, and looked to e functioning safely. The s not aware of any residents mechanical lift or EZ stand lift, would update him in that type want to go look at the lift or ect the lift for safety and proper atted, EZ way, Inc. smart stand ng guidelines document ding system, separating ifferent colored binding on the colored represent a size 90-220 pounds, 34-46 inches f patient's torso where harness art indicates the size/weight of	F3	23		

Facility ID: 00164

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES		TIDI			0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245242	B. WING	i		08/	24/2017
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			007 EAST 14TH STREET /INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	guidelines. A proper judgement of the ca R228 quarterly Min 7/28/17, indicated F impairment and req transferring.	himum Data Set(MDS) dated R228 had severe cognitive quired assist of two for	F	323			
	7/28/17, indicated F impairment and req transferring. R228 face sheet ind dementia with Lewy	R228 had severe cognitive					

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PRINTED: 10/09/2017

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	. 0938-039 TE SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	CON	<b>MPLETED</b>
		245242	B. WING		08	/24/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 323	Continued From pa major depressive c	-	F 323			
	R228 required ass impaired mobility re	vision dated 8/19/17, indicated ist with transfers due to elated to Parkinson disease. ected staff "transfers with assist t."				
		ed nursing assistant care //17, indicated for R228 "				
	6:44 p.m. indicated EZ stand lift, R228 hold on to the bar of lowered R228 to the staff assisted R228 mechanical lift. The	brogress note dated 8/19/17, at d while transferring R228 with became weak and unable to of the lift and nursing staff re ground by his arms. Three 8 to bed utilizing a (EZ lift) full e note indicated the EZ lift or R228 and an order obtained e lift for R228.				
	nurses aide (NA)-C an EZ stand down room. NA-O verbal use the EZ stand to chair to his bed. NA sling under R228 b forward so can get arm is on right." NA EZ stand handles of feet onto stand to t wheelchair to his b with transfer from of	tion on 8/24/17, at 1:14 p.m. D and nurses aide (NA)-P rolled the hallway and entered R228 lly cued R228 she was going to o transfer him from his wheel A-O and NA-P placed an EZ back and cued R228 "lean sling behind you, your weaker A-O cued R228 to hold onto with his arms. NA-O placed his ransfer R228 from his ed. NA-O and NA-P continued wheelchair to the bed. As R228 edge of bed he said "wait a				

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		AND HUMAN SERVICES				FORM	: 10/09/2017 APPROVED
		& MEDICAID SERVICES					. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245242	B. WING			08/	24/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
AUGUST	ANA HEALTH CARE (	CENTER OF MINNEAPOLIS			007 EAST 14TH STREET /INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323		ge 70 on 8/24/17, at 1:30 p.m. with M)-A stated R228 had a	F3	323			
	recent accident with R228 legs and arms him to safely be trai CM-A stated R228 been changed to us	n the EZ stand. CM-A stated s were not strong enough for nsferred with an EZ stand. careplan interventions had se of a EZ lift to ensure a safe					
	care plan changes careplan review and the NA-O and NA-F EZ lift with R228. D , NA-O approached R228 was hollering strap between his le CM-A stated to NA- transferred with the	ed staff were made aware of through shift communication, d aid care sheets. CM-A stated P should have been using the uring the interview with CM-A I the desk area and stated and said he didn't want a egs so she used an EZ stand. O, he was supposed to be EZ lift. NA-O did not respond.					
	director of nursing ( had been updated of used as R228 had and was not safe to	on 8/24/17, at 3:59 p.m. with (DON) stated R228 care plan on 8/19/17 for an EZ lift to be weakness in arms and legs o use on a EZ stand. DON also en informed of the changes education.					
	7/15/17, identified F and had diagnoses disease, schizophre MDS identified R22 activities of daily live	nimum Data Set (MDS) dated R224 was cognitively intact which included: Parkinson's enia and hypertension. The 44 was independent with all ing (ADL's.) except required h dressing, toilet use and					

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		AND HUMAN SERVICES			FORM	10/09/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245242	B. WING		08/:	24/2017
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		007 EAST 14TH STREET /INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	personal hygiene. T ambulated indepen for mobility. R224's care plan re- identified R224 aml of a walker. The ca- fatigue with distance staff and visitors to walker and was not plan directed staff t self performance w indicated R224 was and did not use a w plan further instruct total assist to proper depending on weak R224 was at risk for disease effects, use use of a devise and behavior related to directed staff to end ambulate with his 4 The untitled, undate sheet indicated R22 4 wheeled walker a The sheet further ir independent with tr instructed staff to o mobility if R224 bed unsteady gait. On 8/21/17, at 6:39 seated on the benc the hallway near the assistant (NA)-F put	The MDS identified R70 idently and required a walker evised 8/21/17, at 8:03 p.m. bulated independently with use are plan indicated R224 had the at times, would often ask push him on the seat of the t easily re-directed. The care to assist R224 if a decline in vas noted. The care plan is independent with transfers wheelchair regularly. The care ted staff to use extensive to al R224's wheelchair transs. The care plan identified or falls related to Parkinson's e of antihypertensive meds, d the potential for unsafe schizophrenia. The care plan courage and remind R224 to wheeled walker. ed nursing assistant care 24 was ambulatory and used a and wheelchair as needed. indicated R224 was ansfers. The care sheet ffer use of wheelchair for came weak or had an op.m. R224 was observed th of his 4 wheeled walker in e nurses station, while nursing ushed R224's walker down the R224, seated on the bench of	F 323			

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DAT	<u>0938-039</u> E SURVEY	
ND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		CON	IPLETED	
		245242	B. WING			08/	24/2017	
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		-	07 EAST 14TH STREET INNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 323	Continued From pa	age 72	F3	323				
		eet from the nursing station		20				
	desk to the table in	the dining room located past						
		area. R224 stood up and chair at the dining room table.						
	sealed miniseli in a	t chair at the dining room table.						
		p.m. NA-F confirmed she had						
		utilizing the bench of his IA-F indicated R224 had						
		ush him to the dining room						
	because he felt we	ak. NA-F indicated she						
		Itilizing the bench of his						
		ery 2-3 weeks. NA-F visualized rsing assistant care sheet that						
		ized a 4 wheeled walker and						
	had a wheel chair t	to be used as needed.						
		p.m., clinical manager (CM)-A						
		esent at the nursing station						
		d NA-F transport R224 from to the dining room. CM-A						
		ed R224 while he sat on the						
		eled walker. CM-A indicated						
		o transport R224 while he sat did not intervene. CM-A						
		nstructed staff not to transport						
	residents while the	y sat on the bench of their						
		licated R224 at times the staff						
	would use a wheel	chair to transport R224.						
		a.m. R224 indicated he was						
		dependently with his 4						
		224 confirmed in the past staff tor walker to transport him						
		bench of the walker.						
		0 a.m. director of rehab (DR)-A						
		d not recommend a 4 wheeled for transportation while a						
		bench. DR-A indicated that if						

Facility ID: 00164

If continuation sheet Page 73 of 80

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/09/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245242	B. WING	à		08/2	24/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	she witnessed a sta while they sat on th she would intervene indicated she would would be educated as a wheelchair for On 8/23/17, at 9:10 (DON) confirmed sh had utilized R224's facility. DON indica would not push resi bench of their 4 who Review of undated attached to R224's Medical Rollator rev be used as a wheel to tip-over, resulting The facility's EZ-st directed staff to che damaged parts and was not ripped or fr address sling sizes. The facility's Accide policy, dated 4/2017 committed to provid residents, and woul to assist in the iden analysis of risk fact need for supervisio or individual resider resident's environm and hazards as pos	aff member pushing a resident e bench of a 4 wheeled walker e and stop them. DR-A d expect staff and residents to not use 4 wheeled walkers transportation. a.m. director of nursing he had been made aware staff walker to transport him in the ted she would expect staff dents while they sat on the eeled walkers. manufacturer's guidelines, Rollator walker titled Roscoe vealed Rollators are NOT to chair. Doing so may cause it g in injury. tand policy dated 04/08, eck for loose nuts and bolts, to check the sling to ensure it ayed. The policy did not the policy did not to check the sling to ensure it ayed. The policy did not to check the facility was ling a safe environment for d use a systematic approach tification, evaluation and ors in the environment and n for either groups of resident ths with the goal that: each ent remain as free of accident supervision and assistive	F	323	3		

If continuation sheet Page 74 of 80

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	· · /	TE SURVEY	
	or connection	IDENTIFICATION NOMBER.	A. BUILDING _		CON	NFLETED	
		245242	B. WING		08	/24/2017	
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS	10	REET ADDRESS, CITY, STATE, ZIP CODE 07 EAST 14TH STREET NNEAPOLIS, MN 55404	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 431	Continued From pa	age 74	F 431				
F 431 SS=D		h) DRUG RECORDS, UGS & BIOLOGICALS	F 431			10/12/17	
(   	drugs and biologica them under an agre §483.70(g) of this p unlicensed person	ovide routine and emergency als to its residents, or obtain eement described in part. The facility may permit nel to administer drugs if State ly under the general ensed nurse.					
	pharmaceutical ser that assure the acc dispensing, and ad	facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and t the needs of each resident.					
		ation. The facility must e services of a licensed					
	disposition of all co	ystem of records of receipt and ntrolled drugs in sufficient accurate reconciliation; and					
	that an account of	t drug records are in order and all controlled drugs is riodically reconciled.					
	labeled in accordar professional princip appropriate access	als used in the facility must be nee with currently accepted bles, and include the					

	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION		
IND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COM	PLETED
		245242	B. WING _			24/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	Ε	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
F 431	the facility must sto locked compartment controls, and permine have access to the (2) The facility must permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distrift quantity stored is must be readily detected. This REQUIREMENT by: Based on observat review, the facility fat was labeled with act of 1 resident (R323 to be mislabeled dut administration. Findings include: R323's Physician O 2/23/18, identified F included diabetes must and kidney failure. for Humalog (insulin (milliliter) 12 units (I before breakfast, 14 units before dinner. Humalog to be give	with State and Federal laws, re all drugs and biologicals in its under proper temperature tonly authorized personnel to keys. It provide separately locked, I compartments for storage of ed in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can NT is not met as evidenced ion, interview, and document ailed to ensure medication curate directions for use for 1 ) whose insulin was observed	F 43	F431: It is the policy of the Augustan Care Center that drugs and bi used in the facility must be lat accordance with currently acc professional principles, and in appropriate accessory and ca instructions, and the expiration applicable. Corrective Action: Clinical Manager immediately medication change labels from pharmacy and placed on the i upon identification by the surv 8-22-17 Identification of Other Resider All med carts were audited to proper labeling of medications residents . 9-29-17	ologicals beled in epted clude the utionary n date when obtained n the nsulin bottle eyor. hts: ensure	
	and kidney failure. for Humalog (insulir (milliliter) 12 units (I before breakfast, 14 units before dinner. Humalog to be give included to give 12 400.	The report included an order a) solution 100 unit/ml J) injected subcutaneously 4 units before lunch, and 10 R323 had an order for n with a sliding scale that		<ul> <li>pharmacy and placed on the i upon identification by the surv 8-22-17</li> <li>Identification of Other Resider All med carts were audited to proper labeling of medications residents .</li> </ul>	nsulin bottle eyor. nts: ensure s for	

Facility ID: 00164

STATEMEN	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	0938-0391 SURVEY PLETED	
	OF CORRECTION					COM	FLETED	
		245242	B. WING			08/2	24/2017	
	PROVIDER OR SUPPLIER	CENTER OF MINNEAPOLIS		1	STREET ADDRESS, CITY, STATE, ZIP CODE 007 EAST 14TH STREET MINNEAPOLIS, MN 55404	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 431	was observed to pro R323's insulin. RN Humalog insulin into 10 units for R323's because the physic want to give more the scale dose of 12 un R323's Humalog via medication contained with administration subcutaneous 3 tim sliding scale param blood sugar 130-15 blood sugar 151-20 blood sugar 201-25 blood sugar 301-35 blood sugar 301-35 blood sugar 301-35 blood sugar 351-40 blood sugar 351-40 blood sugar greater doctor) On 8/21/17, at 6:43 Humalog order had indicated the order always be relied on directions/dose. RN practice was to com the correct dose of RN-E verified the de Humalog container Medication Adminis On 8/23/17, at 7:33 (LPN)-D prepared 2 R323. LPN- explain	epare for administration of l-E had drawn 22 units of o the syringe. RN-E explained dinner dose and 12 units ian was called and did not han the current highest sliding its. al was kept in a amber er. The container was labeled directions to inject 10 units res daily before meals with eters as follows: 0=0 0=2U 0=4U 0=6U 0=8U 0=10U than 400 call MD (medical p.m. RN-E verified R323's changed on 7/20/17. RN-E labels on medications can not	F 4	.31	re-educated with a read and sign document specific to medication lat 10-11-17 Monitoring Mechanisms: Clinical Managers or their designed audit their unit med carts one time to to ensure proper labeling for the net days. 10-10-17 10-24-17 10-31-17 11-4-17 Clinical Managers or their designed audit their unit med carts monthly for next 60 days. 12-4-17 1-4-18 Med cart audits will be reviewed by Quality Improvement Committee to ensure clinical standards of practic medication labeling on or before 10-31-17 11-30-17 12-31-17 1-31-18 Responsible Person/s Director of Nursing or designee Clinical Managers or designee Quality Improvement Director	e will weekly ext 30 e will or the the		

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/09/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245242	B. WING _			08/2	24/2017
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-	
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			07 EAST 14TH STREET INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	insulin medication b than the directions is change of order stice On 8/23/17, at 8:10 (CM)-B verified R32 were changed 8/22, called to provide a co- place on the insulin the clinical record C scale order had also from 10 units to 12 reading of 351 to 40 order had changed placed to alert staff should have. On 8/24/17, at 10:1 (DON) verified med based on the the M The DON indicated noted staff were exp orders and if there of the pharmacy shou change of order stice staff to a dosage ch a possible medicatii knowledge of the m recent order change change.	<ul> <li>a.m. LPN-D verified R323's pottle container was different in the MAR and did not have a cker on it.</li> <li>a.m. the clinical manager 23's Humalog insulin orders /2017, and the pharmacy was change of order sticker to bottle. With further review of CM-B verified the insulin sliding o changed in July, increasing units for a blood sugar 00. CM-B verified when the in July a sticker had not been of the order change, and</li> <li>4 a.m the director of nursing lications were administered AR and the medication label. when a discrepancy was pected to check the original was a dosage change found, ld have been contacted for a cker. The DON verified a cker would be used to alert hange and aid in prevention of on error. The DON verified redication, the e and prior sliding scale order</li> </ul>	F 4:	31			
F 465 SS=D	483.90(i)(5)	ity policy was not provided. L/SANITARY/COMFORTABL	F 4	65			10/12/17

		AND HUMAN SERVICES				FORM A	10/09/2017 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (7		SURVEY
		245242	B. WING _			08/2	4/2017
NAME OF F	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			007 EAST 14TH STREET IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 465	Continued From pa	ige 78	F 40	65			
	(i) Other Environme	ental Conditions					
		ovide a safe, functional, ortable environment for the public.					
	applicable Federal, regulations, regardi and smoking safety non-smoking reside	es, in accordance with State, and local laws and ing smoking, smoking areas, that also take into account ents. NT is not met as evidenced					
	review, the facility faservices necessary sanitary condition in bathrooms for 2 of	tion, interview and document ailed to provide housekeeping to maintain a clean and resident rooms and 2 resident rooms and shared 09, 111, East 252) reviewed.			F465: It is the policy of the Augustana Heal Care Center to provide a safe, functi sanitary, and comfortable environme residents, staff and the public. Corrective Action: The three identified rooms on the 25	onal, ent for	
	Findings include:	ur on 8/22/17, the following			have been deep cleaned and checke numerous times to ensure sanitary conditions have been maintained	ed	
	were noted: - at 2:13 p.m. room	109 and 111 on the first floor nd to have a strong urine odor			9-29-17 Identification of Other Residents: Every resident room was audited for sanitary conditions and deep cleaned indicated.		
		252 on the second floor East ave a strong urine odor m and bathroom.			9-29-17 Measures Put in Place: Mandatory all staff education was conducted on the importance of		
	On 8/24/17, at 11:1 environmental tour environmental serv environmental cond	with the director of ices (DES) the above			maintaining a sanitary, clean and comfortable environment for resident staff and the public. 10-11-17	ts,	
	On 8/24/17, at 11:1	14 a.m. the DES verified the			Monitoring Mechanisms: All resident rooms will be audited one	e time	

