MDH
Minnesota
Department
of Health

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 2557
January 13, 2016

Mr. Todd Carsen, Administrator
Colonial Acres Health Care Center
5825 St. Croix Avenue
Golden Valley, Minnesota 55422

Subject: Colonial Acres Health Care Ctr - IDR
Provider # 245322
Project # S5322024

Dear Mr. Carsen:

This is in response to your letter of October 8, 2015, in regard to your request of an informal dispute resolution (IDR) for the federal deficiency at tag F315 issued pursuant to the survey event N39C11, completed on September 3, 2015.

The information presented with your letter, the CMS 2567 dated September 3, 2015, and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F315 D level 42 CFR §483.25(d) Urinary Incontinence

Based on the resident's comprehensive assessment, the facility must ensure that,
(1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and
§483.25(d) (2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

The facility alleges the deficiency was not properly cited because they alleged medical justification for the continued use of an indwelling urinary catheter for R121 which included immobility, diuretic therapy, rash, and intractable pain.

The 2567 identified R121 had an indwelling urinary catheter placed while in the hospital for diuresis related to a 16 pound weight gain. The catheter was to be removed 7 days after admission to the nursing home. The catheter was never removed by the facility for R121. The facility External Facility Episodic Visit 8/27/15, identified immobility, rash may worsen if came in contact with skin and diuretic therapy as reasons for continued use of the indwelling catheter.

Even though R121 received an oral diuretic, Lasix 20 mg two tablets twice a day, 80 mg per day, (usual initial dose of Lasix is 20 to 80 mg), had a rash on her torso and buttock which improved with

treatment, had improved transfer ability from a Hoyer mechanical lift to assistance of two, and did not have intractable pain because the medication regime was "effective." There was no reason to justify the continued use of the indwelling urinary catheter for R121.

As a result of this information, this is a valid deficiency at F315, and at the correct scope and severity of isolated incident, with no actual harm (D level).

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,

Brenda Fischer

Brenda Fischer, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 320-223-7338 Fax: 320-223-7348

cc: Office of Ombudsman for Long-Term Care
Pam Kerssen , Assistant Program Manager
Licensing and Certification File
Jessica Sellner, St. Cloud Team B Unit Supervisor

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: N39C

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00183

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245322**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **COLONIAL ACRES HEALTH CARE CTR**
(L4) **5825 ST CROIX AVENUE**
(L5) **GOLDEN VALLEY, MN** (L6) **55422**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/19/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **04** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
01/31

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

12.Total Facility Beds **88** (L18)

13.Total Certified Beds **38** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
38				
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Jessica Sellner, Unit Supervisor 10/19/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 10/20/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 10/28/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/12/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245322
October 20, 2015

Mr. Todd Carsen, Administrator
Colonial Acres Health Care Center
5825 St Croix Avenue
Golden Valley, Minnesota 55422

Dear Mr. Carsen:

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

38 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 38 skilled nursing facility beds.

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

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

October 20, 2015

Mr. Todd Carsen, Administrator
Colonial Acres Health Care Center
5825 St Croix Avenue
Golden Valley, Minnesota 55422

RE: Project Number S5322024

Dear Mr. Carsen:

On September 18, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 3, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On October 19, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 3, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 13, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 3, 2015, effective October 13, 2015 and therefore remedies outlined in our letter to you dated September 18, 2015, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245322	A. Building B. Wing	10/19/2015

Name of Facility	Street Address, City, State, Zip Code
COLONIAL ACRES HEALTH CARE CTR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **10/13/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **10/13/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **10/13/2015**
ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **10/13/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **10/13/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **10/13/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	JS/KJ	10/20/2015	29249	10/19/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/3/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: N39C

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00183

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245322**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **COLONIAL ACRES HEALTH CARE CTR**
(L4) **5825 ST CROIX AVENUE**
(L5) **GOLDEN VALLEY, MN** (L6) **55422**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/03/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **04** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
01/31

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

12.Total Facility Beds **88** (L18)

13.Total Certified Beds **38** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
38				
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Christine Bodick-Nord, HFE NE II — 10/01/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 10/11/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0003 4738 3377

September 21, 2015

Mr. Todd Carsen, Administrator
Colonial Acres Health Care Center
5825 St Croix Avenue
Golden Valley, Minnesota 55422

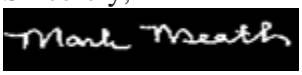
RE: Project Number S5322024
Revised CMS 2567 Enclosed

Dear Mr. Carsen:

Recently you received the survey results for health and life safety code along with the State form for the licensing survey with corresponding letters dated September 18, 2015. Further review revealed language under the Federal deficiency cited at F441 related to the licensing survey. Specifically correction order 1375. The licensing language has been deleted from the Federal deficiency and enclosed you will find a revised CMS 2567 for health only. The State form and life safety code forms were not revised and remain the same.

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0003 4738 3360

September 18, 2015

Mr. Todd Carsen, Administrator
Colonial Acres Health Care Center
5825 St Croix Avenue
Golden Valley, Minnesota 55422

RE: Project Number S5322024, H5322023

Dear Mr. Carsen:

On September 3, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the September 3, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5322023. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the September 3, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5322023 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: Jessica.sellner@state.mn.us

Phone: (320) 223-7343
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

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

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the

deficient practice will not recur;

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your PoC submission.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 3, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 3, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Sincerely,

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL ACRES HEALTH CARE CTR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint H5322023 was completed and was unsubstantiated.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident	F 157		

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

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F 157	Continued From page 1 and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to notify the physician of the development of an unstageable pressure ulcer while in the facility for 1 of 1 resident (R43) reviewed with plans to discharge home with follow care. FINDINGS INCLUDE: R43's Admission Minimum Data Set (MDS) dated 4/28/15, indicated R43 was diagnosed with lung cancer, diabetes and peripheral neuropathy, had not pressure ulcers, was at risk for pressure ulcers, had intact cognition and required assist of one with bed mobility, transfers, dressing and personal hygiene. R43's Pressure Ulcer Care Area Assessment (CAA) dated 4/29/15, indicated R43 required extensive assist with bed mobility, was at risk for skin breakdown, was weak and frail related to	F 157		