Facility ID: 00164

TATEMENT	OF DEFICIENCIES OF CORRECTION	KANNER STATE STREET STREE		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED	
	245242		B. WING _		08/	08/24/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE	
F 465	staff. The DES exp and duties to include - one staff person we total of seven hours -staff were provided and weekly cleanin - identified smells we The DES verified to odorous and difficu- clientele living on the East unit room 252 an ongoing concern the floor. The DES cleaning procedure however, agreed the control. On 8/24/17, at 11:4 improvement direct of environmental se services to residen up checks to ensur- cleaning services. On 8/24/17, at 12:2 office with the adm director of mainten- rooms and shared The DES indicate hand went thorough 252 on the East un only so much time	anaging the house keeping blained housekeeping staffing de the following: was assigned to each unit for a s per day. d schedules to follow for daily ig tasks. were managed promptly. the first floor main unit was bit to manage due to the hat unit. The DES agreed the 2 was odorous and had been in due to residents urinating on identified numerous additional es to manage the odors, hat the problem was not under	F 46	weekly for the next 30 day sanitary, clean and comfo environment is maintained 10-10-17 10-17-17 10-24-17 10-31-17 All resident rooms will be a monthly for the next 60 da sanitary, clean and comfo environment is maintained 11-30-17 12-31-17 Resident Room audits will the Quality Improvement of compliance with providing clean and comfortable envi before 10-31-17 12-31-17 1-31-18 Responsible Person/s Director of Environmental Quality Improvement Direct	rtable d. audited 2 times tys to ensure a rtable d. I be reviewed by committee for a sanitary, vironment on or Services		

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		AND HUMAN SERVICES		Ŧ	6242025	FORM	10/03/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>I</b> ` '		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245242	B. WING			08/	22/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS			007 EAST 14TH STREET IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	КC	000			
	FIRE SAFETY						
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.					
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	conducted by the M Public Safety, State August 22, 2017. A Augustana Health C was found not in co requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) Standard 10 Chapter 19 Existing	•					
	PLEASE RETURN CORRECTION FOI DEFICIENCIES (K-	R THE FIRE SAFETY					
	Healthcare Fire Ins State Fire Marshal						
	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						09/29/2017

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

DEPARTMENT OF HEAL CENTERS FOR MEDICA					FORM	10/03/2017 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB	CLIA (X2) M		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE	E SURVEY PLETED
	245242	B. WIN	IG		08/;	22/2017
NAME OF PROVIDER OR SUPPLI	ER			TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUSTANA HEALTH CAP	RE CENTER OF MINNEAPO	LIS		007 EAST 14TH STREET /IINNEAPOLIS, MN 55404		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FL R LSC IDENTIFYING INFORMATIC		) FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
Angela.Kappenr THE PLAN OF O DEFICIENCY M FOLLOWING IN 1. A description to correct the de 2. The actual, or 3. The name and responsible for o prevent a reoccu Augustana Healt a 6-story building constructed at 3 building was cond determined to be 1968, an addition side of the buildi Type II(222) cond was constructed that was determing construction. Be the additions me for existing build one building. The throughout by an and has a compl detection in the o	<ul> <li>St., Suite 145</li> <li>State.mn.us and han@state.mn.us</li> <li>CORRECTION FOR EACH UST INCLUDE ALL OF THE FORMATION:</li> <li>Sof what has been, or will be ficiency.</li> <li>proposed, completion dated of the person orrection and monitoring for title of the person orrection and monitoring for the deficiency.</li> <li>h Care Center of Minneage with a full basement that different times. The origin structed in 1945 and was a of Type II(222) construct in was constructed to the Struction. In 1974, an add to the West side of the build to be of Type II(222) cause the original building et the construction type and the struction type and the struction type and the struction type and the struction type and the the construction type and the construction type and the the construction type and the struction type and the struction type and the the construction type and the type and type and the type and type and the type and ty</li></ul>	H HE he, done te. to colis is was hal ion. In South be of ition uilding g and llowed eyed as ystems is smoke in to the	. 000			

Facility ID: 00164

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	OF DEFICIENCIES	E & MEDICAID SERVICES		LE CONSTRUCTION		0938-039 E SURVEY
	PLAN OF CORRECTION		A. BUILDING 01 - MAIN BUILDING 01 B. WING		08/22/2017	
NAME OF	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINNEAPOLIS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
K 000	Continued From pa	age 2	K 000			
	The facility has a c census of 231 at ti	apacity of 250 beds and had a me of the survey.				
K 521 SS=F	NOT MET as evide NFPA 101 HVAC HVAC	t 42 CFR, Subpart 483.70(a) is enced by: n, and air conditioning shall	K 521			10/12/17
	comply with 9.2 an accordance with th specifications. 18.5.2.1, 19.5.2.1,					
	Based on observation facility's heating, very in not in compliance 9.2, 19.5.2.1 and N	is not met as evidenced by: tion and staff interview, the entilation, and air conditioning e with the 2012 LSC NFPA 101 IFPA 90A. This deficient ct all 231 residents.		See attached waiver for K521		
	Findings include:					
	1500 on August 22 that the ventilation	etween the hours of 1000 and , 2017, observation revealed system for the main building ing the egress corridor as an				
		tice was verified by the Director the time of discovery.				

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#### Name of Facility

Augustana HCC

#### 2012 LIFE SAFETY CODE

#### 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 An annual/continuing waiver is being requested for K521. SS=F A. Compliance with this provision will cause an unreasonable hardship because: The building heating, 1. The most recent cost estimate dated April 12, 2017 for a complying ducted HVAC system is ventilation and air \$2,028,000.00 (See attached letterhead from Metropolitan Mechanical for costs and scope of conditioning equipment (HVAC) does not comply project work) with LSC (00) Section 2. This project would displace residents for several months, many would need to be transferred 9.2, and NFPA 90A, 1999 out to other facilities as we rarely have available beds in the facility due to census of 92% as a Ed., because the monthly average. This displacement of residents would cause significant emotional distress to corridors are being used residents which could also affect their physical health status in many cases as a plenum 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) Office Date Title Thomas Linkell 12424 Fire Safety Supervisor State Fire Marshal 10-03-2017

Form CMS-2786R (10/2016)

## Name of Facility Augustana HCC MPLS

## 2012 LIFE SAFETY CODE

#### 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	<ul> <li>Continued</li> <li>4. Due to these extensive costs, disruption and possible relocation of residents there are no immediate plans to implement the above major physical plant renovation. In addition to the extra associated projects and costs, the ducted system would need to penetrate load bearing walls decreasing building structural integrity.</li> <li>5. The building is currently 55 years old and not slated for replacement in the foreseeable future. The building has a useful life of an additional 75+ years and meets all LSC to ensure a safe physical environment for residents and staff, which in turn allows the existing non-complying HVAC to remain in use</li> </ul>
	<ul> <li>B. There will be no adverse effect on the building occupant's safety in accordance with SOM 2480B because:</li> <li>1. The facility is Type II with an interior finish rating of Class A.</li> <li>2. The walls, floors, ceiling and vertical openings resist the passage of smoke</li> </ul>

Surveyor (Signature)	Title	Office	Date
Fire Authority Official (Signature)	Title	Office	Date
Themas Linkeff 12424	Fire Safety Supervisor	State Fire Marshal	10-03-2017

Form CMS-2786R (10/2016)

#### Name of Facility

Augustana HCC

#### 2012 LIFE SAFETY CODE

#### PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

JUSTIFICATION

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)

K400 K 521 Continued SS=F 3. The following safety features are installed: a. Fire Alarm EST-3 addressable, transmission type SD4 Version 5.2 The building heating, b. The building is protected by a complete fire sprinkler system that complies with NFPA 13, ventilation and air 1199 Ed. As of January 2008. (Fully conditioning equipment (sprinkled, wetpipe quick response) (HVAC) does not comply with LSC (00) Section c. Fire extinguishers - Dry chemical 4-A 60-BC 9.2, and NFPA 90A, 1999 d. The building is equipped with an approved, addressable fire alarm/smoke detector system, Ed., because the and all resident rooms are equipped corridors are being used with automatic smoke detection tied into the nurses call station. as a plenum 4. In accordance with LSC 19.7.2.2, the facility has a compliant fire safety plan which included fire plans for all departments and employees, training on plans is conducted upon hire, and annually for all employees. Fire drills are conducted at least quarterly on each shift. 5. Operational plans include: Plans for all departments, and all office areas, Fire Out, Fire Drills, Fire Watch Alarms Out, Fire Watch Sprinkler systems out. ÷ Surveyor (Signature) Title Office Date Fire Authority Official (Signature) Title Office Date Themas Linkoff 12424 Fire Safety Supervisor State Fire Marshal 10-03-2017

Form CMS-2786R (10/2016)

Page 49

# Name of Facility

#### Augustana HCC

## 2012 LIFE SAFETY CODE

## 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	Continued 6. The facility sets a staff ratio at 3.70 nursing hours per day per resident.
The building heating, ventilation and air conditioning equipment	<ol> <li>There are 5 smoke compartments on Ground Floor, 1st, 2nd, and 3rd floor, 4 smoke compartments on 4th floor, and 3 on 5th floor Main which is currently closed</li> </ol>
(HVAC) does not comply with LSC (00) Section 9.2, and NFPA 90A, 1999	8. TCU residents are located on the first floor of both the East and Main building and houses 53 residents, the dementia care unit is located on 4th floor Main and houses 28 residents
Ed., because the corridors are being used as a plenum	9. The closest fire department is 1 mile away and has an average of 5 minutes or less response time.

Surveyor (Signature)	Title	Office	Date
Fire Authority Official (Signature)	Title	Office	Date
	Fire Safety Supervisor		10-03-2017

Form CMS-2786R (10/2016)

Page 49



April 12, 2017

Clark Worden Augustana Apartments 1007 East 14<sup>th</sup> Street Minneapolis, MN 55404

RE: Bldg A Ventilation Budget

Dear Mr. Worden:

Per your request the following budget proposal is to provide 100% outside air ventilation to all floors of the main building.

Included items in this proposal:

- Demo and relocate existing exhaust fans and roof vents to accommodate new air handler.
- Furnish and install one (1) 100% outside air rooftop complete with desiccant wheel, roof curb and controls.
- Structural engineering design for new rooftop and core drilling for new shafts.
- Necessary new ductwork and diffusers.
- Necessary new gas piping. New meter required and provided by others.
- Necessary new fire smoke dampers.
- Temperature controls
- Rigging
- Equipment rental
- Power wiring
- Insulation
- Air balance
- Check, Test, Start

The following items are not included:

- Overtime labor
- Painting
- Condition of existing systems.
- Dumpsters
- Structural Work Required
- General Construction

The budget cost to complete this scope of work is.....\$2,028,000.00

Thank you for the opportunity! Please contact me with any questions.

Metropolitan Mechanical Contractors, Inc. 7340 Washington Avenue South ♦ Eden Prairie, Minnesota 55344 Phone: 952-941-7010 ♦ Fax: 952-941-9118



Sincerely,

Metropolitan Mechanical Contractors, Inc. Accepted By:\_\_\_\_\_\_ Augustana

Date:\_\_\_\_\_

Apartments

Dale Haupert Service Sales Manager 612-919-4701 dale.haupert@metromech.com

> Metropolitan Mechanical Contractors, Inc. 7340 Washington Avenue South Eden Prairie, Minnesota 55344 Phone: 952-941-7010 Fax: 952-941-9118

# DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 20, 2017

Ms. Jean Cole, Administrator Augustana Health Care Center of Minneapolis 1007 East 14th Street Minneapolis, MN 55404

Re: State Nursing Home Licensing Orders - Project Number S5242027

Dear Ms. Cole:

The above facility was surveyed on August 21, 2017 through August 24, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Augustana Health Care Center of Minneapolis September 20, 2017 Page 2

"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 Gail Anderson at (218) 332-5140 or email: gail.anderson@state.mn.us**.

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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

# Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: <u>mark.meath@state.mn.us</u> Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

Minnesc	ta Department of He	alth				1 01 101	
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM		-		(X3) DATE COMP	SURVEY LETED
		00164	В	3. WING		08/2	4/2017
NAME OF	PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, S	TATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MIN	1007 EAST 1 MINNEAPOL				
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2 000	Initial Comments		2	2 000			
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORD	ER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has	issued on, it is cited violation dance rule of been tag below. ire to idered upon rule will the item				
	that may result fron orders provided tha the Department wit	hearing on any asses n non-compliance with t a written request is hin 15 days of receipt nt for non-compliance	n these made to of a				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The State delineated on the a	participate in the ele- nsure orders consiste artment of Health in 14-01, available at tate.mn.us/divs/fpc/pr elicensing orders are	ent with				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENT	ATIVE'S SIGNAT	TURE	TITLE		(X6) DATE 09/29/17

Electronically Signed

STATE FORM

If continuation sheet 1 of 76

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00164	B. WING		08/	24/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S <sup>-</sup>	TATE, ZIP CODE		
AUGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th	Alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rrected" in the box available for indicate in the electronic cess, under the heading the date your orders will be electronically submitting to the nent of Health.				
	surveyors of this De above provider and orders are issued. electronic plan of c	7, 8/23/17, and 8/24/17, epartment's staff visited the I the following correction Please indicate in your orrection that you have lers, and identify the date wher tted.	ı			
	the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled " II statute/rule out of c "Summary Stateme and replaces the "T correction order. TI findings which are after the statement evidence by." Follo	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute c, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMN "PROVIDER'S PLA	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00164	B. WING		08/	/24/2017	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE			
AUGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 000	Continued From pa	age 2	2 000				
	THIS WILL APPEA	AR ON EACH PAGE.					
	PLAN OF CORRE	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF FE STATUTES/RULES.					
2 302	MN State Statute 1 or related disorder	44.6503 Alzheimer's disease train	2 302			10/12/17	
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144						
	Alzheimer's disease or related segregated or gene care staff	ility serves persons with disorders, whether in a eral unit, the facility's direct ors must be trained in dementia	a				
	<ol> <li>an explanation related disorders;</li> <li>assistance with</li> <li>problem solving and</li> <li>communication</li> <li>The facility shall written or electronic training program, the trained, the frequent topics covered.</li> </ol>	ed training include: of Alzheimer's disease and activities of daily living; g with challenging behaviors; skills. Il provide to consumers in c form a description of the he categories of employees ncy of training, and the basic Il document compliance with					
	This MN Requirem	ent is not met as evidenced					

STATE FORM

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/24/2017	
		00164	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE		ST 14TH STF POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MINNEAPOLIS, MN55404EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)ID PREFIX TAGPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)Je 32 302		(X5) COMPLET DATE		
2 302	Continued From pa	age 3	2 302			
	by: Based on interview and document review, the facility failed to provide consumers in written or electronic form, information regarding facility staff training for Alzheimer's disease and related disorders.			Corrected		
	Findings include:					
	registered nurse (F aware of the requir written or electronic consumers, of staff with Alzheimer's dis	n 8/22/17, at 10:01 a.m. RN)-A indicated she was not ement regarding provision of c information to facility f training for care of residents sease and related disorders. provided only upon request in copy format.				
	director of nursing not provided all fac electronic form, the regarding what trai were trained or the DON indicated this	a 8/22/17, at 1:59 p.m. the (DON) verified the facility had ility consumers in writing or e details of Alzheimer training ning is provided, what staff frequency of training. The information was only provided itted to the memory care unit				
	Dementia Care Tra document for the p	ty's document labeled ining directed access to the ublic would be provided to ronic or hard copy format per				
	DON or designee of staff training to the consumer informat	THOD OF CORRECTION: The could add information regarding resident admission packet for ion. The DON or designee and conduct audits to ensure				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X:	3) DATE SURVEY COMPLETED	
		00164	B. WING		08/24/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE		OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		
2 302	Continued From pa	age 4	2 302			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565		10/12/17	
		omprehensive plan of care I personnel involved in the t.				
	by: Based on observat review, the facility f interventions for us of 2 residents (R12	ent is not met as evidenced ion, interview and document ailed to implement care plan e of transfer equipment for 2 23, R228) who required use of nent for assistance with		Corrected		
	Findings include:					
	required extensive transfers, staff to c transfers, R123 ma resident reports fee plan dated 8/14/17	ated 8/22/17, indicated R123 assistance of one staff with ue resident before and during ay use the EZ stand when eling weak. R123's fall care , indicated R123 was resized a fall, appropriate large fitting g obtained.				
	fall risk, required ex stand pivot transfer protective boot, OF	re sheet, indicated R123 was a xtensive assist of one staff for r with four wheeled walker and R required EZ stand with large t report feeling weak. The				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00164	B. WING		08/	24/2017
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		08/	24/2017
		1007 FAS	ST 14TH STRE			
UGUST	ANA HEALTH CARE	MINNEAL	POLIS, MN 55	5404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 5	2 565			
	following words were typed on the care sheet and underlined and in red ink wer " be sure to use LG(large) sling with all EZ stand transfers."					
	was observed lying (NA)-A present in t she was ready to g yes, NA-A proceed At 7:55 a.m. NA-A mechanical lift and lift had a sling with over the top of the lift up to the edge of her feet on the lift's lift into place. NA-A R123's back, attact the hooks of the EZ safety belt around R123's calves. NA and utilized the hyo while R123 wore b held on to both har unlock the EZ stan and transferred R1	n on 8/23/17, at 7:29 a.m. R123 g in bed, nursing assistant he room. NA-A asked R123 if jet up for the day, R123 stated led to provide morning cares. A retrieved an EZ stand I brought into R123's room, the beige colored binding draped lift. NA-A brought the EZ stand of the bed, R123 placed both of a foot platform and locked the A then placed the sling behind hed all loops of the sling on to Z stand lift, and attached the R123's abdomen and behind A-A used the remote control, draulic lift to stand R123 upright lack grippy type gloves and ndles. NA-A proceeded to id lift brakes, widened the legs 23 in front of her wheelchair,	t			
	front of her wheelc control to lower R1 R123 was seated i NA-A was really go on. NA-A unlocked removed her feet fi belts were released sling with beige col NA-A confirmed the was a size medium	e lift in place once R123 was in hair, and used the remote 23 into her wheelchair. Once n the wheelchair, she stated ood about putting all the belts d the EZ stand lift, R123 rom the platform, both safety d, loops unhooked, and the lored binding was removed. e sling used to transfer R123 n, as she visualized the white sling with a letter M on the tag				
	During interview or	n 8/23/17, at 8:07 a.m. R123 om the EZ stand lift a few				

TATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY PLETED	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COM	PLETED	
		00164	B. WING		08/	08/24/2017	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
UGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55				
(X4) ID			ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE	
2 565	Continued From pa	ige 6	2 565				
		reported when the staff					
		er up to the lift, the staff					
		ok the safety belt around her only attached the loops on to					
		. R123 reported since she fell					
	from the lift all staff	had been hooking up all of					
		has not had any further falls.					
		r she fell she had pain from down to her bottom. R123					
		scared, and repeats the					
	picture in her mind	of falling when she gets					
		stated she now wears gripper					
		e she has a secure hold on ift during transfers. R123					
		r fall from the lift, staff were					
	not always attachin	g the safety belt around her					
		ted she had not reported that					
		nurses. R123 stated the fall ift has been her only fall since					
	admission.						
	During interview on	8/23/17, at 8:17 a.m. NA-A					
		quired extensive assistance of					
		or all ADL's, with the exception	1				
		was independent. NA-A					
		care guide sheets that resident needs for assistance.					
		3 did have one fall only that					
		stated R123 fell from the lift					
		s not working. NA-A verified					
		oose which size sling to use and stated if the sling fits, we					
		med she used a medium sized					
	sling to transfer R1	23, and verified the tag					
		n it. NA-A also indicated a					
		d to the lift used for R123's ated slings with a beige					
		re size medium. NA-A also					

STATEMEN	ta Department of Here Tor Deficiencies OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00164	B. WING		08/	08/24/2017	
IAME OF F	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
UGUST	ANA HEALTH CARE	CENTER OF MINI	ST 14TH STRE POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	age 7	2 565				
	stated sling size wa discretion and to the staff document the sheet. RN-C was in be transferred with stated R123's iden plan and care sheet but reported the re sling felt comfortate R123. When interviewed licensed practical re were measured and sling sizes were de like a girdle. LPN- used was document	n 8/24/17, at 9:44 a.m. RN-C as determined by staff he resident's comfort level, ther e size on the care plan and care notified R123 was observed to a medium sized sling, RN-C tified sling size on her care et indicated a large size sling, sident stated the medium sized ble for her when she visited with on 8/23/17, at 11:50 a.m. hurse (LPN)-B stated residents ound their abdomen, then the etermined by the measurement B stated the sling size to be nted in the resident's care plan 23 should use a large sized ers.					
	reported the staff h slings for the EZ st not have the correct laundry to obtain th	on 8/23/17, at 12:14 p.m. NA-E nad access to several sizes of tand lift, and stated if they do ct size, staff would notify ne correct size. 23 required an extra large sized					
	verified R123 used transfers and exter NA-C stated R123 sized sling for all tr information was also	on 8/24/17, at 9:30 a.m. NA-C d an EZ stand lift for all nsive assistance of one staff. required the use of a large ransfers, and indicated this so on the care sheets. NA-C ven education on the use of s upon hire.					
		on 8/24/17, at 9:20 a.m. NA-D puired extensive assistance of					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00164	B. WING	B. WING		08/24/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
AUGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
2 565	Continued From pa	age 8	2 565				
	one staff and the E a large sized sling.	one staff and the EZ stand lift for all transfers with a large sized sling.					
	LPN-C confirmed F for all transfers, an always transferred. completed the asse appropriate sling si	on 8/24/17, at 9:36 a.m. R123 required the EZ stand lift d indicated that is how she had . LPN-C confirmed RN-C essments to determine the izes for each resident, an the pocumented on the care sheet					
	director of nursing had the fall from th analysis was comp R123 let go of the l felt the harness wa investigated, the w incident report, due popped off. The D involved was imme ensure the sling fit The DON stated af believed a different The DON confirme a medium sized sli determining the pro- weight, but weights according the man She stated we take resident's comfort width, and what loo sling size assessm	on 8/24/17, at 11:30 a.m. the (DON) reported after R123 e EZ stand lift, a root cause bleted. The DON reported handles on the lift because she is a little tight, as staff further ording popped off was in the e to being too tight or the loop ON stated the staff member ediately given education to properly and was comfortable. Iter the investigation, staff t size sling should be used. ed prior to the fall R123 utilized ng. The DON stated when oper size sling, staff look at is were pretty fluid and variable ufacture's chart and guidelines is in to consideration the level of sling, generalized oks safe. The DON verified the tent was not documented, as it gement based on clinical					
	factors, then the size care sheet and car should use a large	ze was documented on the e plan. The DON verified staff sized sling for all EZ stand lift 3, unless there was some					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED		
		00164	B. WING		08/	08/24/2017	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
UGUST	ANA HEALTH CARE	CENTER OF MINE	ST 14TH STRE POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	age 9	2 565				
	DON stated staff d sling size changes, indicated on the ca size. The DON sta manager re-assess sling size, and base did, the sling shoul all staff should be p the care sheets and indicates a large si confirmed there we assessments regan stand lift, other tha stated the interdisco of a discussion, tal picture of what hap new interventions s all done "off the red DON reported the expected to visuali: of sling and lift prio maintenance routir slings. R228 care plan rev R228 required assi impaired mobility re R228 careplan dire of two via an EZ lift The untitled, undat sheet updated 8/21 "Transfers: EZ-Lift.	ed nursing assistant care /17, indicated for R228 "					
	nurses aide (NA)-C an EZ stand down room. NA-O verbal	tion on 8/24/17, at 1:14 p.m. ) and nurses aide (NA)-P rolled the hallway and entered R228 ly cued R228 she was going to o transfer him from his wheel					

TATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		00164	B. WING	B. WING		08/24/2017	
AME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
UGUST	ANA HEALTH CARE (		OLIS, MN 55				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 565	Continued From pa	ge 10	2 565				
	sling under R228 ba forward so can get arm is on right." NA EZ stand handles w feet onto stand to tr wheelchair to his be with transfer from w was lowered to on e minute." R228 lear removed from the E lifted R228 legs up him in bed. During an interview clinical manager (C recent accident with R228 legs and arms him to safely be trai CM-A stated R228 been changed to us transfer. CM-A state care plan changes careplan review and the NA-O and NA-F EZ lift with R228. D , NA-O approached R228 was hollering strap between his le CM-A stated to NA- transferred with the During an interview director of nursing ( had been updated o used as R228 had	A-O and NA-P placed an EZ ack and cued R228 "lean sling behind you, your weaker -O cued R228 to hold onto <i>v</i> ith his arms. NA-O placed his ransfer R228 from his ed. NA-O and NA-P continued <i>v</i> heelchair to the bed. As R228 edge of bed he said "wait a ned to right side as legs EZ stand. NA-O and NA-P onto the bed and positioned on 8/24/17, at 1:30 p.m. with M)-A stated R228 had a n the EZ stand. CM-A stated s were not strong enough for nsferred with an EZ stand. careplan interventions had se of a EZ lift to ensure a safe ed staff were made aware of through shift communication, d aid care sheets. CM-A stated s hould have been using the uring the interview with CM-A the desk area and stated and said he didn't want a egs so she used an EZ stand. O, he was supposed to be EZ lift. NA-O did not respond. on 8/24/17, at 3:59 p.m. with DON) stated R228 care plan on 8/19/17 for an EZ lift to be weakness in arms and legs o use on a EZ stand. DON also					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
UGUST	ANA HEALTH CARE		ST 14TH STR POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLET DATE	
2 565	Continued From pa	age 11	2 565				
	indicated care plan written guides for ir resident to meet th care and psychoso	Plan policy dated 11/2016, s are developed to provide ntervention, assisting the eir needs for ADL's, health cial needs and to provide for evelopment of the resident's					
	The director of nurs a system to educat monitoring system	THOD OF CORRECTION: sing or designee could develop e staff and develop a to ensure staff are providing the written plan of care.	0				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one	e				
2 570	MN Rule 4658.040 Plan of Care; Revis	5 Subp. 4 Comprehensive sion	2 570			10/12/1	
	care must be review interdisciplinary tea physician, a register for the resident, an disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within	A comprehensive plan of wed and revised by an im that includes the attending pred nurse with responsibility d other appropriate staff in rmined by the resident's needs practicable, with the resident, the resident's legal n representative at least n seven days of the revision of resident assessment required subpart 3, item B.					
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview and document ailed to revise the care plan to ed interventions to effectively	,	Corrected			

Minneso	ta Department of He	ealth			FORM	APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		00164	B. WING		08/2	24/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINI	ST 14TH STRE			
		MINNEA	POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 12	2 570			
	communicate with 1 of 1 resident (R338) with a language barrier.					
	Findings include:					
	dated 2/5/17, identi which included arth and unspecified un indicated R338 had memory problems, cognitive skills for of preferred language wanted an interpre- or health care staff R338 required exter mobility, dressing, did not ambulate. F R338 was frequent	Minimum Data Set (MDS) ified R338 had diagnoses mitis, chronic pain syndrome, rinary incontinence. The MDS d both short and long term had moderately impaired daily decision making, her was Somali and needed or ter to communicate with doctor . The MDS also indicated ensive assistance for bed toileting, personal hygiene and Further, the MDS indicated ty incontinent of urine and on a toileting program.				
	2/9/17, indicated R Somali and family r times R338 though listed various caus which included cult recognizing caregiv risk factors include decreased progress therapies. Also, the bowel and bladder control, history of s was not consistent needs to be change	not trigger and was not				
nnesota De		DS dated 8/5/17, indicated impaired cognition, her				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00164	B. WING		08/	24/2017
AME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, S			
UGUST	ANA HEALTH CARE	CENTER OF MINE	ST 14TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 570	Continued From pa	age 13	2 570			
	wanted an interpre or health care staff required extensive daily living (ADL). T was occasionally ir incontinent of bowe program. R338's current care listed the problem of adequate, and indi- understood through directed staff to rep communicate, und- hear and to refer for R338's care plan ic language was Som weakness, dement assistance with be assist to lift legs in/ in bed. R338's care simply and clearly a environmental cues communicate at ey explain cares/treat needed and consis cares. The care pla opportunity for pati social services as n talk through anger schedule an interpr practitioner/physici	e was Somali and needed or ter to communicate with doctor . The MDS indicated R338 assistance for all activities of The MDS also indicated R338 noontinent of urine, frequently el and had no toileting e plan, revised on 8/22/17, of communication, hearing was cated R338 made herself n an interpreter. The care plan bort any changes in ability to erstand others, or in ability to erstand others, or in ability to or hearing exam as needed. dentified R338's primary nali, had frequent pain, ia, required extensive d mobility, boost up in bed, fout of bed, and sitting position e plan directed staff to speak and repeat as needed, utilize s as calendars, clocks, notes, re level and establish calm, ments before beginning, as itent routine when providing an directed to provide ent to express feelings, involve needed, encourage resident to and frustration, and to reter for rehab therapies, nurse an visits, care conferences and urther care plan interventions				
	or assistive devices R338. Review of R338's u	tively communicate with R338, s to use to communicate with undated Transitional Care Card ventions which included				

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			E SURVEY PLETED	
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
UGUST	ANA HEALTH CARE	CENTER OF MINI	ST 14TH STRE POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 570	Continued From pa	age 14	2 570				
		Ls, however, the care card ntions for R338's language					
	R338 wore a hospi of her bed with he (NA)-G entered R3 light and asked R3 proceeded to repeat repeatedly tapped NA-G stated she w R338 was trying to repeat the foreign w of her hands out in R338 extended he front of her groin w sound repeatedly.	as on 8/23/17, at 8:56 a.m. ital gown, seated on the edge r call light on. Nursing assistan 338's room, deactivated the cal 38 what she needed. R338 at foreign words, and her thigh with her left hand. vas unable to understand what tell her. R338 continued to words, proceeded to place both front her, and spread her legs r fingers open and arms out in while making a "sheeeew" R338 continued make the and gestures for NA-G until om at 8:59 a.m.	h				
	R338 wanted, but the She stated, "No on it's very hard, I don indicated she was facility who spoke I hard to communicate gestures or movem gestures and move	stated she did not know what thought she was having pain. he here speaks this language, i't understand her." NA-G not aware of anyone in the R338's language and felt it was ate with R338 utilizing hand hents. NA-G indicated the hand ements staff utilized to attempt th R338 were not effective R338.	s A				
	bed, and R338's ca began to speak for fast to registered n entered her room a left hand on the lef	was seated on the edge of her all light was again on. R338 reign words repetitively very urse (RN)-D and NA-G as they at that time. R338 tapped her t side of her thigh area and t foreign words in a very fast,					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	CONSTRUCTION		E SURVEY PLETED	
		00164	B. WING		08/	08/24/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
AUGUST	ANA HEALTH CARE	CENTER OF MINI	ST 14TH STRE POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 570	Continued From pa	age 15	2 570				
	hands out in front h extended her finge of her groin while n repeatedly. R338 the "sheeeew" sou repeatedly if she w appeared to get m in her foreign langu her uneaten food it waved her left arm her head. NA-G sta she wants."	bice. She placed both of her her, spread her legs and rs open and arms out in front naking a "sheeeew" sound continued to gesture and make nd while RN-D asked her as having pain. R338 hore frustrated, talking very fast uage. NA-G asked R338 about rems on her room tray, R338 towards the door and shook ated she was "not sure what	t				
	cry and stated, "hu indicated she was need to go to the b bedpan to the bed. to place the bedpa she removed R338 repeatedly moaned rapid, frustrated vo place the bedpan b out of the way of th placed under her b	e and proceeded to whimper, h, huh, huh" repeatedly. RN-D unsure, but felt R338 may athroom and brought a RN-D proceeded to attempt n under R338's buttocks, while S's disposable brief. R338 d, "uhhh, uhhh, uhhh" in a ice and frantically assisted to by moving her hospital gown he bedpan. With the bedpan uttocks, R338 proceeded to a large amount of urine.					
	stated staff had a h wanted when she o staff have to guess	n 8/23/17, at 9:11 a.m. RN-D nard time knowing what R338 called for assistance and stated a lot of the time and the ted during that time.	k				
	stated in the past v facility to visit R338 stated he was awa	B p.m. family member (FM)-A when family have come to b, she had been crying. FM-A re R338 had attempted to not rel movement, to avoid being					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
UGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 16	2 570			
	FM-A indicated he R338's elimination had been told the s R338. FM-A indicat R338's wall for stat communicate with On 8/23/17, at 9:21 difficult to commun language barrier au few words such as primary language.	I a.m. RN-D indicated it was nicate with R338 due to the nd indicated she only knew a medication, pain in R338's RN-D indicated she had son when she was not sure				
	interview with NA-C gestures to attemp and stated she was interventions to util R338. NA-G indica the family member R338 needed assis had not utilized an	I a.m. during a follow up G, she stated she used hand t to communicate with R338 s not aware of any other lize while communicating with ted in the past she had called to attempt to figure out what stance with. NA-G stated she interpreter in the past and was equest for or use needed S.				
	On 8/23/17, at 9:50 communication wa she pointed at obje when he was availa routine was to stan point until she figur	D a.m. NA-H indicated is difficult with R338 and stated acts or had her son translate able. NA-H indicated her usual id in her room, have R338 red out what R338 needed or cated she had not utilized				
	present in the build	18 p.m. an interpreter was ling and he stated interpreter red for scheduled medical				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
			-			
		00164	B. WING		08/	24/2017
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
AUGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 17	2 570			
	of any other time ir in the facility. The i (8/23/17), was the a schedule medicat today. On 8/23/17, at 12:2 the interpreter and not communicate w with that sometime had been left on th the past, she had t so she could avoid R338 indicated she incontinent product bedpan and stated sometimes made h if she was able to of care would be bett welcome staff help	residents and was not aware nterpreter services were utilized nterpreter indicated that day first time he had met R338 for al appointment with the doctor 20 p.m. during interview with R338, R338 stated she could with staff and her son helps es. R338 indicated because she bedpan without assistance in ried not to go to the bathroom that from happening again. that from happening again. that bowel movements in her t due to avoiding use of the it made her feel bad, her cry. R338 indicated she felt communicate with staff, her er. R338 indicated she would by but staff comes in her room, without providing assistance				
	education when sh blamed herself and learning the langua isolated, could not because staff could they were unable to the interpreter, R33 receive assistance and bursting. R338 her room in the pas communication, ho	felt regret not getting the le was younger and stated she d people before her for not age. R338 indicated she felt get up on her own, and stated d not communicate with her, o help her. Through the use of 38 stated when she did not at times she felt like exploding b indicated she had pictures in st for assistance with owever, the pictures were no				
	longer in her room pictures were. On 8/23/17 at 12:2 interview, FM-A inc	and was not aware where the 5 p.m. during second dicated he posted a note with s to the wall in R338's room to				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00164	B. WING		08/24/201	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
UGUST	TANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 570	help with R338's lat staff did not use the had been told by th cares and did not u R338 would call hin facility to get R338 stated he felt if R33 were offering, she w indicated he felt the care had been com language barrier. FM-A indicated he w assist R338 with to everything she nee ago, he had come t been incontinent of had reported that si longer. FM-A indica concerns with the la facility staff many ti he had suggested u utilize pictures of va the Internet to use the R338. FM-A stated "maybe once" and I R338's room since. not utilized an interpic communication for On 8/24/17, at 8:37 edge of her bed, wi left, and was obsert telephone. Above the to R338's bed, a whapproximately 8 incomes the wall. On the page	nguage barrier, but the facility e telephone numbers. FM-A e facility staff R338 refused se her call light. FM-A stated n on telephone, he called the assistance with toileting. FM-A 88 understood what the staff would not refuse. FM-A e number one issue with her munication with R338's visited everyday and would ileting, dressing and ded. FM-A stated a few days to the facility and R338 had urine all over the bed and she he could not hold her urine any ated he had discussed his anguage barrier for R338 with mes in the past. He indicated use of an interpreter or staff to arious items or objects from to assist communication with he had seen pictures used had not seen the pictures in FM-A stated the facility had preter to assist in cares for R338.				