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F 157	Continued From page 2 chemotherapy and radiation treatment for metastatic lung cancer. R43's Care plan dated 5/7/15 identified R43 at risk of pressure ulcer, weight loss, poor appetite and diagnosis of cancer with metastasis. Interventions were to check skin for redness, skin tears, swelling, or pressure areas daily with cares. Updating MD as needed. Report any signs of skin breakdown. Review of R43's treatment record dated May 2015, indicated R43 had a stage one (red, non-blanchable) on the upper right buttock crease and barrier cream application to the area was started 5/11/15, twice a day. The record revealed the barrier cream treatment continued until discharge on 5/28/15. Review of R43's clinical progress notes revealed the following: R43's clinical progress note dated 5/27/15, identified a wound was noted to coccyx area which measured 1.0 cm X 1.0 cm, superficial, scabbed over area. Surrounding skin is blanchable with 3.0 cm x 2.0 cm of pink colored skin. Surrounding skin is intact. Aquacel (moisture wicking) dressing applied for protection. R43's clinical progress note dated 5/29/15, included a summary of R43's coccyx pressure ulcer which identified the pressure ulcer was unstageable and measured 1.0 cm x 1.0 cm with a light brown scab over the area. The note further	F 157		

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F 157	Continued From page 3 indicated Aquacel dressing was to be applied for protection. Additionally, the note indicated R43 was discharged to home on 5/28/15, with home care services. The note lacked evidence that R43's physician had been notified of the pressure ulcer and lacked any evidence of changes related to the care and treatment of the ulcer. Review of R43's physician orders revealed the following: R43's Physician Order's dated 4/28/15, directed the nurse to complete a weekly skin / pain assessment which included to document in nurses note if skin was intact or if new areas developed, compare it to previous notes and if new areas then do risk watch and initiate treatment if needed. The note also included the directive to monitor pain level. Physicians orders dated 5/27/15, indicated R43 was ok to discharge to home with physical therapy/occupational therapy and Registered nurse home health agency. The physician orders did not identify R43's newly developed unstageable pressure ulcer and lacked interventions for treatment. On 9/3/15, at 10:57 a.m. registered nurse (RN)-A verified R43 had developed an unstageable pressure ulcer while in the facility. RN-A also verified R43's physician had not been notified of the development and worsening of R43's coccyx pressure ulcer and had discharged to home on 5/28/15. RN-A stated she had informed the home	F 157		

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F 157	Continued From page 4 care agency of R43's unstageable pressure ulcer, however, she had not notified R43's physician. On 9/3/15, at 12:57 p.m. the director of nurses (DON) stated R43 had developed an unstageable pressure ulcer in the facility and confirmed the facility's current policy. The DON stated she would expect staff to follow the policy and implement treatment. The facility's Pressure Ulcer Management form dated 9/1/10, directed staff to notify the physician and family when a pressure ulcer was identified, to implement a skin flow sheet and the ulcer monitoring tool in order to identify if the would changes over time / healing. The form further indicated the pressure ulcer should be re-assessed at least weekly or if the condition of resident or wound deteriorated.	F 157		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 314		

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F 314	Continued From page 5 facility failed to comprehensively assess and monitor a newly developed pressure ulcer for 1 of 1 resident who developed an unstageable pressure ulcer in the facility. Findings include: R43's admission MDS dated 4/28/15, indicated R43 was diagnosed with lung cancer, diabetes and peripheral neuropathy. The MDS also indicated R43 had no pressure ulcers, was at risk for pressure ulcers and required one assist with bed mobility, transfers, dressing and personal hygiene. R43's Pressure Ulcer Care Area Assessment (CAA) dated 4/29/15, indicated R43 required extensive assist with bed mobility, was at risk for skin breakdown and was weak / frail related to chemotherapy and radiation treatment for metastatic lung cancer. R43's Care plan dated 5/7/15, indicated R43 was at risk of pressure ulcers related to weight loss, poor appetite and diagnosis of cancer with metastasis. The care plan directed staff to check R43's skin for redness, skin tears, swelling or pressure areas daily, with cares. The plan also directed staff to report signs of skin breakdown and update R43's physician as needed if there were changes. Review of R43's treatment record dated May 2015, indicated R43 had a stage one (red, non-blanchable) on the upper right buttock crease and barrier cream application to the area was	F 314		

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F 314	Continued From page 6 started 5/11/15, twice a day. The record revealed the barrier cream treatment continued until discharge on 5/28/15. Review of R43's clinical progress notes (CPN) revealed the following: R43's CPN dated 5/27/15, indicated a superficial, scabbed over (unstagable: full thickness tissue loss in which actual depth of the ulcer is obscured by slough and /or eschar) wound was noted to R43's coccyx area which measured 1.0 cm x 1.0 cm. The note further indicated the surrounding tissue was pink, blanchable and measured 3.0 cm x 2.0 cm. Aquacel (moisture wicking dressing) dressing applied for protection. R43's CPN dated 5/29/15, included a summary of R43's coccyx pressure ulcer which identified the pressure ulcer was unstageable and measured 1.0 cm x 1.0 cm with a light brown scab over the area. The note further indicated Aquacel was to be applied for protection. Additionally, the note indicated R43 was to be discharged to home on 5/28/15, with home care services. R43's clinical record identification and measurements of the coccyx when first observed on 5/11/15. However, R43's clinical record lacked documentation regarding any ongoing assessments or observations identifying changes to the pressure ulcer until the note on 5/27/15, which indicated the wound had worsened and was now unstageable. Review of R43's physician orders revealed the	F 314		

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F 314	Continued From page 7 following: R43's Physician Order's dated 4/28/15, directed the nurse to complete a weekly skin / pain assessment which included to document in nurses note if skin was intact or if new areas developed, compare it to previous notes and if new areas then do risk watch and initiate treatment if needed. The note also included the directive to monitor pain level. Physicians orders dated 5/27/15, indicated R43 was ok to discharge to home with physical therapy/occupational therapy and Registered nurse home health agency. The physician orders did not address R43's newly developed unstageable pressure ulcer and lacked orders for treatment On 9/3/15, at 10:57 a.m. RN-A verified R43 had developed an unstageable pressure ulcer while in the facility. RN-A confirmed a skin assessment had not been completed when the wound was identified on 5/11/15. In addition, RN-A verified R43's clinical record lacked evidence of monitoring of the pressure ulcer which had worsened from a stage one to a stage four (unstagable) pressure ulcer. RN-A also verified R43's physician had not been notified of the development and worsening of R43's coccyx pressure ulcer nor the presence of the ulcer on discharge. On 9/3/15, at 12:57 p.m. the DON stated R43 had developed an unstageable pressure ulcer in the facility and confirmed the facility's current policy.	F 314		