STATEMEN	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE	00/	24/2017
AUGUST	ANA HEALTH CARE	CENTER OF MINI	ST 14TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 570		age 19 a.m. RN-G was present in ndicated staff had used	2 570			
	R338 was not able "so did not really w was easier to have communication and indicated the usual something, she wo son would call the R338 wanted or ne confirmed the inter posted in R338's re now. RN-G indicate assistance in time incontinent of urine always continent of not aware of any co	rds with words on them, but to read the cards and stated, ork that well." RN-G stated it staff to assist with d to translate for her. RN-G practice if R338 needed udd call her son and then her desk to let staff know what beded assistance with. She preter hot line information bom had not in her room until ed of R338 did not receive or had urgency she would be and stated she felt R338 was f bowel. RN-G denied she was ommunication concerns with I don't think the problem is				
	interview, FM-A inc respond to her, she bed and stated "ha and holds it." He in assistance she wo FM-A stated the int	a.m. during a follow up dicated when staff did not e would be incontinent on the uppens quite a bit, she holds it, dicated when she called for uld have incontinence issues. terpreter information in R338's e until they came to visit her				
	able to speak the s R338. She indicat her hip when she h stated other staff th but R338 used the to go to the bathroo assistance with toil	D a.m. NA-J stated she was same language (Somali) as ed R338 would point or slap had to go to the bathroom. She hink this gesture was for pain se gestures to indicate she has om. NA-J verified R338 needed leting, used the bedpan and t for assistance. NA-J	5			

Minnesota Department of Health STATE FORM

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TATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         ND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00164	B. WING		08/	24/2017
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		• · · ·
UGUST	ANA HEALTH CARE	CENTER OF MINI	ST 14TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 20	2 570			
	incontinence with b staff who do not un cared for her. NA- R338, she was cor but when staff who communicate with R338 wore a brief. reported she was a incontinence episo aware the interpret when R338 had sc appointments. NA- staff many times of language barrier, a hotline posted in R until recently. She s paper in her room I On 8/24/17, at 9:07 able to speak the s R338. NA-K verifie with toileting, used use the call light. N continent of bowel R338 will have inco assisting her with to what R338 needed of the staff did not verified R338 has h not understanding and stated "she ha NA-K indicated R33	J stated she had told nursing f her concerns with R338's and confirmed the interpreter 338's room was not present stated, "She did not have that				
	confirmed R338 pr and indicated he w	efuse cares. 08 p.m. social worker (SW)-A imary language was Somali ould schedule an interpreter e online service when R338				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00164	B. WING		08/	24/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
AUGUS	TANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 570	Continued From pa	ige 21	2 570			
	his portion of the M facility practice was son to translate, off be patient and expl indicated staff were plan and to utilize th having trouble com indicated he was no communicating with other interventions R338 to effectively On 8/24/17, at 12:3 (DON) confirmed F stated she expected plan, staff to assist needs consistently. expect staff to assist continent, help the call lights. DON ind barrier due to not s expect staff to call a available, or use pin She stated all staff interpreter services utilize the resource with R338. The DO aware of any conce barrier. The DON in admitted who have facility practice was to all staff to notify i resident's primary I available to assist. we have family to a The DON indicated an interpreter for th medical appointme	attments or when he completed IDS. SW-A indicated the usual is to encourage R338 to use the ner staff members, and staff to ain cares to her. The SW-A e expected to follow the care he online interpreter services if municating with R338. He of aware of any problems in R338. SW-A confirmed no had been put in place to assist communicate with staff. B3 p.m. director of nursing R338's current care plan and ed staff to follow R338's care as needed, and meet her DON indicated she would st the resident to stay resident with cares, answer licated R338 had a language peaking English and would an interpreter, family if cture cards or online service. had access to the online and she would expect staff to s available to communicate DN indicated she was not erns with R338's language indicated when residents were language barriers, the usual a to send an email notification them of the individual anguage and if the family was She stated "90%" of the time (ccommodate for their needs. I the facility routinely scheduled arts, and stated the facility did arther services unless they felt				

ND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00164	B. WING		08/	24/2017
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	IATE, ZIP CODE		
UGUST	ANA HEALTH CARE	CENTER OF MINN	ST 14TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 570	Continued From pa	age 22	2 570			
	indicated 338's sor and stated she had with communicatio Review of the facili revised on 11/2016 developed after co assessment or as a will be reviewed at needed. The policy personal and cultur incorporated into the plan goals. The policy provide written guid the resident to meet care and psychoso person-centered de plan of care. This p sheets and /or prof	a was unclear. The DON a came to the facility quite a lot d not heard of any concerns in that impacted 338's care. ty policy titled Care Plans, s, indicated care plans are mpletion of the comprehensive changes occur. The care plan least quarterly and revised as a also indicated the residents ral references will be ne development of the care licy further indicated care plan des for intervention, assisting et their needs for ADL's, health icial needs and to provide for evelopment of the resident's policy also indicated "NAR Car illes are updated per care plan the practice of following the	e			
	The director of nur- develop and implei related to care plar designee, could pro- staff related to the revisions. The qual committee could po- ensure compliance TIME PERIOD FO	THOD OF CORRECTION: sing (DON) or designee, could ment policies and procedures n revisions. The DON or ovide training for all nursing timeliness of care plan lity assessment and assurance erform random audits to a. R CORRECTION: Twenty-one	9			
	(21) days. MN Rule 4658.052					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00164	B. WING		08/24/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF MINI	ST 14TH STF POLIS, MN &			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 830	receive nursing car custodial care, and individual needs ar the comprehensive plan of care as de 4658.0405. A nurs of bed as much as written order from t	age 23 general. A resident must re and treatment, personal and l supervision based on nd preferences as identified in e resident assessment and scribed in parts 4658.0400 and sing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident				
	by: Based on observat review, the facility f individualized equip the appropriate tran during transfers for who had a history of a mechanical lift. In follow manufacture use of a wheeled w	ent is not met as evidenced ion, interview and document failed to implement oment requirements to ensure nsfer equipment was utilized r 2 of 2 residents (R123, R228) of fall during a transfer utilizing n addition, the facility failed to er's guidelines for the proper valker to prevent accident resident (R224) who utilized a		Corrected		
	current diagnoses bilateral leg weakn disorder with seizu depression, pain in and repeated falls	dated 12/29/16, identified of chronic pain, muscle and ess, lymphedema, conversion res or convulsions, anxiety, left ankle and joints of left foot prior to admission. Minimum Data Set (MDS)				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00164	B. WING		08/	08/24/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S <sup>-</sup>	TATE, ZIP CODE			
AUGUST	ANA HEALTH CARE	CENTER OF MINE	ST 14TH STRE POLIS, MN 55				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 830	Continued From pa	age 24	2 830				
		sfers, had a history of falls and had intact cognition.					
	1/9/17, indicated R required extensive was at risk for falls deconditioning, pse obesity, impaired b	Assessment (CAA) dated 123 admitted with weakness, assistance for transfers and related to a history of falls, euedoseizures, depression, valance, the need for extensive tivities of daily living (ADL's), edications.					
	required extensive transfers, staff to c transfers, R123 ma resident reports fee plan dated 8/14/17	ated 8/22/17, indicated R123 assistance of one staff with ue resident before and during ay use the EZ stand when eling weak. R123's fall care , indicated R123 was resized a fall, appropriate large fitting g obtained.					
	fall risk, required ex stand pivot transfer protective boot, or sling when residen following words we	re sheet, indicated R123 was a xtensive assist of one staff for r with four wheeled walker and required EZ stand with large t reports feeling weak. The are typed on the care sheet and hk "be sure to use LG [large] and transfers."					
	was observed lying (NA)-A present in the she was ready to g yes, NA-A proceed At 7:55 a.m. NA-A mechanical lift and lift had a sling with over the top of the	on 8/23/17, at 7:29 a.m. R123 in bed, nursing assistant he room. NA-A asked R123 if let up for the day, R123 stated ed to provide morning cares. retrieved an EZ stand brought into R123's room, the beige colored binding draped lift. NA-A brought the EZ stand of the bed, R123 placed both of					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		00164	- В. WING		08/	08/24/2017	
IAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		00/24/2017	
UGUST	ANA HEALTH CARE	CENTER OF MINE	ST 14TH STRE POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 25	2 830				
	lift into place. NA-A R123's back, attack the hooks of the Ez safety belt around I R123's calves. NA and utilized the hyd while R123 wore bl held on to both han proceeded to unlow widened the legs of in front of her whee in place once R123 wheelchair, and use R123 into her whee really good about p unlocked the EZ sta from the platform, b released, loops un beige colored bindi confirmed the sling size medium, as sh attached to the slin Review of Event Re p.m. indicated R12 during an EZ stand report, the the sling straight out. R123 v of the fall. At the tim pain, hitting her hea extremities without were no signs of in	a foot platform and locked the A then placed the sling behind hed all loops of the sling on to Z stand lift, and attached the R123's abdomen and behind A-A used the remote control, draulic lift to stand R123 upright lack, grippy type gloves and hdles of the lift. NA-A ck the EZ stand lift brakes, f the lift and transferred R123 elchair, she then locked the lift B was in front of her ed the remote control to lower elchair. Once R123 was lochair, she stated NA-A was putting all the belts on. NA-A and lift, R123 removed her fee both safety belts were hooked, and the sling with ing was removed. NA-A i used to transfer R123 was a ne visualized the white tag g with a letter M on the tag. eport dated 8/5/17, at 5:45 3 suffered a witnessed fall I transfer. According to the d suddenly stopped moving, asistant was unable to ppened next, then one side of f place which caused R123 to as, on the floor, with legs was wearing shoes at the time me of the fall R123 denied ad, range of motion in all pain or limitations, and there jury. The Event Report s alert and oriented times					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00164	B. WING	B. WING		24/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
AUGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 26	2 830			
	Interventions identi educated resident checking on function using it, staff re-ed stand and to ensur Evaluation note of transferring R123 f EZ(stand) stanc [si causing resident to injuries observed, no oriented. Staff re-ed	ble to describe what happened. ified on the Event Report, and staff the importance of on of the equipment before ucated on proper use of EZ re correct size sling is used. the event, indicated while from her chair to bed, the ic] sling popped out of place o land on her buttocks. No resident remains alert and educated on proper use of EZ re correct size sling was being				
	8/7/17, indicated R no injury. The inte and documented th -no medication cor concerns or chang Care Changes/New re-educated on pro-	ncident Review Form dated 123 had a fall on 8/5/17, with rdisciplinary team reviewed ne following: ncerns, Environmental e of condition noted. Plan of w Interventions: staff oper use of EZ stand and to sling used, obtained large				
	8/7/17, indicated st related to the incor causing resident to procedures and sta reviewed with NA-I -All assigned tasks meticulous attentio our resident depen -Correct use of EZ residents and staff -Correct size of slir	stand is vital to safety of members. ng is extremely pertinent for				
nnesota D	providing safe tran	sfers; all slings used should be e at all times. The proper fit	•			

	ta Department of He					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00164	B. WING		08/24/2017	
					08/	24/2017
	PROVIDER OR SUPPLIER	1007 FA	DDRESS, CITY, S <sup>-</sup> <b>6T 14TH STRE</b>			
AUGUST	ANA HEALTH CARE		POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 27	2 830			
	will involve the judg -Nursing assistants both machine, batt ensure safety. -The sling must be both sides; the foot latched prior to eve -A copy of the EZ V to resident and play Review of nursing 18/22/17, revealed t -On 8/7/17, at 1:45 rib pain, no bruises R123's nurse pract rule out fracture. -8/7/17, at 4:02 p.n with negative resul R123 continued to side, medication ar relief noted, also no 2 cm bruise to R12 -On 8/8/17, at 2:46 of left side and rib of Results of x-ray we nurse practitioner, -On 8/13/17, at 6:5 indicated while trar to bed, the EZ(star of place causing re No injuries observe oriented. Staff re-es stand and to ensur used. -No further compla documented after 8 Review of X-ray re	gment of the caregiver. s has the task of inspecting ery and sling before every lift to secured to the machine on t and waist buckle must be ery lift. WAY harness sizing chart given ced on machine. progress notes dated 8/5/17 to he following: p.m. R123 complained of left a noted. A call was placed to titioner to request an x-ray to n., R123 returned to the facility, t from x-ray. At 11:32 p.m. complain of pain to the left nd a cold pack given with some ote was a 2 centimeter (cm) x 23's inner right arm. p.m. R123 complained of pain cage area, and rated 8/10. ere sent to R123's primary no new orders received. 1 a.m. resolution of fall noted, nsferring R123 from her chair nd) stanc [sic] sling popped out esident to land on her buttocks. ed, resident remains alert and educated on proper use of EZ e correct size sling was being ints of pain or injuries				
	however, no acute	fracture was found.				
inesota De ATE FORM	epartment of Health		6899 M	4PX11	If continuati	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00164	B. WING		08/	24/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
UGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
2 830	Continued From pa	age 28	2 830				
	Review of R123's fall risk assessment dated 6/21/17, indicated R123 did not have any falls within the past six months, and was a low fall risk for falls. During interview on 8/23/17, at 8:07 a.m. R123 reported she fell from the EZ stand lift a few weeks ago. R123 reported when the staff member hooked her up to the lift, the staff member did not hook the safety belt around her abdomen, and had only attached the loops on to the hooks of the lift. R123 reported since she fell from the lift all staff had been hooking up all of the belts, and she has not had any further falls.						
	R123 reported afte her ribs all the way stated she still gets picture in her mind transferred. R123	r she fell she had pain from down to her bottom. R123 s scared, and repeats the of falling when she gets stated she now wears gripper re she has a secure hold on					
	the handles of the l reported prior to he not always attachin abdomen, then stati information to any information the EZ stand	lift during transfers. R123 er fall from the lift, staff were ig the safety belt around her ted she had not reported that nurses. R123 stated the fall lift has been her only fall since					
	R123 reported afte her ribs all the way verified she did rec no fractures, she st in that location of h	interviewed at 12:49 a.m., r she fell she had pain from down to her bottom. R123 eive an x-ray and there were tated she did not have the pain er body prior to the fall, and we discomfort in her lower					
	confirmed R123 re- one staff member f	a 8/23/17, at 8:17 a.m. NA-A quired extensive assistance of for all ADL's, with the exception was independent. NA-A					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00164	B. WING			
		00164			08/24/2017	
IAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST <b>ST 14TH STRE</b>			
UGUST	ANA HEALTH CARE		POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ige 29	2 830			
	indicate what each NA-A reported R12 she was aware of, is because the lift was staff decide and ch for each resident, a use it." NA-A confil sized sling to transf marked with a M or color guide attache transfer which indic colored binding we indicated the sling s NA-A reported whe safety belts were to and behind legs. N education regarding lifts when she starte During interview on confirmed R123 fel transfer. RN-C s she believed the sti thought the size of RN-C stated re-edu member involved re sizes. RN-C verifie specific assessmen correct sling size to the color coded slin lifts, and when aske the size of sling to to size, she did not ar During follow up int a.m. RN-C stated s staff discretion and	care guide sheets that resident needs for assistance. 3 did have one fall only that stated R123 fell from the lift s not working. NA-A verified oose which size sling to use and stated if the sling fits, "we rmed she used a medium fer R123, and verified the tag n it. NA-A also indicated a d to the lift used for R123's sated slings with a beige re size medium. NA-A also size was on R123's care plan. n staff use the EZ stand lift, all b be attached, on the abdoment IA-A verified she had received g the safe use of the EZ stand ed working at the facility. 8/23/17, at 11:43 a.m. RN-C I from the EZ stand lift during a tated after talking with staff rap snapped off or open, and the sling was maybe incorrect. Ucation was given to the staff egarding the lift use and sling ed the staff did not complete a nt when determining the o use. RN-C was not aware of ng size sticker attached to the ed how the staff determines use, if they go by weight or nswer.				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/24/2017	
		00164	B. WING			
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
UGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
2 830	Continued From pa	age 30	2 830			
	sling, RN-C stated her care plan and o sling size, but repore medium sized sling she visited with R1 not injured from the complain of pain, a out fractures, and o atelactisis. RN-C v investigations or do fall on 8/5/17. When interviewed licensed practical r were measured are sling sizes were do like a girdle. LPN- used was docume	nsferred with a medium sized R123's identified sling size on care sheet indicated a large orted the resident stated the g felt comfortable for her when 23. RN-C reported R123 was e fall, confirmed R123 did an x-ray was completed to rule was found to have some verified there were no further boumentation regarding R123's on 8/23/17, at 11:50 a.m. hurse (LPN)-B stated residents bound their abdomen, then the etermined by the measurement B stated the sling size to be inted in the resident's care plan 23 should use a large sized ers.	,			
	reported the staff h slings for the EZ st not have the correct laundry to obtain th	on 8/23/17, at 12:14 p.m. NA-E nad access to several sizes of and lift, and stated if they do ct size, staff would notify ne correct size. 23 required an extra large sized				
	verified R123 used transfers and exter NA-C stated R123 sized sling for all tr information was also	on 8/24/17, at 9:30 a.m. NA-C I an EZ stand lift for all insive assistance of one staff. required the use of a large ransfers, and indicated this so on the care sheets. NA-C ven education on the use of s upon hire.				
	When interviewed	on 8/24/17, at 9:20 a.m. NA-D				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00164	B. WING	B. WING		08/24/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
AUGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
2 830	Continued From pa	age 31	2 830		- ,		
		uired extensive assistance of Z stand lift for all transfers with	1				
	LPN-C confirmed F for all transfers, an always transferred. completed the asso appropriate sling si	on 8/24/17, at 9:36 a.m. R123 required the EZ stand lift d indicated that is how she had . LPN-C confirmed RN-C essments to determine the izes for each resident, an the ocumented on the care sheet					
	director of nursing had the fall from th analysis was comp R123 let go of the life felt the harness wai investigated, the wincident report, due "popped off." The involved was immerent ensure the sling fit The DON stated af believed a different The DON confirme a medium sized slii determining the pro- weight, but weights according the man She stated we take resident's comfort width, and what loop sling size assessmit	on 8/24/17, at 11:30 a.m. the (DON) reported after R123 e EZ stand lift, a root cause bleted. The DON reported handles on the lift because she is a little tight, as staff further ording "popped off" was in the e to being too tight or the loop DON stated the staff member ediately given education to properly and was comfortable. there the investigation, staff t size sling should be used. ed prior to the fall R123 utilized ng. The DON stated when oper size sling, staff look at is were pretty fluid and variable ufacture's chart and guidelines in to consideration the level of sling, generalized oks safe. The DON verified the ent was not documented, as it gement based on clinical					
	factors, then the size care sheet and car should use a large	ze was documented on the e plan. The DON verified staff sized sling for all EZ stand lift 3, unless there was some					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		E SURVEY PLETED	
		00164	B. WING			24/2017	
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
AUGUST	ANA HEALTH CARE	CENTER OF MINE	ST 14TH STRE POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From par reason there neede would be reviewed DON stated staff de sling size changes, indicated on the car size. The DON star manager re-assess sling size, and base did, the sling should all staff should be p the care sheets and indicates a large size confirmed there we assessments regars stand lift, other that stated the interdisc of a discussion, tall picture of what hap new interventions a all done "off the red DON reported the re expected to visualiz of sling and lift prio maintenance routin slings. When interviewed of director of mainten completed monthly mechanical lifts use stated he looked fo and replaced them ensure the lifts wer DOM stated he was ever falling from a fit then stated if staff.	age 32 ed to be a change, the change by the clinical manager. The o not routinely document if the then stated it would be re sheet as being a different ted she had the clinical s R123 on 8/23/17 for proper ed on the assessment that she d be a large size, and verified providing care as directed by d care plan which also ze sling to be used. The DON ere no other documents or rding R123's fall from the EZ in the event report. The DON siplinary team (IDT) had more ks with people to get more of a opened, so we know what the should be, and verified this is cord" as the IDT talked. The nursing assistants were ze the lifts for obvious damage r to each use, and stated hely inspects the lifts and on 8/24/17, at 3:52 p.m. the ance (DOM) indicated he r audits and inspections on all ed in the facility. The DOM or broken, loose or worn parts, as needed, and looked to re functioning safely. The s not aware of any residents mechanical lift or EZ stand lift, would update him in that type want to go look at the lift or	2 830				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00164	B. WING		08/	08/24/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE	·		
AUGUST	ANA HEALTH CARE	CENTER OF MINE	ST 14TH STRE POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 33	2 830				
	manufacturer's sizi included a color co different sizes by d harnesses. Beige medium for use of of circumference o is applied. The cha designations were guidelines. A prope judgement of the c R228 quarterly Min 7/28/17, indicated I	ated, EZ way, Inc. smart stand ng guidelines document ding system, separating ifferent colored binding on the colored represent a size 90-220 pounds, 34-46 inches f patient's torso where harness art indicates the size/weight of merely estimates and basic er fit would involve the aregiver. himum Data Set (MDS) dated R228 had severe cognitive quired assist of two for					
	dementia with Lew	dicated diagnoses included y Bodies, Parkinson disease, orthostatic hypotension, and lisorder.					
	R228 required assi impaired mobility re	rision dated 8/19/17, indicated ist with transfers due to elated to Parkinson disease. ected staff "transfers with assist t."					
		ed nursing assistant care //17, indicated for R228 "					
	6:44 p.m. indicated EZ stand lift, R228 hold on to the bar of lowered R228 to th staff assisted R228 mechanical lift. The	brogress note dated 8/19/17, at I while transferring R228 with became weak and unable to of the lift and nursing staff e ground by his arms. Three B to bed utilizing a (EZ lift) full e note indicated the EZ lift or R228 and an order obtained					

Minneso	ta Department of He	ealth				APPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			SURVEY PLETED
		00164	B. WING		08/2	24/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE		ST 14TH STR POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 34	2 830			
	for evaluation of th	e lift for R228.				
	nurses aide (NA)-C an EZ stand down room. NA-O verbal use the EZ stand to chair to his bed. Na sling under R228 to forward so can get arm is on right." Na EZ stand handles of feet onto stand to to wheelchair to his b with transfer from of was lowered to on minute." R228 lea removed from the	tion on 8/24/17, at 1:14 p.m. D and nurses aide (NA)-P rolled the hallway and entered R228 Ily cued R228 she was going to o transfer him from his wheel A-O and NA-P placed an EZ back and cued R228 "lean sling behind you, your weaker A-O cued R228 to hold onto with his arms. NA-O placed his transfer R228 from his red. NA-O and NA-P continued wheelchair to the bed. As R228 edge of bed he said "wait a ned to right side as legs EZ stand. NA-O and NA-P o onto the bed and positioned				
	clinical manager (C recent accident wit R228 legs and arm him to safely be tra CM-A stated R228 been changed to u transfer. CM-A stat care plan changes careplan review an the NA-O and NA- EZ lift with R228. E , NA-O approached R228 was hollering strap between his I CM-A stated to NA transferred with the	v on 8/24/17, at 1:30 p.m. with CM)-A stated R228 had a th the EZ stand. CM-A stated as were not strong enough for ansferred with an EZ stand. B careplan interventions had se of a EZ lift to ensure a safe ted staff were made aware of through shift communication, and aid care sheets. CM-A stated P should have been using the During the interview with CM-A d the desk area and stated g and said he didn't want a legs so she used an EZ stand. -O, he was supposed to be a EZ lift. NA-O did not respond.				
nnesota De	During an interviev	v on 8/24/17, at 3:59 p.m. with				
ATE FORM	-		6899 N	<i>I</i> /4PX11	If continuation	on sheet 35 of

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00164	B. WING		08/24/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
AUGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 35	2 830			
	had been updated used as R228 had and was not safe to stated staff had be and were provided R224's quarterly M 7/15/17, identified and had diagnoses disease, schizophr MDS identified R22 activities of daily liv staff assistance wij personal hygiene.	(DON) stated R228 care plan on 8/19/17 for an EZ lift to be weakness in arms and legs o use on a EZ stand. DON also en informed of the changes education. linimum Data Set (MDS) dated R224 was cognitively intact s which included: Parkinson's renia and hypertension. The 24 was independent with all <i>v</i> ing (ADL's.) except required th dressing, toilet use and The MDS identified R70 indently and required a walker				
	identified R224 am of a walker. The c fatigue with distance staff and visitors to walker and was no plan directed staff self performance v indicated R224 wa and did not use a v plan further instruc- total assist to prop- depending on weal R224 was at risk for disease effects, us use of a devise and behavior related to	evised 8/21/17, at 8:03 p.m. abulated independently with use are plan indicated R224 had be at times, would often ask o push him on the seat of the t easily re-directed. The care to assist R224 if a decline in was noted. The care plan s independent with transfers wheelchair regularly. The care ted staff to use extensive to el R224's wheelchair kness. The care plan identified or falls related to Parkinson's se of antihypertensive meds, d the potential for unsafe schizophrenia. The care plan courage and remind R224 to 4 wheeled walker.				
		ed nursing assistant care 24 was ambulatory and used a				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00164	B. WING		08/	8/24/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
AUGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLE THE APPROPRIATE DATE		
2 830	Continued From pa	age 36	2 830				
	The sheet further in independent with tr instructed staff to o	and wheelchair as needed. ndicated R224 was ransfers. The care sheet offer use of wheelchair for came weak or had an					
	seated on the benc the hallway near th assistant (NA)-F pu hall. NA-F pushed the walker while he approximately 50 fe desk to the table in the common sitting	9 p.m. R224 was observed ch of his 4 wheeled walker in e nurses station, while nursing ushed R224's walker down the R224, seated on the bench of a faced backwards, eet from the nursing station the dining room located past a area. R224 stood up and chair at the dining room table.					
	transported R224 u wheeled walker. N requested her to pu because he felt we transported R224 u wheeled walker eve and verified the nur indicated R224 utili	p.m. NA-F confirmed she had utilizing the bench of his IA-F indicated R224 had ush him to the dining room ak. NA-F indicated she utilizing the bench of his ery 2-3 weeks. NA-F visualized rsing assistant care sheet that ized a 4 wheeled walker and to be used as needed.	1				
	verified she was pr when she observed the nursing station verified NA-F push bench of his 4 whe she told NA-F not t on his walker, but c indicated she had i residents while the	4 p.m., clinical manager (CM)- resent at the nursing station d NA-F transport R224 from to the dining room. CM-A ed R224 while he sat on the eled walker. CM-A indicated to transport R224 while he sat did not intervene. CM-A nstructed staff not to transport y sat on the bench of their licated R224 at times the staff					

United     B. WING     OB/24/2017       VAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     1007 EAST 14TH STREET MINNEAPOLIS, MN 55404       (X4) ID PREFIX     SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION)     PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFIX PREFIX     PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH ODENCE WILL BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFIX PREFIX     CONFICT WASTING INFORMATION     COMPLET       2 830     Continued From page 37     2 830     2 830     Construction of the appropriate DEFICIENCY)     COMPLET       2 830     No 8/23/17, at 8:17 a.m. R224 indicated he was able to ambulate independently with his 4 wheeled walker. R224 confirmed in the past staff had used the Rollator walker to transport him while he sat on the bench of the walker.     D n 8/23/17, at 9:00 a.m. director of rehab (DR)-A indicated she would not recommend a 4 wheeled walker to be used for transportation while a resident sat on the bench of a 4 wheeled walker she would intervene and stop them. DR-A indicated she would expect staff and residents would be educated to not use 4 wheeled walker she would intervene and stop them. DR-A indicated she would expect staff and residents would be educated to not use 4 wheeled walkers as a wheelchair for transportation.     In 8/23/17, at 9:10 a.m. director of nursing (DON) confirmed she had been made aware staff had utilized R224's walker to transport him in the facility. DON indicated she would expect staff     In 8/23/17, at 9:10 a.m. director of nursing (DON) confirmed she had been made aware staff had utilized R224's w	STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
<b>AUGUSTANA HEALTH CARE CENTER OF MINI 1007 EAST 14TH STREET</b> MINNEAPOLIS, MN 55404         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTIVE ACTION RECTION (EACH CORRECTIVE ACTION ACTION OF LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY)       (x5) OCMPLET         2 830       Continued From page 37 would use a wheelchair to transport R224.       0       2 830       2 830         On 8/23/17, at 8:17 a.m. R224 indicated he was able to ambulate independently with his 4 wheeled walker. R224 confirmed in the past staff had used the Rollator walker to transport him while he sat on the bench of the walker.       0       0 n 8/23/17, at 9:00 a.m. director of rehab (DR)-A indicated she would not recommend a 4 wheeled walker to be used for transportation while a resident sat on the bench. DR-A indicated that if she witnessed a staff member pushing a resident while they sat on the bench of a 4 wheeled walkers as a wheelchair for transportation.       DR-A indicated she would expect staff and residents would be educated to not use 4 wheeled walkers as a wheelchair for transportation.       DN 8/23/17, at 9:10 a.m. director of nursing (DON) confirmed she had been made aware staff had utilized R224's walker to transport him in the			00164	B. WING		08/	24/2017
Add USINA HEALTH CARE CENTER OF MINI     MINNEAPOLIS, MN 55404       Image: Constraint of the submark of the DEFICIENCIES (EACH DEFICIENCY)     ID     PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (SP) (CONFURENT OF DEFICIENCIES)     ID     PREFIX TAG     COMPLET     PREFIX TAG     PREFIX TAG     PREFIX TAG     PREFIX TAG     PREFIX TAG     COMPLET     PREFIX TAG	NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
(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 CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE       CMPLET DEFICIENCY         2 830       Continued From page 37 would use a wheelchair to transport R224.       2 830       2 830         On 8/23/17, at 8:17 a.m. R224 indicated he was able to ambulate independently with his 4 wheeled walker. R224 confirmed in the past staff had used the Rollator walker to transport him while he sat on the bench of the walker.       0 0 8/23/17, at 9:00 a.m. director of rehab (DR)-A indicated she would not recommend a 4 wheeled walker to be used for transportation while a resident sat on the bench. DR-A indicated that if she witnessed a staff member pushing a resident while they sat on the bench of a 4 wheeled walker sa a wheelchair for transportation.       DR - 8/23/17, at 9:10 a.m. director of nursing (DON) confirmed she had been made aware staff had utilized R224's walker to transport him in the	AUGUST	ANA HEALTH CARE					
<ul> <li>would use a wheelchair to transport R224.</li> <li>On 8/23/17, at 8:17 a.m. R224 indicated he was able to ambulate independently with his 4 wheeled walker. R224 confirmed in the past staff had used the Rollator walker to transport him while he sat on the bench of the walker.</li> <li>On 8/23/17, at 9:00 a.m. director of rehab (DR)-A indicated she would not recommend a 4 wheeled walker to be used for transportation while a resident sat on the bench. DR-A indicated that if she witnessed a staff member pushing a resident while they sat on the bench of a 4 wheeled walker she would expect staff and residents would be educated to not use 4 wheeled walkers as a wheelchair for transportation.</li> <li>On 8/23/17, at 9:10 a.m. director of nursing (DON) confirmed she had been made aware staff had utilized R224's walker to transport him in the</li> </ul>	PRÉFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO	FION SHOULD BE THE APPROPRIATE	COMPLET
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<ul> <li>able to ambulate independently with his 4</li> <li>wheeled walker. R224 confirmed in the past staff</li> <li>had used the Rollator walker to transport him</li> <li>while he sat on the bench of the walker.</li> <li>On 8/23/17, at 9:00 a.m. director of rehab (DR)-A</li> <li>indicated she would not recommend a 4 wheeled</li> <li>walker to be used for transportation while a</li> <li>resident sat on the bench. DR-A indicated that if</li> <li>she witnessed a staff member pushing a resident</li> <li>while they sat on the bench of a 4 wheeled walker</li> <li>she would intervene and stop them. DR-A</li> <li>indicated she would expect staff and residents</li> <li>would be educated to not use 4 wheeled walkers</li> <li>as a wheelchair for transportation.</li> <li>On 8/23/17, at 9:10 a.m. director of nursing</li> <li>(DON) confirmed she had been made aware staff</li> <li>had utilized R224's walker to transport him in the</li> </ul>		would use a wheel	chair to transport R224.				
		able to ambulate in wheeled walker. Ri had used the Rolla while he sat on the On 8/23/17, at 9:0 indicated she woul walker to be used in resident sat on the she witnessed a st while they sat on the she would interven indicated she woul would be educated as a wheelchair for On 8/23/17, at 9:10 (DON) confirmed shad utilized R224's	adependently with his 4 224 confirmed in the past staff tor walker to transport him bench of the walker. 0 a.m. director of rehab (DR)-A d not recommend a 4 wheeled for transportation while a bench. DR-A indicated that if aff member pushing a resident be bench of a 4 wheeled walke e and stop them. DR-A d expect staff and residents I to not use 4 wheeled walkers r transportation. 0 a.m. director of nursing she had been made aware staff walker to transport him in the	r			
		be used as a whee to tip-over, resultin	elchair. Doing so may cause it g in injury.				
Medical Rollator revealed Rollators are NOT to be used as a wheelchair. Doing so may cause it to tip-over, resulting in injury.		directed staff to ch damaged parts and was not ripped or f	eck for loose nuts and bolts, d to check the sling to ensure it rayed. The policy did not				
be used as a wheelchair. Doing so may cause it			ent Prevention and Reduction 7 indicated the facility was				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00164	B. WING		08/	24/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
AUGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC <sup>1</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	committed to provid residents, and wou to assist in the iden analysis of risk fact need for supervisio or individual resident resident's environm and hazards as pos receives adequate devices to prevent SUGGESTED MET The director of nurs all residents that ut ensure they are use of nursing or design audits of the delive appropriate care ar	ding a safe environment for ld use a systematic approach atification, evaluation and cors in the environment and in for either groups of resident nts with the goal that: each ment remain as free of accident ssible and each resident supervision and assistive	2 830			
2 910	Incontinence Subp. 5. Incontinen- have a continuous management to rec- unnecessary use o comprehensive res- home must ensure A. a resident w without an indwellir unless the resident that catheterization B. a resident w receives appropriat	5 Subp. 5 A.B Rehab - nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: tho enters a nursing home ng catheter is not catheterized 's clinical condition indicates was necessary; and ho is incontinent of bladder te treatment and services to ct infections and to restore as	2 910			10/12/17