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F 314	Continued From page 8 The DON also stated she would expect staff to follow the policy and implement treatment as directed. The facility's Pressure Ulcer Management form dated 9/1/10, directed staff to notify the physician and family when a pressure ulcer was identified, to implement a skin flow sheet and the ulcer monitoring tool in order to identify if the would changes over time / healing. The form further indicated the pressure ulcer should be re-assessed at least weekly or if the condition of resident or wound deteriorated. The facility Pressure Ulcer Management policy and procedure reviewed on 1/2/15, indicated it was facility policy to ensure all residents received care for skin and skin related issues. Those who were admitted to the facility without pressure ulcers would remain free of pressure ulcers as was medically possible. Further, it is the policy to prevent all skin breakdown and /or infection as possible within the scope of the resident's condition and to provide treatment to all resident with skin related issues.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315		

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F 315	Continued From page 9 infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure medical justification for the continued use of an indwelling Foley catheter for 1 of 3 residents, (R121) who was admitted with a Foley catheter. Findings include: R121's physician note dated 8/31/15, indicated R121 had a developed a retroperiteanal bleed / hemorrhage while in the hospital receiving anticoagulation therapy for a blood clot. R121 was treated with a diuretic due to a 16 pound weight gain / fluid volume overload with edema, therefore, the Foley indwelling catheter was placed while in the hospital for diuresis as well as R121 requiring a mechanical total lift for transfers and lack of motivation to get out of bed. During interview on 9/3/15, at 12:46 p.m. social worker (SW)-A stated R121's admission Minimum Data Set (MDS) had not yet been completed, however, on 8/20/15, and 8/27/15, SW-A completed a cognitive assessment which indicated R121 had intact cognition. R121's Park Nicollet Methodist Hospital discharge form dated 8/13/15, instructed staff to discontinue R121's Foley catheter within seven	F 315		

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F 315	Continued From page 10 days. R121's Bladder Assessment Form dated 8/18/15, indicated R121 had an indwelling Foley catheter, however, the assessment did not include the medical justification for the ongoing use of the catheter. R121's Foley Catheter Assessment and Management form dated 8/21/15, indicated an indwelling catheter should only be used when there was valid medical justification. The document lacked indication of the medical justification for R121's continued indwelling catheter use. An External Facility Episodic Visit dated 8/27/15, indicated R121 continued to use a Foley catheter due to her immobility, R121's rash may worsen if it came into contact with urine and also because of diuretic therapy and urine output monitoring. There was no indication if an attempt at discontinuing the Foley catheter had been attempted. During observation 9/2/15, at 9:25 a.m. R121 was lying in bed watching television. A Foley catheter bag with urine was visible through R121's pant leg. During interview on 9/2/15, at 1:34 p.m. nursing assistant (NA)-A stated R121 did not use the bathroom because she had an indwelling catheter and used a bed pan for bowel movements.	F 315		

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F 315	Continued From page 11 During interview on 9/3/15, at 9:20 a.m. registered nurse (RN)-B verified R121's physician orders dated 8/21/15, did not have an appropriate diagnosis for the continued use of the Foley catheter. During interview on 9/3/15, at 10:03 a.m. R121 stated she believed she still had the Foley catheter because it was easier for staff so they did not need to come into her room and assist her to the toilet all the time. R121 stated the facility had not tried to remove the Foley catheter. The facility policy titled Bowel and Bladder Management dated 9/1/10, indicated if an indwelling catheter continued to be in place, the ongoing process was to ensure documentation of the justification for the continued use was in place. In addition, the policy indicated if the catheter use was not justified per assessment, the facility would initiate procedures for removal.	F 315		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and	F 425		

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F 425	Continued From page 12 administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to administer inhaler medication as directed by manufacturer's directions for 1 of 1 residents (R46) observed to receive inhaler medication. Findings include: During observation on 8/31/2015, at 7:10 p.m. registered nurse (RN)-D was observed assisting R46 with administering an inhaler medication. RN-D handed R46 an Advair dose counter inhaler, R46 administered his inhaler and handed the device back to RN-D. RN-D did not offer water to R46 to swish / rinse his mouth. -At 7:14 p.m. RN-D handed the Advair inhaler back to R46 and R46 administered the second dose of his Advair inhaled medication and handed the device back to RN-D. After the administration of the medication, RN-D left the room and did not offer water or encourage R46 in order to swish / rinse his mouth.	F 425		

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F 425	Continued From page 13 R46's August 2015 Physician Order Sheet indicated an order for Advair Dose Counter two puffs twice a day followed by a directive to rinse mouth / gargle after use. R46's September 2015 Medications sheet indicated Advair Dose Counter two puffs twice a day with the directive to rinse mouth / gargle after use. The Advair Dose Counter manufacturer recommendations included the directive to rinse mouth after use. The medication label attached to R46's Advair Dose Counter inhaler included the directive to rinse mouth after use. On 8/31/15, at 8:13 p.m. R46's Advair physician order, medication label and manufacturer recommendations to rinse mouth after use of the medicaiton were reviewed with RN-D. RN-D stated she should have provided water to R46 to rinse / gargle his mouth following the administration of the inhaled medication. During interview on 9/3/15, at 8:31 a.m. RN-B unit manager, verified RN-D should have offered R46 water to rinse his mouth following the administration of the medication. During interview on 9/3/15, at 1:00 p.m. the director of nursing (DON) verified staff should	F 425		

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F 425	Continued From page 14 have followed the manufacturer's recommendation for the Advair inhaler which included the directive to swish/ rinse the mouth after use. The facility policy titled, Administering Medications dated 7/1/2009, indicated medications must be administered in a timely manner and in accordance with the attending physician's written / verbal orders. In addition, the policy indicated the individual administering the medicaiton must ensure the right medication, right dosage, right time and right method of administration are verified before the medication is administered and directed staff to review the medication label, physician orders, etc.	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431		

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F 431	Continued From page 15 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper narcotic storage and security for 1 of 1 emergency kits (ekit) which contained narcotic medications. This had the potential to affect all residents residing in the facility who could potentially require narcotics from the emergency kit. Findings include: On 9/2/2015, at 1:55 p.m. during the medication storage tour of the main medication room with registered nurse (RN)-A. The facility ekit narcotic storage box, which was a clear plastic box approximately 12 inches by 10 inches with a label which indicated it's contents, was stored in a locked drawer in the med room. The ekit was not secured and was easily opened. RN-A stated the facility policy was to have the box secured shut	F 431		