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED
		00164	B. WING		08/	24/2017
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
UGUST	ANA HEALTH CARE	CENTER OF MINI	ST 14TH STA POLIS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 910	Continued From pa	age 39	2 910			
	much normal blado	der function as possible.				
	by: Based on observat review, the facility f bowel and bladder toileting program to and bladder to the residents (R338) w assistance with toil language barrier. F	ent is not met as evidenced ion, interview, and document failed to accurately assess patterns and implement a prestore continence of bowel extent possible for 1 of 1 who was not being provided eting routinely due to a R338 sustained harm due to ease in bowel and bladder		Corrected		
	Findings include:					
	dated 2/5/17, ident which included arth and unspecified un indicated R338 had memory problems, cognitive skills for of preferred language wanted an interpre or health care staff R338 required exter mobility, dressing, did not ambulate. F R338 was frequent	Minimum Data Set (MDS) ified R338 had diagnoses pritis, chronic pain syndrome, rinary incontinence. The MDS d both short and long term had moderately impaired daily decision making, her e was Somali and needed or ter to communicate with docto . The MDS also indicated ensive assistance for bed toileting, personal hygiene and Further, the MDS indicated ty incontinent of urine and on a toileting program.				
	2/9/17, indicated R incontinence with s	Assessment (CAA) dated 338 had bowel and bladder come control and history of e. Contributing factors included				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
AUGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 910	Continued From pa	age 40	2 910			
	mobility related to extremity wounds we use of narcotics, a barrier. Staff were rising, before and a rounds and as nee was not consistent needed to be chan with peri care with R338's quarterly M R338 was moderate extensive assistan transfers and exten dressing, toileting a MDS also indicated incontinent of urine and had no toileting R338's quarterly M	IDS dated 5/8/17, indicated tely impaired, needed ce of two staff for bed mobility, nsive assistance of one staff fo and personal hygiene. The d R338 was frequently and always continent of bowe g program. IDS dated 8/5/17, indicated	r			
	extensive assistan activities of daily liv R338 was occasion	r impaired cognition, needed ce of one staff for all of her ring. The MDS also indicated nally incontinent of urine and ent of bowel and had no				
	8/22/17, indicated bowel and bladder of stress incontiner included: dementia related to weakness	current care plan revised on R338 had incontinence of with some control and history nce. Contributing factors a, obesity, impaired mobility ss, right lower extremity				
	anti-depressants a confusion she is no know she needs to the bedpan. The ca	mia, use of narcotics, nd language barrier. Related to ot consistent with letting staff be changed or when to use are plan listed various as: check and change upon				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
AUGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 910	Continued From pa	age 41	2 910			
	rounds and as nee confused, peri care and needed extens depending on cogr listed on how to co regarding the languincontinence or toil Review of R338's NA (nursing assista was max for toiletin calls for assistance was continent of bo occasional incontir incontinent brief. N how to communication	after meals, before bed, night ded, offer bed pan when not es with incontinence episodes, sive assist of one or two staff nition. No interventions were mmunicate with R338 uage barrier and her leting needs. Transitional Care Plan for the ant) undated, indicated R338 ng assistance and resident e. The sheet indicated R338 owel and bladder with hence of bladder and wore a lo interventions were listed on the with R338 regarding the nd her incontinence or toileting				
	R338 wore a hospi of her bed with her (NA)-G entered R3 light and asked R3 proceeded to repeatedly tapped NA-G stated she w R338 was trying to repeat the foreign of her hands out in R338 extended her front of her groin w sound repeatedly. "sheeeew" sounds NA-G exited the ro		1			
	R338 wanted, but t	stated she did not know what thought she was having pain. he here speaks this language,				

ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00164	B. WING		08/	24/2017
PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
ANA HEALTH CARE					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLETE DATE
it's very hard, I don indicated she was a facility who spoke F hard to communicat gestures or mover gestures and move to communicate wi when working with At 9:02 a.m. R338 bed, and R338's ca began to speak for fast to registered n entered her room a left hand on the left continued to repeat angry, frustrated vo hands out in front F extended her finge of her groin while n repeatedly. R338 o the "sheeeew" sour repeatedly if she w appeared to get m in her foreign langu her uneaten food it waved her left arm her head. NA-G sta she wants."	't understand her." NA-G not aware of anyone in the R338's language and felt it was the with R338 utilizing hand nents. NA-G indicated the hance ements staff utilized to attempt th R338 were not effective R338. was seated on the edge of her all light was again on. R338 eign words repetitively very urse (RN)-A and NA-G as they at that time. R338 tapped her t side of her thigh area and t foreign words in a very fast, pice. She placed both of her ner, spread her legs and rs open and arms out in front naking a "sheeeew" sound continued to gesture and make nd while RN-D asked her as having pain. R338 ore frustrated, talking very fast tage. NA-G asked R338 about ems on her room tray, R338 towards the door and shook ated she was "not sure what appear upset, talking very e and proceeded to whimper, h, huh, huh" repeatedly. RN-D				
	T OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER ANA HEALTH CARE SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Continued From pa it's very hard, I don indicated she was n facility who spoke F hard to communicat gestures or mover gestures and move to communicate wi when working with At 9:02 a.m. R338 bed, and R338's ca began to speak for fast to registered n entered her room a left hand on the left continued to repeat angry, frustrated vo hands out in front h extended her finge of her groin while n repeatedly. R338 out the "sheeeew" sour repeatedly if she wa appeared to get m in her foreign langu her uneaten food it waved her left arm her head. NA-G sta she wants."	TOF DEFICIENCIES OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         00164       00164         ROVIDER OR SUPPLIER ANA HEALTH CARE CENTER OF MINI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 42         it's very hard, I don't understand her." NA-G indicated she was not aware of anyone in the facility who spoke R338's language and felt it was hard to communicate with R338 utilizing hand gestures or movements. NA-G indicated the hand gestures and movements staff utilized to attempt to communicate with R338 were not effective when working with R338.         At 9:02 a.m. R338 was seated on the edge of her bed, and R338's call light was again on. R338 began to speak foreign words repetitively very fast to registered nurse (RN)-A and NA-G as they entered her room at that time. R338 tapped her left hand on the left side of her thigh area and continued to repeat foreign words in a very fast, angry, frustrated voice. She placed both of her hands out in front her, spread her legs and extended her fingers open and arms out in front of her groin while making a "sheeeew" sound repeatedly. R338 continued to gesture and make the "sheeeew" sound while RN-D asked her repeatedly if she was having pain. R338 appeared to get more frustrated, talking very fast in her foreign language. NA-G asked R338 about her uneaten food items on her room tray, R338 waved her left arm towards the door and shook her head. NA-G stated she was "not sure what she wants."         R338 continued to appear upset, talking very rapid in a loud voice and proceeded to whimper, cry and stated, "huh, huh, huh" repeatedly. RN-D indicated she was unsure, but felt R338 may	TOF DEFICIENCIES OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE A. BUILDING:         O0164       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, S         ANA HEALTH CARE CENTER OF MINI       1007 EAST 14TH STRE MINNEAPOLIS, MN 55         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 42       2 910         Continued From page 43       2 910         Continued From page 42       2 910         It's very hard, I don't understand her." NA-G indicated she was not aware of anyone in the facility who spoke R338's language and felt it was hard to communicate with R338 utilized to attempt to communicate with R338 usere not effective when working with R338.         At 9:02 a.m. R338 was seated on the edge of her bed, and R338's call light was again on. R338 began to speak foreign words repetitively very fast to registered nurse (RN)-A and NA-G as they entered her room at that time. R338 tapped her left hand on the left side of her thigh area and continued to repeat foreign words in a very fast, angry, frustrated voice. She placed both of her hands out in front her, spread her legs and extended her fingers open and arms out in front of her groin while making a "sheeeew" sound repeatedly. R338 continued to gesture and make the "sheeeew" sound while RN-D asked her repeatedly. R338 continued to gesture and make the "sheeeew" sound while RN-D asked her repeatedly. R338 continued to appear upset, talking very rapid in a loud voice and proceeded to whimper, cry and stated, "huh, huh, huh" repeatedly. RN-D indic	TOF DEFICIENCIES OF CORRECTION       (X1) PROVIDER/SUPPLIER/LIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING:         00164         STREET ADDRESS, CITY, STATE, ZIP CODE         1007 EAST 14TH STREET MINNEAPOLIS, MN 55404         ROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         1007 EAST 14TH STREET MINNEAPOLIS, MN 55404         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PROCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PROVIDERS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PROCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         STREET ADDRESS, CITY, STATE, ZIP CODE         OUTON         Continued From page 42       2 910         Continued To may any 838 was colspan="2">Continue to many any 838<	TOF DEPRICENCIES       (X1) PROVIDERSUPPLIERCIAL       (X2) MUTIFILE CONSTRUCTION       (X3) DATA         OPF CORRECTION       00164       B. WING       08/         INCURPT       OD164       B. WING       08/         INCURPT       STREET ADDRESS, CITY, STATE, ZIP CODE       1007 EAST 14TH STREET       1007 EAST 14TH STREET         INNEAPOLIS, MN 55404       STREET ADDRESS, CITY, STATE, ZIP CODE       1007 EAST 14TH STREET       1007 EAST 14TH STREET         INNEAPOLIS, MN 55404       SIMMARY STATEMENT OF DEFICIENCES       ID       PROVIDER'S PLAN OF CORRECTION         IEAOH CORRECTIVE ACTION NUMBER:       ID       PREPARATION NUMBER:       IEAOH CORRECTIVE ACTION STATE         ISUMMARY STATEMENT OF DEFICIENCES       ID       PREPARATION NUMBER:       IDEFICIENCES       IDEFICIENCES         SUMMARY STATEMENT OF DEFICIENCES       ID       PREPARATION       IEAOH CORRECTIVE ACTION PROPERIATE         Continued From page 42       2 910       IS       IEAOH CORRECTIVE ACTION PROPERIATE         Continued From page 43       ID       IDEFICIENCES       IDEFICIENCES         What O communicate with R338 tilligh pand       gestures and movements staff utilized to attempt       IDEFICIENCY         ID       ID       ID       ID       ID       ID         Weat, and TS38's call light was again on. R338 </td

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00164	B. WING		08/	24/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
AUGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	age 43	2 910			
	out of the way of the the bedpan placed proceeded to void of of urine. R338's dist Review of R338's and Assessment, dated short term memory need or urge to void was able to use the toilet sometimes, and incontinence. The and had incontinence of episodes with positi indicated R338 had recent surgery, obe assistance to trans incontinent of bowe irregularity, loose s constipation and was had urgency. The and documentation was voiding pattern and The analysis of the had confusion, was staff know she nee be on a check and before and after me rounds and as need.	by moving her hospital gown e bedpan. At 9:05 a.m., with under her buttocks, R338 on the bedpan a large amount sposable brief was dry. admission Bowel and Bladder d 2/9/17, indicated R338 had r loss, was able to identify the d/defecate some of the time, e call light, ask to go to the nd had been admitted with assessment indicated R338 f bladder, had incontinence tion changes. The assessment d diagnoses which included esity, edema and required fer. Further, R338 was el, had no problem with pattern tools or diarrhea or as functionally disabled and assessment indicated R338 ctional incontinence. The s blank regarding R338's 3 day I for the 3 day bowel pattern. assessment indicated R338 s not consistent with letting ded to be changed and was to change program, upon arising eals, before bed, with night ded and wore a brief.				
	short term memory to urge to void/defe use call light, able t assessment indicat	4/28/17, indicated R338 had r loss, able to identify the need ecate all of the time, able to to ask to go to the toilet. The ted R338 was incontinent of now long resident has been				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00164	B. WING		08/	24/2017
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
UGUST	ANA HEALTH CARE		ST 14TH STRE	ET		
		MINNEA	POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	age 44	2 910			
	coughing, changing exercise. The asset continent of bowel, constipation proble symptoms affecting Further, the assess assistance with am adaptive equipment elimination patterns assistance, resider patterns of urinary hours, was able to a shifts and had prob assessment indica incontinence (decrease unwillingness). R33 scheduled toileting impaired, functionat dependent. The eli and change due to retraining to return to feel sensation, a inhibit urge, toilets assist and prompt toilet (however a re continence was ne included for R338 to commode for voidit for bowel movement Review of R338's E Assessment, revier bladder and bowel effective and no ch current plan of care	sed or loss mobility or persona 38's elimination plan was due to being cognitively al disabilities and care giver mination plan included: Check cognitive impairment, to previous pattern due to able able to understand and learn to independently or with minimal voiding due to able to request etraining program to improve ver implemented). The plan to utilize the bedpan or ng and to use the commode nts and wore a brief. Bowel and Bladder Quarterly wed on 5/4/17, indicated the management programs were hanges were needed to the				
		Bowel and Bladder Quarterly wed on 7/13/17, indicated				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00164	B. WING		08/	24/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
AUGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 910	Continued From pa	age 45	2 910			
	current bowel and	ent of bladder and bowel, the bladder plan was effective and y changes to the current plan o				
	Center physician p dated 4/18/17, from indicated "nursing continent of bowel	Hennepin County Medical rogress notes revealed a note n the nurse practitioner which assistants report the patient is and bladder and is utilizing a onally utilizing commode."				
	stated in the past w facility to visit R338 stated he was awa void or have a bow left on the bedpan FM-A indicated he R338's elimination had been told the s R338. FM-A indica	B p.m. family member (FM)-A when family have come to B, she had been crying. FM-A re R338 had attempted to not rel movement, to avoid being for extended periods of time. had reported the concerns with needs, to nursing staff and staff do not have time to assist ted he had posted a note on ff to utilize to call him to help 338.				
	difficult to commun language barrier at few words such as primary language.	a.m. RN-D indicated it was licate with R338 due to the nd indicated she only knew a medication, pain in R338's RN-D indicated she had son when she was not sure I or wanted.				
	the interpreter and not communicate w with that sometime had been left on th the past, she had t	20 p.m. during interview with R338, R338 stated she could with staff and her son helps es. R338 indicated because she e bedpan without assistance in ried not to go to the bathroom that from happening again.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00164	B. WING		08/	24/2017
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
UGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 910	Continued From pa	age 46	2 910			
	bedpan and stated sometimes made h if she was able to o care would be bette welcome staff help then they just leave and indicated she h education when sh blamed herself and learning the langua isolated, could not because staff could they were unable to the interpreter, R33 receive assistance and bursting. R338 her room in the pas communication, ho	t due to avoiding use of the it made her feel bad, her cry. R338 indicated she felt communicate with staff, her er. R338 indicated she would , but staff comes in her room, e without providing assistance felt regret not getting the he was younger and stated she d people before her for not age. R338 indicated she felt get up on her own, and stated d not communicate with her, o help her. Through the use of 38 stated when she did not at times she felt like exploding B indicated she had pictures in st for assistance with owever, the pictures were no and was not aware where the				
	used communication but R338 was not a stated, "So did not stated it was easer communication and indicated the usual something, she wo son would call the R338 wanted or ne	S a.m. RN-G indicated staff had on cards with words on them, able to read the cards and really work that well." RN-G to have staff to assist with d to translate for her. RN-G practice if R338 needed udd call her son and then her desk to let staff know what preded assistance with. She preter hot line information				

NU PLAN (	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	` ´ · ·	ESURVEY
		IDENTIFICATION NUMBER.	A. BUILDING: _		COM	PLETED
		00164	B. WING		08/24/2017	
AME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
UGUSTA	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	ge 47	2 910			
	R338 and stated, "I communication."	don't think the problem is				
	interview, FM-A ind continent of bowel a sick and was only in when she was sick. not respond to R33 the bed and stated,					
	able to speak the s R338. She indicate her hip when she h stated other staff th but R338 used thes to go to the bathroo assistance with toild utilized the call light indicated she was a incontinence with b staff who do not un cared for her. NA- R338, she was con but when staff who communicate with I R338 wore a brief. reported she was a incontinence episod aware the interprete when R338 had sch appointments. NA-	her provided cares for R338, She indicated R338 had fraid she would have des. NA-J indicated she was er only came to the facility	1			
		a.m. NA-K stated she was				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00164	B. WING		08/24/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
UGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 910	Continued From pa	age 48	2 910			
	R338. NA-K verifie with toileting, used use the call light. N continent of bowel R338 will have inco assisting her with to what R338 needed of the staff did not verified R338 has h not understanding and stated, "she has NA-K indicated R33	ame language (Somali) as d R338 needed assistance the bedpan and was able to IA-K confirmed R338 was and bladder. NA-K indicated ontinence if staff were late oileting and not understanding I. NA-K indicated she felt a lot know what R338 wanted and had incontinence due to staff what she is trying to tell them as not had accidents for me." 38 was able to communicate etty pleasant, cooperative with efuse cares.				
	(DON) confirmed F stated she expected plan, staff to assist needs consistently. expect staff to assist continent, help the call lights. DON incomparing barrier due to not s expect staff to call available, or use pi She stated all staff interpreter services utilize the resource with R338. The DO	B3 p.m. director of nursing R338's current care plan and ed staff to follow R338's care as needed, and meet her . DON indicated she would st the resident to stay resident with cares, answer dicated R338 had a language speaking English and would an interpreter, family if cture cards or online service. had access to the online s and she would expect staff to as available to communicate DN indicated she was not erns with R338's language				
	Programming/Toile indicated the facility					

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00164	B. WING		08/2	24/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE		ST 14TH STR POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	SUGGESTED MET The director of nurs all residents at risk assure they are rec treatment/services	THOD OF CORRECTION: sing or designee, could review for urinary incontinence to reiving the necessary to prevent urinary tract store as much normal bladder	2 910			
	function as possibl designee, could con delivery of care to e services are impler	e. The director of nursing or nduct random audits of the ensure appropriate care and				
2 915	Subp. 6. Activities comprehensive res home must ensure A. a resident is treatments and ser abilities in activities deterioration is a not the resident's cond part, activities of da resident's ability to: (1) bathe, dres (2) transfer an (3) use the toil (4) eat; and (5) use speec	given the appropriate vices to maintain or improve of daily living unless ormal or characteristic part of ition. For purposes of this ily living includes the ss, and groom; d ambulate;	2 915			10/12/17
Minnesota Do	This MN Requirem	ent is not met as evidenced				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00164	B. WING		08/24/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
	ANA HEALTH CARE		ST 14TH STR	REET		
400051		MINNEA	POLIS, MN 5	5404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 915	Continued From pa	age 50	2 915			
	review, the facility f communication ser living to ensure bas resident (R338) wit deficient practice re for R338, who expe emotional distress her basic needs we	ion, interview and document ailed to provide sufficient vices for activities of daily sic needs were met for 1 of 1 h a language barrier. This esulted in psychosocial harm erienced isolation and related to incontinence when ere unable to be met due to unication with facility staff.		Corrected		
	Findings include:					
	dated 2/5/17, identi which included arth and unspecified ur indicated R338 hac memory problems, cognitive skills for of preferred language wanted an interpret or health care staff. R338 required exte mobility, dressing, t did not ambulate. F R338 was frequent	Minimum Data Set (MDS) fied R338 had diagnoses pritis, chronic pain syndrome, inary incontinence. The MDS d both short and long term had moderately impaired daily decision making, her was Somali and needed or ter to communicate with doctor . The MDS also indicated ensive assistance for bed toileting, personal hygiene and further, the MDS indicated ly incontinent of urine and on a toileting program.				
	2/9/17, indicated R Somali and family r times R338 though listed various caus which included cult recognizing caregiv risk factors included	Assessment (CAA) dated 338's primary language was reported confusion and at t she was in Africa. The CAA ses and contributing factors ural/language barrier, not vers or medical equipment and d social isolation, confusion, s and participation in rehab				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED	
		00164	B. WING		08/	08/24/2017	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
UGUST	ANA HEALTH CARE	CENTER OF MINI	ST 14TH STRE POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 915	Continued From pa	age 51	2 915		,		
2 915	control, history of s was not consistent needs to be change communication did addressed on the C R338's quarterly M R338 had severely preferred language wanted an interpre- or health care staff required extensive daily living (ADL). T was occasionally in	not trigger and was not	r				
	listed the problem of adequate, and indi- understood through directed staff to rep communicate, undo- hear and to refer for R338's care plan io language was Som weakness, dement assistance with bed assist to lift legs in/ in bed. R338's care simply and clearly a environmental cues communicate at ey explain cares/treatin needed and consis cares. The care pla opportunity for patie	e plan, revised on 8/22/17, of communication, hearing was icated R338 made herself in an interpreter. The care plan port any changes in ability to erstand others, or in ability to or hearing exam as needed. dentified R338's primary hali, had frequent pain, ita, required extensive d mobility, boost up in bed, fout of bed, and sitting position e plan directed staff to speak and repeat as needed, utilize is as calendars, clocks, notes, re level and establish calm, ments before beginning and as itent routine when providing an directed to provide ent to express feelings, involve needed, encourage resident to	3				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00164	B. WING		08/	08/24/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
AUGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55				
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 915	Continued From pa	ige 52	2 915				
	practitioner/physicia upon request. No fu were listed to effect	eter for rehab therapies, nurse an visits, care conferences and urther care plan interventions tively communicate with R338, s to use to communicate with					
	listed various interv assistance with AD	Indated Transitional Care Card rentions which included Ls, however, the care card itions for R338's language					
	R338 wore a hospit of her bed with her (NA)-G entered R3 light and asked R33 proceeded to repeat repeatedly tapped H NA-G stated she w R338 was trying to repeat the foreign w of her hands out in R338 extended her front of her groin w sound repeatedly.	s on 8/23/17, at 8:56 a.m. tal gown, seated on the edge call light on. Nursing assistant 38's room, deactivated the call 38 what she needed. R338 at foreign words, and her thigh with her left hand. as unable to understand what tell her. R338 continued to words, proceeded to place both front her, and spread her legs. fingers open and arms out in hile making a "sheeeew" R338 continued make the and gestures for NA-G until om at 8:59 a.m.					
	R338 wanted, but the She stated, "No one it's very hard, I don' indicated she was refacility who spoke F hard to communicate gestures or movem gestures and move	stated she did not know what hought she was having pain. e here speaks this language, 't understand her." NA-G not aware of anyone in the R338's language and felt it was the with R338 utilizing hand thents. NA-G indicated the hand ments staff utilized to attempt th R338 were not effective					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00164	B. WING		08/24/2017		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
AUGUST	ANA HEALTH CARE	CENTER OF MINI	ST 14TH STRE POLIS, MN 55				
(X4) ID PREFIX TAG			SUMMARY STATEMENT OF DEFICIENCIES ID PROVID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COI		PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 915	Continued From page 53		2 915				
	when working with	R338.					
	began to speak for fast to registered n entered her room a left hand on the lef continued to repea angry, frustrated vo hands out in front h extended her finge of her groin while n repeatedly. R338 of the "sheeew" soun repeatedly if she w appeared to get m in her foreign langu her uneaten food it waved her left arm	all light was again on. R338 reign words repetitively very jurse (RN)-D and NA-G as they at that time. R338 tapped her t side of her thigh area and t foreign words in a very fast, oice. She placed both of her her, spread her legs and rs open and arms out in front naking a "sheeeew" sound continued to gesture and make d while RN-D asked her vas having pain. R338 hore frustrated, talking very fast uage. NA-G asked R338 about tems on her room tray, R338 towards the door and shook ated she was "not sure what					
	rapid in a loud voic cry and stated, "hu indicated she was need to go to the b bedpan to the bed. to place the bedpa she removed R338 repeatedly moaned rapid, frustrated vo place the bedpan b out of the way of th placed under her b	appear upset, talking very ee and proceeded to whimper, h, huh, huh" repeatedly. RN-D unsure, but felt R338 may bathroom and brought a . RN-D proceeded to attempt n under R338's buttocks, while 3's disposable brief. R338 d, "uhhh, uhhh, uhhh" in a bice and frantically assisted to by moving her hospital gown he bedpan. With the bedpan buttocks, R338 proceeded to n a large amount of urine.					
	stated staff had a h	n 8/23/17, at 9:11 a.m. RN-D nard time knowing what R338					
nesota De	epartment of Health		6899 M	4PX11	lf continuati	on sheet 54 o	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00164	B. WING		08/	08/24/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
AUGUST	ANA HEALTH CARE	CENTER OF MINI	ST 14TH STRE POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 915	Continued From pa	age 54	2 915				
	staff have to guess	wanted when she called for assistance and stated staff have to guess a lot of the time and the resident got frustrated during that time.					
	Review of R338's progress notes from 5/1/17 to 8/21/17, revealed the following:						
	had moderately im moderate risk for n reported trouble fa trouble concentrati appetite. R338 did diagnoses, not reco medications, refuse	erpreter used for assessment, paired cognition and was at nood disturbance. R338 had lling asleep, feeling tired and ng because of pain and poor not have mental health eiving psychotropic ed psychiatric services referral. tial services would follow up led.					
	-5/7/17, alert and o interpreter, no Eng	rientated to facility, needs lish.					
		rence scheduled for that day, interpreter requested					
		se visited with patient, her son isit and R338 had no					
	patient's family thro discuss room trans	rvices met with patient and bugh phone interpreter to sfer. Patient and family reeable to transfer.					
	-7/24/17, R338 tran facility	nsferred to another unit in the					
	indicated that he is	rvice met with son and son present at most times but nterpreter be utilized for formal					

STATE FORM

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00164	B. WING		08/	24/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
AUGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 915	Continued From pa	age 55	2 915			
	assessments.					
	language barrier. S needs were not bei as she was not abl Facility staff sugger pictures as well as resident to use to o indicated he would implemented, and f flash cards and pro- -8/4/17, resident ur language barrier. F with communication communication by cards. No further d implementation of f of the flash cards o communication aid -8/10/17, R338 hos	flash cards, the effectiveness or any alternative les were found in the chart. spitalized at this time, social				
	service assessmer reported R338 had problems, had diffie daily decision maki symptoms of mood	nt done by staff interview. Staff no short or long term memory culty in new situations only with ing skills and minimal				
	to language and in	ability to understand. 3 p.m. family member (FM)-A				
	stated in the past w facility to visit R338 stated he was awa	when family have come to 8, she had been crying. FM-A re R338 had attempted to not rel movement, to avoid being				
	left on the bedpan FM-A indicated he	for extended periods of time. had reported the concerns with needs, to nursing staff and				

	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00164	B. WING		08/	08/24/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
UGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 915	Continued From pa	age 56	2 915				
	R338. FM-A indicat	staff do not have time to assist ted he had posted a note on if to utilize to call him to help R338.					
	difficult to commun language barrier ar few words such as primary language.	a.m. RN-D indicated it was icate with R338 due to the nd indicated she only knew a medication, pain in R338's RN-D indicated she had son when she was not sure or wanted.					
	interview with NA-C gestures to attempt and stated she was interventions to util R338. NA-G indicat the family member R338 needed assis had not utilized an	a.m. during a follow up G, she stated she used hand t to communicate with R338 s not aware of any other ize while communicating with ted in the past she had called to attempt to figure out what stance with. NA-G stated she interpreter in the past and was equest for or use needed S.					
	communication wa she pointed at obje when he was availa routine was to stan point until she figur	a.m. NA-H indicated s difficult with R338 and stated ects or had her son translate able. NA-H indicated her usual d in her room, have R338 red out what R338 needed or cated she had not utilized s with R338.					
	present in the build services were utiliz appointments with of any other time in	8 p.m. an interpreter was ling and he stated interpreter ed for scheduled medical residents and was not aware iterpreter services were utilized nterpreter indicated that day	k				

STATEMEN	DT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00164	B. WING		08/	24/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
AUGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 915	Continued From pa	age 57	2 915			
		-				
	the interpreter and not communicate w with that sometime had been left on the the past, she had tr so she could avoid R338 indicated she incontinent product bedpan and stated sometimes made h if she was able to o care would be bette welcome staff help, then they just leave and indicated she f education when she blamed herself and learning the langua isolated, could not because staff could they were unable to the interpreter, R33 receive assistance and bursting. R338 her room in the pas communication, ho longer in her room pictures were. On 8/23/17 at 12:22 interview, FM-A ind telephone numbers help with R338's la staff did not use the	20 p.m. during interview with R338, R338 stated she could with staff and her son helps s. R338 indicated because she e bedpan without assistance in ried not to go to the bathroom that from happening again. e had bowel movements in her due to avoiding use of the it made her feel bad, her cry. R338 indicated she felt communicate with staff, her er. R338 indicated she would , but staff comes in her room, e without providing assistance elt regret not getting the e was younger and stated she l people before her for not ge. R338 indicated she felt get up on her own, and stated a not communicate with her, o help her. Through the use of 88 stated when she did not at times she felt like exploding indicated she had pictures in st for assistance with wever, the pictures were no and was not aware where the 5 p.m. during second licated he posted a note with s to the wall in R338's room to nguage barrier, but the facility e telephone numbers. FM-A e facility staff R338 refused				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED	
		00164	B. WING		08/24/2017		
AME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55	ET			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 915	Continued From pa	age 58	2 915				
	R338 would call hin facility to get R338 stated he felt if R33 were offering, she indicated he felt the care had been com language barrier. FM-A indicated he assist R338 with to everything she nee ago, he had come been incontinent of had reported that s longer. FM-A indic concerns with the I facility staff many t he had suggested utilize pictures of v the Internet to use R338. FM-A stated "maybe once" and						
	edge of her bed, w left, and was obser telephone. Above t to R338's bed, a w approximately 8 ind the wall. On the pa	7 a.m. R338 was seated on the ith a cellular telephone in her ved to dial the cellular he night stand, which was next hite piece of paper, ches (in) by 11 in. was taped to per, typed in black ink, were itacting an online interpreter	t				
	R338's room and in	a.m. RN-G was present in ndicated staff had used rds with words on them, but					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
			-			
		00164	B. WING		08/2	24/2017
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
AUGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 915	Continued From pa	age 59	2 915			
	R338 was not able "so did not really w was easier to have communication and indicated the usual something, she wo son would call the of R338 wanted or ne confirmed the inter posted in R338's ro now. RN-G indicate assistance in time always continent of not aware of any co R338 and stated, " communication." On 8/24/17 at 9:43 interview, FM-A ind respond to her, she bed and stated "ha and holds it." He in assistance she woo FM-A stated the int	to read the cards and stated, ork that well." RN-G stated it				
	able to speak the s R338. She indicate her hip when she h stated other staff th	a.m. NA-J stated she was ame language (Somali) as ed R338 would point or slap ad to go to the bathroom. She nink this gesture was for pain				
	to go to the bathroo assistance with toil utilized the call ligh indicated she was	se gestures to indicate she has om. NA-J verified R338 needed eting, used the bedpan and t for assistance. NA-J aware R338 has had				
		oowel and bladder when other derstand what she wants				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00164	B. WING		08/	24/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
AUGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 915	Continued From pa	age 60	2 915			
	R338, she was cor but when staff who communicate with R338 wore a brief. reported she was a incontinence episo aware the interpret when R338 had sc appointments. NA- staff many times of language barrier, a hotline posted in R	J stated she had told nursing f her concerns with R338's and confirmed the interpreter 338's room was not present stated, "She did not have that				
	able to speak the s R338. NA-K verifie with toileting, used use the call light. N continent of bowel R338 will have inco assisting her with t what R338 needed of the staff did not verified R338 has h not understanding and stated "she ha NA-K indicated R3	7 a.m. NA-K stated she was same language (Somali) as d R338 needed assistance the bedpan and was able to IA-K confirmed R338 was and bladder. NA-K indicated ontinence if staff were late oileting and not understanding I. NA-K indicated she felt a lot know what R338 wanted and had incontinence due to staff what she is trying to tell them s not had accidents for me." 38 was able to communicate etty pleasant, cooperative with efuse cares.				
	confirmed R338 pr and indicated he w for R338 or use the had medical appoin his portion of the M	08 p.m. social worker (SW)-A imary language was Somali ould schedule an interpreter online service when R338 ntments or when he completed IDS. SW-A indicated the usual s to encourage R338 to use the				

TATEMENT (	Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00164	B. WING		08/24/2017	
AME OF PRO	OVIDER OR SUPPLIER		DDRESS, CITY, S	TATE. ZIP CODE		
	IA HEALTH CARE	1007 FAS	ST 14TH STRE			
UGUSTAN		MINNEA	POLIS, MN 55	404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 915 C	ontinued From pa	age 61	2 915			
bin phi in cloir R C(I si phi e cloir bie a S in u w a bia fatore a w T a m nt	e patient and expl dicated staff were lan and to utilize the aving trouble com- indicated he was no ommunicating with ther interventions 338 to effectively on 8/24/17, at 12:3 DON) confirmed F tated she expected lan, staff to assist eeds consistently. xpect staff to assist eeds consistently. xpect staff to assist ontinent, help the all lights. DON ind arrier due to not s xpect staff to call vailable, or use pic the stated all staff therpreter services tilize the resource ware of any conce arrier. The DON ind mitted who have acility practice was o all staff to notify esident's primary I vailable to assist. we have family to a he DON indicated n interpreter for the nedical appointme ot schedule any fune communication	her staff members, and staff to lain cares to her. The SW-A e expected to follow the care he online interpreter services if municating with R338. He ot aware of any problems h R338. SW-A confirmed no had been put in place to assist communicate with staff. B3 p.m. director of nursing R338's current care plan and ed staff to follow R338's care as needed, and meet her . DON indicated she would st the resident to stay resident with cares, answer licated R338 had a language peaking English and would an interpreter, family if cture cards or online service. had access to the online s and she would expect staff to s available to communicate DN indicated she was not erns with R338's language indicated when residents were anguage barriers, the usual s to send an email notification them of the individual anguage and if the family was She stated "90%" of the time accommodate for their needs. If the facility routinely scheduled interapy appointments and ents, and stated the facility did urther services unless they felt was unclear. The DON in came to the facility quite a lot				