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F 431	Continued From page 16 with two numerical zip locks on the two corners of the ekit box. At this time, RN-A verified the ekit was not secured and stated all staff had been educated on this procedure. During interview on 9/2/15, at 2:18 p.m. RN-A stated the narcotic ekit was to be double sealed with red numerical ties and placement of the seal ties were to be verified by two nurses at shift change in order to maintain security of the medications. RN-A stated the instructions for securing and monitoring the ekit were on the counter for staff to refer to. RN-A stated if the seals were not present, then the narcotic count was to be verified and the ekit was to be resealed. The contents of the ekit were as follow and verified by RN-A: -6 tablets of Ativan 0.5 milligrams (mg) (antianxiety) -5 tablets of Oxycodone 5.0 mg (opioid pain medication) -3 tablets Norco 5.0 mg. (opioid / Tylenol pain medication) -3 tablets Percocet 5/325 mg (oxycodone / Tylenol pain medication) -5 tablets Dilaudid 2 mg (derivative of morphine, pain medication) RN-A and RN-C verified the narcotic medication count was accurate. Both were observed to secure the ekit with numerically coded ziplock seals. The ekit was then returned to the locked drawer.	F 431		

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F 431	Continued From page 17 During interview on 9/2/15, at 2:25 p.m. the director of nursing (DON) verified the nurses should have been ensuring the ekit was locked with the required zip seal in order to prevent potential drug diversion. A policy for narcotic storage and security was requested but not provided.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441		

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F 441	Continued From page 18 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate personal and environmental infection control procedures were implemented in order to prevent the spread of infection for 1 of 1 resident (R158) observed who required contact precautions. This had the potential to affect 21 of 22 residents who resided in the fireside unit. In addition, the facility failed to store community reusable resident use ice packs in a sanitary manner to prevent potential infection in 1 of 1 nourishment freezers. This had the potential to affect 21 of 22 residents who resided on the Fireside unit. Findings include: R158 was diagnosed with clostridium difficile (C. diff) and Vancomycin resistant enterococci (VRE) and the facility failed to wear personal protective attire and perform appropriate environmental cleaning in order to prevent the spread of the infections. R158's record review indicated R158 was diagnosed with clostridium difficile, (C. diff), (a bacterial infection that causes symptoms	F 441		

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F 441	Continued From page 19	F 441		

including diarrhea), and Vancomycin resistant enterococci (VRE), (which are bacteria that commonly live in the bowel, that can cause infection, and are usually resistant to many antibiotics).
During tour of the facility on 8/31/2015, at 2:13 p.m., a plastic cart with supplies was observed stationed in the hallway outside of R158's room. On R158's door was a sign which instructed visitors to please see nurse prior to entering the room.
During interview on 8/31/15, at 2:15 p.m. registered nurse-A (RN-A) stated R158 was admitted to the facility with a positive culture for C. diff and VRE. In light of this diagnosis, isolation precautions were put into place. The sign on the door was to alert people entering the room to seek out the nurse for further instructions.
On 9/2/2015, at 2:27 p.m., housekeeping-A (HK-A) was observed coming out of R158's room. HK-A was observed cleaning other resident rooms on 158's hallway prior to this observation. When HK-A exited R158's room, she was observed to be garbed only in her uniform and without personal protective attire on such as a gown which was part of isolation precautions warranted due to R158's diagnoses. At the time of the observation, HK-A was asked what information was provided with the sign on the door and HK-A stated the sign was posted to make sure gowns and gloves were worn when in R158's room. When asked if she had applied a gown and gloves while entering and cleaning this room, HK-A stated "no, I just cleaned the bathroom." The isolation unit personal protective cart was observed placed directly outside of R158's room with supplies appropriately placed in drawers. At this time, HK-A was instructed that

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F 441	Continued From page 20 the equipment used with R158's room cleaning could not be used in subsequent rooms without appropriate disinfecting. HK-A stated understanding. At 2:40 p.m. on 09/02/2015, RN-D stated if there was a chance to be in contact with any bodily secretions, people entering R158's room should apply a gown and gloves. RN-D also stated housekeeping definitely were informed and were aware of the precautions required because they would need to sanitize the room differently. On 9/3/15, at 9:12 a.m. the infections control nurse (ICN) stated the facility's Standard Precautions and Transmission Based Precautions instruction / information book was place din all neighborhoods for all staff to refer too. The ICN stated based on the signage on the resident door, housekeeping staff were instructed to seek out the nurse for further instructions. Review of policy entitled Transmission Based Precautions Infection Control Policies listed that the appropriate contact precautions for an individual with clostridium difficile is the use of gloves and gowns when entering the room if there is to be substantial contact with environmental surface. It is recommended that cleaning products be single use products if possible. If this is not possible, then per the recommendation of the policy, it is necessary for items to be adequately cleaned and disinfected before use with another resident. This policy was most recently revised 6/03. Ice Packs A tour of the facility dining room serving kitchen(s) was conducted on 8/31/15, at 1:40 p.m. with the	F 441		

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F 441	Continued From page 21 director of dining (DD) and production coordinator. The following observations were noted: The Fireside One nourishment freezer contained seven small reusable gel ice packs, and eight blue reusable relief cold packs (approximately 10 inch wide by 15 inches long). No snacks were in the freezer at the time. The Fireside Two nourishment freezer contained one reusable relief cold pack stored with three opened boxes of ice cream treats and three ice cream cups. During the tour, the DD stated nursing staff were responsible for monitoring the nourishment refrigerators and freezers. During interview on 8/31/15, at 1:44 p.m. RN-A stated the patient use ice packs should not have been stored in the freezers with food. During interview on 8/31/15, at 1:50 p.m. RN-B stated the ice packs found in both Fireside nourishment freezers had always been stored there and if ice cream / food was in the freezer, nursing would make sure the ice packs and food did not touch. During interview on 9/1/15, at 1:45 p.m. licensed practical nurse (LPN)-A stated the ice packs were used for resident bumps and bruises and were taken from the freezer and put in a towel or pillowcase because they are too cold to put right on the skin, therefore, there was no specific instruction on how to clean the ice packs before placing them back in the freezer.	F 441		

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F 441	Continued From page 22 During interview on 9/2/15, at 8:23 a.m. the director of nursing (DON) stated the reusable ice packs should not have been stored in the resident nourishment freezers, and it was her expectation that staff put the cold pack in a towel or pillowcase, and when the resident was done with the ice pack, staff should wipe it down with a, "Sanitizing wipe." Review of the facility Standard Precautions Infection Control policy dated 7/1/09, indicated that reusable resident care equipment was not used for the care of another resident until it had been appropriately cleaned and disinfected. The procedure lacked direction on where resident reusable cold packs could be stored and to not store the cold packs together with food.	F 441		

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint H5322023 was completed and was unsubstantiated.	F 000	**F 000** This Credible Allegation of Compliance has been prepared and timely submitted. Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiency were correctly cited, and is also not be construed as admission against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of Deficiencies as a condition to participate in the Medicare program. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with allegations of non-compliance or admissions by the Facility.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident	F 157		

accepted 10/5/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Healthcare Administrator (X6) DATE: 9/30/15

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

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F 157	Continued From page 1 and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to notify the physician of the development of an unstageable pressure ulcer while in the facility for 1 of 1 resident (R43) reviewed with plans to discharge home with follow care. FINDINGS INCLUDE: R43's Admission Minimum Data Set (MDS) dated 4/28/15, indicated R43 was diagnosed with lung cancer, diabetes and peripheral neuropathy, had not pressure ulcers, was at risk for pressure ulcers, had intact cognition and required assist of one with bed mobility, transfers, dressing and personal hygiene. R43's Pressure Ulcer Care Area Assessment (CAA) dated 4/29/15, indicated R43 required extensive assist with bed mobility, was at risk for skin breakdown, was weak and frail related to	F 157	**F157: Notify of changes** **RESIDENT**: R43 has been discharged **IDENTIFY OTHERS AFFECTED**: Review of Risk Watch and pressure ulcers previously identified have been reviewed for documentation of physician notification. **INTERVENTIONS**: Licensed Nurses meetings conducted on September 22nd and 24th, 2015. Agenda included review of policy and procedure regarding notification of physician related to pressure ulcer. **MONITOR:** Periodic audits will be conducted throughout facility to ensure proper notification of physicians for pressure ulcers. Results will be reviewed by Health Care Administrator, Director of Nursing and Quality Assurance Interdisciplinary Team (IDT). **DATES OF COMPLETION:** October 13, 2015 **RESPONSIBLE:** Director of Nursing/designee	

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F 157	Continued From page 2 chemotherapy and radiation treatment for metastatic lung cancer. R43's Care plan dated 5/7/15 identified R43 at risk of pressure ulcer, weight loss, poor appetite and diagnosis of cancer with metastasis. Interventions were to check skin for redness, skin tears, swelling, or pressure areas daily with cares. Updating MD as needed. Report any signs of skin breakdown. Review of R43's treatment record dated May 2015, indicated R43 had a stage one (red, non-blanchable) on the upper right buttock crease and barrier cream application to the area was started 5/11/15, twice a day. The record revealed the barrier cream treatment continued until discharge on 5/28/15. Review of R43's clinical progress notes revealed the following: R43's clinical progress note dated 5/27/15, identified a wound was noted to coccyx area which measured 1.0 cm X 1.0 cm, superficial, scabbed over area. Surrounding skin is blanchable with 3.0 cm x 2.0 cm of pink colored skin. Surrounding skin is intact. Aquacel (moisture wicking) dressing applied for protection. R43's clinical progress note dated 5/29/15, included a summary of R43's coccyx pressure ulcer which identified the pressure ulcer was unstageable and measured 1.0 cm x 1.0 cm with a light brown scab over the area. The note further	F 157		

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F 157	Continued From page 3 indicated Aquacel dressing was to be applied for protection. Additionally, the note indicated R43 was discharged to home on 5/28/15, with home care services. The note lacked evidence that R43's physician had been notified of the pressure ulcer and lacked any evidence of changes related to the care and treatment of the ulcer. Review of R43's physician orders revealed the following: R43's Physician Order's dated 4/28/15, directed the nurse to complete a weekly skin / pain assessment which included to document in nurses note if skin was intact or if new areas developed, compare it to previous notes and if new areas then do risk watch and initiate treatment if needed. The note also included the directive to monitor pain level. Physicians orders dated 5/27/15, indicated R43 was ok to discharge to home with physical therapy/occupational therapy and Registered nurse home health agency. The physician orders did not identify R43's newly developed unstageable pressure ulcer and lacked interventions for treatment. On 9/3/15, at 10:57 a.m. registered nurse (RN)-A verified R43 had developed an unstageable pressure ulcer while in the facility. RN-A also verified R43's physician had not been notified of the development and worsening of R43's coccyx pressure ulcer and had discharged to home on 5/28/15. RN-A stated she had informed the home	F 157		

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F 157	Continued From page 4 care agency of R43's unstageable pressure ulcer, however, she had not notified R43's physician. On 9/3/15, at 12:57 p.m. the director of nurses (DON) stated R43 had developed an unstageable pressure ulcer in the facility and confirmed the facility's current policy. The DON stated she would expect staff to follow the policy and implement treatment. The facility's Pressure Ulcer Management form dated 9/1/10, directed staff to notify the physician and family when a pressure ulcer was identified, to implement a skin flow sheet and the ulcer monitoring tool in order to identify if the would changes over time / healing. The form further indicated the pressure ulcer should be re-assessed at least weekly or if the condition of resident or wound deteriorated.	F 157		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 314		