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00164	B. WING	B. WING		08/24/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
UGUST	ANA HEALTH CARE	CENTER OF MINI	ST 14TH STRE POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 915	Continued From pa	age 62	2 915				
	with communication	n that impacted 338's care.					
	medical director (M if the facility had a hours a day. The M all residents would care to meet their r felt it was difficult for	3 p.m. during a phone interview 1D) indicated he was not aware ccess to an interpreter 24 1D indicated he would expect have ongoing assessment and needs and also indicated he or foreign speaking resident o not always tell staff the	9				
	Interpreter/Translat English Proficiency the interdisciplinary communication nee pre-admission, adm residents stay at the worker will arrange needs for resident. Center will be resp worker will write a p communication nee policy listed various used such as: univ communication boo	olicy titled, Communication: tion Services for limited y revised on 1/2016, indicated y team will assess residents eds/deficits upon mission and throughout the le care center. the social of for any on-going interpreter Augustana Health Care onsible for the charges. Social progress note describing eds and arrangements. The s auxiliary aids to be available ersal communication cards, ards and if additions aids are rdered in a prompt manner.					
	The director of nurs all residents that ne daily living with con they are receiving t treatment/services designee, could co	. The director of nursing or nduct random audits of the ensure appropriate care and	f				
	services are impler						

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X:	B) DATE SURVEY COMPLETED
		00164	B. WING		08/24/2017
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
UGUST	ANA HEALTH CARE		ST 14TH STR POLIS, MN 5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 915	Continued From pa	uge 63	2 915		
	(21) days				
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920		10/12/1
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,			
	by: Based on observat review the facility fa shaving for 1 of 3 re	ent is not met as evidenced ion, interview, and document ailed to provide assistance with esidents (R162) reviewed who tance to complete activities of		Corrected	
	Findings include:				
	7/14/17, indicated F included Alzheimer and chronic pain. T severely impaired c extensive assistance indicated R162 req	inimum Data Set (MDS) dated R162 had diagnoses which 's disease, psychotic disorder 'he MDS indicated R162 had cognition and required ce for dressing. The MDS uired set up help for al hygiene including shaving th bathing.			
	required hands on Alzheimer disease	ated 7/23/17, indicated R162 assistance at times due to for grooming and directed staff assist as needed for grooming.			
	Review of R162's n	ursing assistance care sheet,			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00164	B. WING	B. WING		24/2017
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
UGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE <sup>-</sup> DATE
2 920	Continued From pa	age 64	2 920			
	undated, identified R162 received assistance with her shower on Monday mornings.					
	wheelchair at dinin independently eatir several other resid	7 a.m. R162 was seated in her g room table. She was ng the breakfast meal, with ents present in the dining bted to have many long, under her chin.				
	her walker down th room. R162 was of white coarse hairs R162 remained in t	a.m. R162 ambulated with e hallway toward the dining oserved to have the same long under her chin. At 8:58 a.m., the dining room with the same chin hairs present.	,			
	nursing assistant (I many coarse, white stated the usual fac facial hair as part of R162's chin hair sh Monday with her ba hair was noticed or to be taken care of	v on 8/23/17, at 11:17 a.m. NA)-M confirmed R162 had e chin hairs present. NA-M cility practice was to remove of bathing cares. NA-M stated hould have been removed on ath. NA-A stated if long facial in a resident, the facial hair was right away. NA-A confirmed self, but staff assisted her as				
	licensed practical r always liked to look in the past. LPN-A	v on 8/23/17, at 11:49 a.m. with hurse (LPN)-A stated R162 had k nice. but had resisted cares stated R162 typically allowed approached her later.				
	indicated a body au R162. The form inc	Skin-Body Visual ation form, dated 8/21/17, udit had been completed for dicated various inspections ich as visualizing for new				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00164	B. WING		<b>08</b> /	24/2017
AME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, S			
UGUST	ANA HEALTH CARE		AST 14TH STRE APOLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	age 65	2 920			
		d indicated "resident emoved-No, not needed."				
	clinical manager (C was for all resident shower/bath, and e facial hair is remov	on 8/24/17, at 8:24 a.m. with CM)-A stated the expectation s to be checked with everyday with cares to ensure red. CM-A also stated she at the nurse know if a resident				
	Facility policy on gr was not provided.	rooming was requested but				
	The director of nur employees respons for residents the ne	THOD OF CORRECTION: sing could in-service all sible for providing direct cares eed to follow the residents re plan. Also to monitor for	3			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one	e			
21620	MN Rule 4658.134	5 Labeling of Drugs	21620			10/12/1
	Drugs used in the in accordance with	nursing home must be labeled part 6800.6300.	t			
	by: Based on observat review, the facility f was labeled with ad	ent is not met as evidenced ion, interview, and document failed to ensure medication ccurate directions for use for b) whose insulin was observed uring medication		Corrected		

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00164	B. WING		08/24/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
AUGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21620	Continued From pa	age 66	21620			
	Findings include:					
	2/23/18, identified I included diabetes r and kidney failure. for Humalog (insuli (milliliter) 12 units ( before breakfast, 1 units before dinner Humalog to be give	Order Report dated 8/23/17 to R323 had diagnoses which mellitus, Alzheimer's disease The report included an order in) solution 100 unit/ml (U) injected subcutaneously 4 units before lunch, and 10 . R323 had an order for en with a sliding scale that t units if blood sugar was 351 to	5			
	was observed to pr R323's insulin. RN Humalog insulin int 10 units for R323's because the physic	D p.m. registered nurse (RN)-E repare for administration of N-E had drawn 22 units of to the syringe. RN-E explained dinner dose and 12 units cian was called and did not than the current highest sliding nits.				
	medication contain with administration subcutaneous 3 tin sliding scale param blood sugar 130-15 blood sugar 151-20 blood sugar 201-25 blood sugar 151-30 blood sugar 301-35 blood sugar 351-40	50=0 00=2U 50=4U 00=6U 50=8U				
magata	Humalog order had	3 p.m. RN-E verified R323's d changed on 7/20/17. RN-E labels on medications can not				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00164	B. WING		08/	24/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
AUGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21620	Continued From pa	age 67	21620			
	practice was to con the correct dose of RN-E verified the d Humalog container Medication Adminis On 8/23/17, at 7:33 (LPN)-D prepared 2 R323. LPN- explain morning dose of ins sliding scale dose. On 8/23/17, at 8:00 insulin medication I than the directions change of order stil On 8/23/17, at 8:10 (CM)-B verified R32 were changed 8/22 called to provide a place on the insulin the clinical record 0 scale order had als from 10 units to 12 reading of 351 to 4 order had changed	N-E identified the facility nplete three checks to ensure medication was administered. lose transcribed on the did not match the dose in the stration Record (MAR). a.m. licensed practical nurse 24 units of Humalog insulin for ned 12 units for R323's sulin and 12 units for the 5 a.m. LPN-D verified R323's pottle container was different in the MAR and did not have a				
	(DON) verified med based on the the M The DON indicated noted staff were ex orders and if there	4 a.m the director of nursing dications were administered IAR and the medication label. I when a discrepancy was pected to check the original was a dosage change found, Id have been contacted for a				

STATEMEN	DIT DEPARTMENT OF HE NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00164	B. WING		08/	24/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE		ST 14TH STR POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
21620	change of order stie change of order stie staff to a dosage ch a possible medicati knowledge of the m recent order chang change. The requested facil SUGGESTED MET The director of nurs all appropriate staff The director of nurs monitoring systems compliance.	age 68 cker. The DON verified a cker would be used to alert nange and aid in prevention of ion error. The DON verified nedication in question, the e and prior sliding scale order lity policy was not provided. THOD OF CORRECTION: sing or designee could educate members on the processes. sing or designee could develop s to ensure ongoing R CORRECTION: Seven (7)				
21695	Subp. 4. Housekeep provide housekeep necessary to maint comfortable interior ceilings, registers, f and furnishings. This MN Requirem by: Based on observat review, the facility f services necessary sanitary condition in bathrooms for 2 of	5 Subp. 4 Plant eration, & Maintenance reping. A nursing home must ing and maintenance services ain a clean, orderly, and r, including walls, floors, fixtures, equipment, lighting, ent is not met as evidenced ion, interview and document ailed to provide housekeeping to maintain a clean and n resident rooms and 2 resident rooms and shared 09, 111, East 252) reviewed.	21695	Corrected		10/12/17

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00164	B. WING		08/24/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
UGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21695	Continued From pa	age 69	21695			
	Findings include:					
	were noted: - at 2:13 p.m. room	ur on 8/22/17, the following 1 109 and 111 on the first floor nd to have a strong urine odor hared bath room.				
		a 252 on the second floor East ave a strong urine odor om and bathroom.				
	environmental serv	4 p.m. during the with the director of rices (DES) the above cerns were verified.				
	responsibility of ma staff. The DES exp and duties to includ - one staff person v total of seven hours -staff were provided and weekly cleaning	was assigned to each unit for a s per day. d schedules to follow for daily				
	odorous and difficu clientele living on the East unit room 252 an ongoing concern the floor. The DES cleaning procedure	the first floor main unit was lt to manage due to the nat unit. The DES agreed the 2 was odorous and had been n due to residents urinating on identified numerous additional es to manage the odors, nat the problem was not under				
	On 8/24/17, at 11:4 improvement direct epartment of Health	49 a.m. the quality tor (QID) indicated the director				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00164	B. WING		08/	08/24/2017	
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
UGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21695	Continued From pa	age 70	21695				
	services to residen	ervices provided deep cleaning t rooms and completed follow re staff were providing the					
	office with the adm director of mainten- rooms and shared The DES indicate h and went thorough 252 on the East un	23 p.m. in the administrators inistrator, DON, QID, and ance, the DES verified the two bathroom had a strong odor. he personally stripped, waxed clothing and etcetera in room it. The DES stated, "There is we can spend in there."					
	The requested faci	lity policy was not provided.					
	director of environn review and revise t housekeeping and trends of lingering of with the Director of	THOD OF CORRECTION: The nental services (DES) could he policies, educate nursing staff and identify odors. The DES could work nursing (DON) to ensure staff onmental issues appropriately.					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					
21985	MN St. Statute 626 Maltreatment of Vu	5.557 Subd. 3a Reporting - Inerable Adults	21985			10/12/1	
		not required. The following uired to be reported under this					
	specifically prohibit patient identifying in report of suspected	ce where federal law s a person from disclosing nformation in connection with a d maltreatment, unless the r the vulnerable adult's					

M4PX11

If continuation sheet 71 of 76

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00164	B. WING	B. WING		08/24/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE	1		
AUGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21985	has consented to d conforms to federal whose patients or r a federal law shall of suspected maltro resident, or a guard representative, upd admission to the fa prohibited by federa incident of suspect immediately seek of (b) Verbal or phy between patients, r or self-abusive behav not constitute abus serious harm. The designee shall reco self-abusive behav licensing agencies agencies. (c) Accidents as subdivision 3. (d) Events occur an individual's error conduct to a vulner section 626.5572, s 17, paragraph (c), (e) Nothing in thi	ator, or legal representative, lisclosure in a manner which il requirements. Facilities residents are covered by such seek consent to the disclosure eatment from each patient or dian, conservator, or legal on the patient's or resident's icility. Persons who are al law from reporting an ted maltreatment shall consent to make a report. visical aggression occurring residents, or clients of a facility lavior by these persons does to operator of the facility or a ord incidents of aggression and ior to facilitate review by and county and local welfare defined in section 626.5572, rring in a facility that result from r in the provision of therapeutic rable adult, as provided in subdivision clause (4).					
	require a report of t defined in section on the basis of the	is section shall be construed to financial exploitation, as 626.5572, subdivision 9, solely transfer of money or property ensation for services rendered.					

Minnesota Department of Health         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         00164			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00164	B. WING		08/24/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE		ST 14TH STR POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21985	Continued From pa	age 72	21985			
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the State agency (SA) and thoroughly investigate an incident of potential neglect of care for 1 of 3 residents (R123) who fell from a mechanical lift in the facility.		I	Corrected		
	Findings include:					
	current diagnoses bilateral leg weakn disorder with seizu	dated 12/29/16, identified of chronic pain, muscle and ess, lymphedema, conversion res or convulsions, anxiety, left ankle and joints of left foot prior to admission.				
	dated 1/5/17, identi	Minimum Date Set (MDS) ified R123 had intact cognition nsive assistance for transfers.				
	p.m. indicated R12 her chair to bed, E place causing resid Staff re-educated of to ensure correct s Further, the report suddenly stopped r assistant did not re one side of the slin resident landed on was helped off the	eport dated 8/5/17, at 6:45 3 had been transferred from 2 stand sling popped out of dent to land on her buttocks. on proper use of EZ stand and ize sling is being used. listed the EZ stand had moving, resident and nursing member what happened next, g was out of place and the floor on buttocks. Resident floor utilizing a hoyer lift, and were evident at that time.	t			
	8/7/17, indicated R no injury. The inter	ncident Review Form, dated 123 had a fall on 8/5/17, with rdisciplinary team reviewed here were no medication				

Minnesota Department of Health         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1)         PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         00164		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING		08/	08/24/2017		
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		- 00/24/2017		
		1007 FAS	ST 14TH STRE				
AUGUSI	ANA HEALTH CARE	CENTER OF MINI MINNEAU	POLIS, MN 55	5404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21985	Continued From page 73		21985				
	concerns, environmental concerns or change of condition noted. The form listed the new intervention of staff re-educated on proper use of EZ stand and to ensure the proper sling used, obtained large sling.						
	reported a few we the EZ stand lift us reported when the the lift, the staff me safety belt around l attached the loops R123 reported since	a 8/23/17, at 8:07 a.m. R123 eks ago she had fallen from ed during a transfer. R123 staff member hooked her up to ember had not hooked the her abdomen, and had only on to the hooks of the lift. se that fall, all staff had been e belts, and she had not had					
	registered nurse (F the EZ stand lift du talking with staff sh off or open, and the maybe incorrect. F given to the staff m lift use and sling size	a 8/23/17, at 11:43 a.m. RN)-C confirmed R123 fell from ring a transfer, and stated after be believed the strap snapped ought the size of the sling was RN-C stated re-education was rember involved regarding the zes. RN-C verified there were ttions or documentation all on 8/5/17.					
	director of nursing had the fall from th analysis was comp R123 let go of the l felt the harness wa further investigated in the incident repo loop "popped off." not complete a rep	on 8/24/17, at 11:30 a.m. the (DON) reported after R123 e EZ stand lift, a root cause leted. The DON reported nandles on the lift because she s a little tight, and as staff l, the wording "popped off" was rt, due to being too tight or the The DON stated the facility did ort to the SA as the facility did reportable event as there was ne for R123	;				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 08/24/2017			
		00164						
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE				
AUGUSTANA HEALTH CARE CENTER OF MINI MINNEAPOLIS, MN 55404								
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC	N SHOULD BE COMPL			
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH DEFICIENCY		DATE		
21985	Continued From pa	age 74	21985					
	with the administra the current facility p confirmed she expo- suspected neglect needed to be repor administrator and t feel R123's fall from was reportable due negative outcome, negative intent. Th stated they expected	view on 8/24/17, at 3:41 p.m. tor and DON, they confirmed policy, and the administrator ected all neglect of care and or not providing care as ted to the SA. The he DON stated they did not in the EZ stand mechanical lift e to the fact there was no no harm, no abuse or no ne administrator and DON ed staff to give the highest leve and expected the care plan to	1					
	and Investigation P indicated incidents immediately to MD Health) included ne the Administrator a person to investiga including: - review of the incid - the residnets' mere events leading up t - interview the pers - interview the vitro - interview the resid members , interview roommate, family r indicated	dical record to determine o the incident on reporting the incident esses to the incident dent, interview the staff w the the resident's physician, nember, and visitors as sidents to whom the accused						
	Vulnerable Adults F indicated all allegat	ity's Maltreatment of Policy, dated 10/2016, tions and/or suspicious of orted to the administrator						

Minnesota Department of Health         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1)         Department of Lealth         (X1)         PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         00164		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED		
		AME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST	
UGUST	ANA HEALTH CARE		ST 14TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21985	Continued From page 75		21985			
	is unexplainable, of reported or witness neglect a report muthe Minnesota Dep call the administrat also indicated an in reports will be com SUGGESTED MET The administrator, designee could cre needed. They could the importance of f Abuse/Neglect reported in Minnesota- Vulnera policy. They could in gathered from thos assurance perform committee, for a de by the QAPI comm compliance.	policy further indicated if injury r allegation of abuse is sed, if there is caregiver ust immediately be reported to partment of Health (MDH) and for immediately. The policy internal, facility investigation of pleted. THOD OF CORRECTION: director of nursing (DON), or pate/update facility policy if d ensure all staff are aware of following the facility policy for orting. They could establish a ensure all allegations are in accordance with the State of able Adults Act and also facility report that information access amount of time set ittee, to ensure correction and R CORRECTION: Twenty-one				