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F 314	Continued From page 5 facility failed to comprehensively assess and monitor a newly developed pressure ulcer for 1 of 1 resident who developed an unstageable pressure ulcer in the facility. Findings include: R43's admission MDS dated 4/28/15, indicated R43 was diagnosed with lung cancer, diabetes and peripheral neuropathy. The MDS also indicated R43 had no pressure ulcers, was at risk for pressure ulcers and required one assist with bed mobility, transfers, dressing and personal hygiene. R43's Pressure Ulcer Care Area Assessment (CAA) dated 4/29/15, indicated R43 required extensive assist with bed mobility, was at risk for skin breakdown and was weak / frail related to chemotherapy and radiation treatment for metastatic lung cancer. R43's Care plan dated 5/7/15, indicated R43 was at risk of pressure ulcers related to weight loss, poor appetite and diagnosis of cancer with metastasis. The care plan directed staff to check R43's skin for redness, skin tears, swelling or pressure areas daily, with cares. The plan also directed staff to report signs of skin breakdown and update R43's physician as needed if there were changes. Review of R43's treatment record dated May 2015, indicated R43 had a stage one (red, non-blanchable) on the upper right buttock crease and barrier cream application to the area was	F 314	**F314:** Treatment to prevent/heal pressure sores **RESIDENT**: R43 discharged from facility **IDENTIFY OTHERS AFFECTED**: Reviewed assessments of all current residents with identified pressure ulcers. **INTERVENTIONS**: Licensed Nurses meetings conducted on September 22nd and 24th, 2015. Agenda included review of expectation of licensed staff to monitor pressure ulcers including assessment of wound condition, weekly and ongoing skin assessment, physician update and notification. Facility Pressure Ulcer Management policy and procedure reviewed. **MONITOR**: Periodic audits will be conducted for residents with pressure ulcers to ensure assessments are complete and ongoing documentation is in place per facility protocol. Results will be reviewed by Health Care Administrator, Director of Nursing and Quality Assurance IDT **DATES OF COMPLETION:** October 13, 2015 **RESPONSIBLE:** Director of Nursing/designee	

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F 314	Continued From page 6 started 5/11/15, twice a day. The record revealed the barrier cream treatment continued until discharge on 5/28/15. Review of R43's clinical progress notes (CPN) revealed the following: R43's CPN dated 5/27/15, indicated a superficial, scabbed over (unstagable: full thickness tissue loss in which actual depth of the ulcer is obscured by slough and /or eschar) wound was noted to R43's coccyx area which measured 1.0 cm x 1.0 cm. The note further indicated the surrounding tissue was pink, blanchable and measured 3.0 cm x 2.0 cm. Aquacel (moisture wicking dressing) dressing applied for protection. R43's CPN dated 5/29/15, included a summary of R43's coccyx pressure ulcer which identified the pressure ulcer was unstageable and measured 1.0 cm x 1.0 cm with a light brown scab over the area. The note further indicated Aquacel was to be applied for protection. Additionally, the note indicated R43 was to be discharged to home on 5/28/15, with home care services. R43's clinical record identification and measurements of the coccyx when first observed on 5/11/15. However, R43's clinical record lacked documentation regarding any ongoing assessments or observations identifying changes to the pressure ulcer until the note on 5/27/15, which indicated the wound had worsened and was now unstageable. Review of R43's physician orders revealed the	F 314		

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F 314	Continued From page 7 following: R43's Physician Order's dated 4/28/15, directed the nurse to complete a weekly skin / pain assessment which included to document in nurses note if skin was intact or if new areas developed, compare it to previous notes and if new areas then do risk watch and initiate treatment if needed. The note also included the directive to monitor pain level. Physicians orders dated 5/27/15, indicated R43 was ok to discharge to home with physical therapy/occupational therapy and Registered nurse home health agency. The physician orders did not address R43's newly developed unstageable pressure ulcer and lacked orders for treatment On 9/3/15, at 10:57 a.m. RN-A verified R43 had developed an unstageable pressure ulcer while in the facility. RN-A confirmed a skin assessment had not been completed when the wound was identified on 5/11/15. In addition, RN-A verified R43's clinical record lacked evidence of monitoring of the pressure ulcer which had worsened from a stage one to a stage four (unstagable) pressure ulcer. RN-A also verified R43's physician had not been notified of the development and worsening of R43's coccyx pressure ulcer nor the presence of the ulcer on discharge. On 9/3/15, at 12:57 p.m. the DON stated R43 had developed an unstageable pressure ulcer in the facility and confirmed the facility's current policy.	F 314		

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F 314	Continued From page 8 The DON also stated she would expect staff to follow the policy and implement treatment as directed. The facility's Pressure Ulcer Management form dated 9/1/10, directed staff to notify the physician and family when a pressure ulcer was identified, to implement a skin flow sheet and the ulcer monitoring tool in order to identify if the would changes over time / healing. The form further indicated the pressure ulcer should be re-assessed at least weekly or if the condition of resident or wound deteriorated. The facility Pressure Ulcer Management policy and procedure reviewed on 1/2/15, indicated it was facility policy to ensure all residents received care for skin and skin related issues. Those who were admitted to the facility without pressure ulcers would remain free of pressure ulcers as was medically possible. Further, it is the policy to prevent all skin breakdown and /or infection as possible within the scope of the resident's condition and to provide treatment to all resident with skin related issues.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315		

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F 315	Continued From page 9 infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure medical justification for the continued use of an indwelling Foley catheter for 1 of 3 residents, (R121) who was admitted with a Foley catheter. Findings include: R121's physician note dated 8/31/15, indicated R121 had a developed a retroperiteanal bleed / hemorrhage while in the hospital receiving anticoagulation therapy for a blood clot. R121 was treated with a diuretic due to a 16 pound weight gain / fluid volume overload with edema, therefore, the Foley indwelling catheter was placed while in the hospital for diuresis as well as R121 requiring a mechanical total lift for transfers and lack of motivation to get out of bed. During interview on 9/3/15, at 12:46 p.m. social worker (SW)-A stated R121's admission Minimum Data Set (MDS) had not yet been completed, however, on 8/20/15, and 8/27/15, SW-A completed a cognitive assessment which indicated R121 had intact cognition. R121's Park Nicollet Methodist Hospital discharge form dated 8/13/15, instructed staff to discontinue R121's Foley catheter within seven	F 315	**F315** Indication of use for Catheter **RESIDENT**: R121 has discharged from facility **IDENTIFY OTHERS AFFECTED**: Medical record review of all current residents with indwelling Foley catheter to ensure medical justification for continued use of catheter. **INTERVENTIONS**: Licensed Nurses meetings conducted on September 22nd and 24th, 2015. Agenda included review of accepted medical justification for continued use of a catheter. Bowel and Bladder Management policy reviewed. Protocol for ensuring resident admitted with a catheter has clarification of indication for use of catheter reviewed. **MONITOR:** Periodic medical record audits will be conducted for residents admitted with an indwelling catheter to ensure appropriate medical justification for use of catheter. Results will be reviewed by Health Care Administrator, Director of Nursing and Quality Assurance IDT. **DATES OF COMPLETION:** October 13, 2015 **RESPONSIBLE:** Director of Nursing and Nurse Managers/Admission nurse	

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F 315	Continued From page 10 days. R121's Bladder Assessment Form dated 8/18/15, indicated R121 had an indwelling Foley catheter, however, the assessment did not include the medical justification for the ongoing use of the catheter. R121's Foley Catheter Assessment and Management form dated 8/21/15, indicated an indwelling catheter should only be used when there was valid medical justification. The document lacked indication of the medical justification for R121's continued indwelling catheter use. An External Facility Episodic Visit dated 8/27/15, indicated R121 continued to use a Foley catheter due to her immobility, R121's rash may worsen if it came into contact with urine and also because of diuretic therapy and urine output monitoring. There was no indication if an attempt at discontinuing the Foley catheter had been attempted. During observation 9/2/15, at 9:25 a.m. R121 was lying in bed watching television. A Foley catheter bag with urine was visible through R121's pant leg. During interview on 9/2/15, at 1:34 p.m. nursing assistant (NA)-A stated R121 did not use the bathroom because she had an indwelling catheter and used a bed pan for bowel movements.	F 315		

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F 315	Continued From page 11 During interview on 9/3/15, at 9:20 a.m. registered nurse (RN)-B verified R121's physician orders dated 8/21/15, did not have an appropriate diagnosis for the continued use of the Foley catheter. During interview on 9/3/15, at 10:03 a.m. R121 stated she believed she still had the Foley catheter because it was easier for staff so they did not need to come into her room and assist her to the toilet all the time. R121 stated the facility had not tried to remove the Foley catheter. The facility policy titled Bowel and Bladder Management dated 9/1/10, indicated if an indwelling catheter continued to be in place, the ongoing process was to ensure documentation of the justification for the continued use was in place. In addition, the policy indicated if the catheter use was not justified per assessment, the facility would initiate procedures for removal.	F 315		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and	F 425	**F425** Pharmaceutical Services/accurate procedure **RESIDENT**: R46 has received education regarding the manufacturer's recommendation for administration of inhaler which includes rinsing mouth after use of inhaler.	

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F 425	Continued From page 12 administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to administer inhaler medication as directed by manufacturer's directions for 1 of 1 residents (R46) observed to receive inhaler medication. Findings include: During observation on 8/31/2015, at 7:10 p.m. registered nurse (RN)-D was observed assisting R46 with administering an inhaler medication. RN-D handed R46 an Advair dose counter inhaler, R46 administered his inhaler and handed the device back to RN-D. RN-D did not offer water to R46 to swish / rinse his mouth. -At 7:14 p.m. RN-D handed the Advair inhaler back to R46 and R46 administered the second dose of his Advair inhaled medication and handed the device back to RN-D. After the administration of the medication, RN-D left the room and did not offer water or encourage R46 in order to swish / rinse his mouth.	F 425	**IDENTIFY OTHERS AFFECTED**: All current residents with an order for a steroid inhaler have been identified. Medication administration orders reviewed for inclusion of manufacturer's recommendation for rinsing mouth after use of inhaler. **INTERVENTIONS**: Licensed Nurses meetings conducted on September 22nd and 24th, 2015. Agenda included review of proper administration of steroid inhalers. Reviewed policy and procedure for administration of inhalers. **MONITOR:** Periodic direct observation of licensed nurses administering steroid inhalers will be conducted by nurse manager or designee. Staff education will be conducted during observation if necessary with potential for further disciplinary action for failure to follow policy. Audit results will be presented to and reviewed by Quality Assurance IDT. **DATES OF COMPLETION:** October 13, 2015 **RESPONSIBLE:** Director of Nursing/Nurse Manager/Nurse Supervisors.	

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F 425	Continued From page 13 R46's August 2015 Physician Order Sheet indicated an order for Advair Dose Counter two puffs twice a day followed by a directive to rinse mouth / gargle after use. R46's September 2015 Medications sheet indicated Advair Dose Counter two puffs twice a day with the directive to rinse mouth / gargle after use. The Advair Dose Counter manufacturer recommendations included the directive to rinse mouth after use. The medication label attached to R46's Advair Dose Counter inhaler included the directive to rinse mouth after use. On 8/31/15, at 8:13 p.m. R46's Advair physician order, medication label and manufacturer recommendations to rinse mouth after use of the medicaiton were reviewed with RN-D. RN-D stated she should have provided water to R46 to rinse / gargle his mouth following the administration of the inhaled medication. During interview on 9/3/15, at 8:31 a.m. RN-B unit manager, verified RN-D should have offered R46 water to rinse his mouth following the administration of the medication. During interview on 9/3/15, at 1:00 p.m. the director of nursing (DON) verified staff should	F 425		

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F 425	Continued From page 14 have followed the manufacturer's recommendation for the Advair inhaler which included the directive to swish/ rinse the mouth after use.	F 425		
F 431 SS=E	The facility policy titled, Administering Medications dated 7/1/2009, indicated medications must be administered in a timely manner and in accordance with the attending physician's written / verbal orders. In addition, the policy indicated the individual administering the medicaiton must ensure the right medication, right dosage, right time and right method of administration are verified before the medication is administered and directed staff to review the medication label, physician orders, etc. 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431	**F431** Drug records, label/store drugs & Biologicals **Fireside Transitional Care Unit** **INTERVENTIONS**: Licensed Nurses meetings conducted on September 22nd and 24th, 2015. Agenda included review of facility protocol regarding securing narcotic EKit. **MONITOR:** Periodic audits will be conducted by RN Manager and Evening Supervisor to ensure proper storage, securing, and documentation of narcotic EKit. Results of audits will be presented to and reviewed by Quality Assurance IDT to determine need for continued audits/revision of policy. **DATES OF COMPLETION:** October 13, 2015 **RESPONSIBLE:** Director of Nursing/Nurse managers/supervisors	

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F 431	Continued From page 15 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper narcotic storage and security for 1 of 1 emergency kits (ekit) which contained narcotic medications. This had the potential to affect all residents residing in the facility who could potentially require narcotics from the emergency kit. Findings include: On 9/2/2015, at 1:55 p.m. during the medication storage tour of the main medication room with registered nurse (RN)-A. The facility ekit narcotic storage box, which was a clear plastic box approximately 12 inches by 10 inches with a label which indicated it's contents, was stored in a locked drawer in the med room. The ekit was not secured and was easily opened. RN-A stated the facility policy was to have the box secured shut	F 431		

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F 431	Continued From page 16 with two numerical zip locks on the two corners of the ekit box. At this time, RN-A verified the ekit was not secured and stated all staff had been educated on this procedure. During interview on 9/2/15, at 2:18 p.m. RN-A stated the narcotic ekit was to be double sealed with red numerical ties and placement of the seal ties were to be verified by two nurses at shift change in order to maintain security of the medications. RN-A stated the instructions for securing and monitoring the ekit were on the counter for staff to refer to. RN-A stated if the seals were not present, then the narcotic count was to be verified and the ekit was to be resealed. The contents of the ekit were as follow and verified by RN-A: -6 tablets of Ativan 0.5 milligrams (mg) (antianxiety) -5 tablets of Oxycodone 5.0 mg (opioid pain medication) -3 tablets Norco 5.0 mg. (opioid / Tylenol pain medication) -3 tablets Percocet 5/325 mg (oxycodone / Tylenol pain medication) -5 tablets Dilaudid 2 mg (derivative of morphine, pain medication) RN-A and RN-C verified the narcotic medication count was accurate. Both were observed to secure the ekit with numerically coded ziplock seals. The ekit was then returned to the locked drawer.	F 431		

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F 431	Continued From page 17 During interview on 9/2/15, at 2:25 p.m. the director of nursing (DON) verified the nurses should have been ensuring the ekit was locked with the required zip seal in order to prevent potential drug diversion. A policy for narcotic storage and security was requested but not provided.	F 431	**F441** **RESIDENT:** R158 discharged facility/ house wide **IDENTIFY OTHERS AFFECTED**: Reviewed all current residents with infection requiring any level of isolation for proper identification of isolation. All reusable ice packs were removed from nourishment freezer and placed in medication freezers on each neighborhood.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441	**INTERVENTIONS**: On October 12th Director of Housekeeping and Infection Control nurse will conduct training regarding proper use of personal protective attire while performing environmental cleaning in order to prevent the spread of infections. Policy and procedure reviewed and staff education provided for housekeeping personnel. Licensed Nurses meetings conducted on September 22nd and 24th, 2015. Agenda included review of protocol regarding storage of non-nourishment items in the nourishment refrigerator or freezer. Also reviewed new protocol to store reusable ice packs in medication freezer and/or appropriate freezer (for Fireside neighborhood) and continue to clean after use with provided cleaning product. Therapy department also conducted education sessions for internal staff.	

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	245322	A. BUILDING _____ B. WING _____	09/03/2015

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F 441	Continued From page 18 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate personal and environmental infection control procedures were implemented in order to prevent the spread of infection for 1 of 1 resident (R158) observed who required contact precautions. This had the potential to affect 21 of 22 residents who resided in the fireside unit. In addition, the facility failed to store community reusable resident use ice packs in a sanitary manner to prevent potential infection in 1 of 1 nourishment freezers. This had the potential to affect 21 of 22 residents who resided on the Fireside unit. Findings include: R158 was diagnosed with clostridium difficile (C. diff) and Vancomycin resistant enterococci (VRE) and the facility failed to wear personal protective attire and perform appropriate environmental cleaning in order to prevent the spread of the infections. R158's record review indicated R158 was diagnosed with clostridium difficile, (C. diff), (a bacterial infection that causes symptoms	F 441	**MONITOR:** Director of Housekeeping and Infection Control nurse will conduct periodic observation audits to ensure proper use of personal protective attire by housekeeping when cleaning resident room posted for isolation. Infection Control nurse/designee will conduct periodic audits to assure proper storage of reusable ice packs throughout facility. Results will be reported to Quality Assurance IDT. **DATES OF COMPLETION:** October 13, 2015 **RESPONSIBLE**: Director of Housekeeping, DON and Infection Control nurse/designee	

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F 441	Continued From page 19 including diarrhea), and Vancomycin resistant enterococci (VRE), (which are bacteria that commonly live in the bowel, that can cause infection, and are usually resistant to many antibiotics). During tour of the facility on 8/31/2015, at 2:13 p.m., a plastic cart with supplies was observed stationed in the hallway outside of R158's room. On R158's door was a sign which instructed visitors to please see nurse prior to entering the room. During interview on 8/31/15, at 2:15 p.m. registered nurse-A (RN-A) stated R158 was admitted to the facility with a positive culture for C. diff and VRE. In light of this diagnosis, isolation precautions were put into place. The sign on the door was to alert people entering the room to seek out the nurse for further instructions. On 9/2/2015, at 2:27 p.m., housekeeping-A (HK-A) was observed coming out of R158's room. HK-A was observed cleaning other resident rooms on 158's hallway prior to this observation. When HK-A exited R158's room, she was observed to be garbed only in her uniform and without personal protective attire on such as a gown which was part of isolation precautions warranted due to R158's diagnoses. At the time of the observation, HK-A was asked what information was provided with the sign on the door and HK-A stated the sign was posted to make sure gowns and gloves were worn when in R158's room. When asked if she had applied a gown and gloves while entering and cleaning this room, HK-A stated "no, I just cleaned the bathroom." The isolation unit personal protective cart was observed placed directly outside of R158's room with supplies appropriately placed in drawers. At this time, HK-A was instructed that	F 441		

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F 441	Continued From page 20 the equipment used with R158's room cleaning could not be used in subsequent rooms without appropriate disinfecting. HK-A stated understanding. At 2:40 p.m. on 09/02/2015, RN-D stated if there was a chance to be in contact with any bodily secretions, people entering R158's room should apply a gown and gloves. RN-D also stated housekeeping definitely were informed and were aware of the precautions required because they would need to sanitize the room differently. On 9/3/15, at 9:12 a.m. the infections control nurse (ICN) stated the facility's Standard Precautions and Transmission Based Precautions instruction / information book was place din all neighborhoods for all staff to refer too. The ICN stated based on the signage on the resident door, housekeeping staff were instructed to seek out the nurse for further instructions. Review of policy entitled Transmission Based Precautions Infection Control Policies listed that the appropriate contact precautions for an individual with clostridium difficile is the use of gloves and gowns when entering the room if there is to be substantial contact with environmental surface. It is recommended that cleaning products be single use products if possible. If this is not possible, then per the recommendation of the policy, it is necessary for items to be adequately cleaned and disinfected before use with another resident. This policy was most recently revised 6/03. Ice Packs A tour of the facility dining room serving kitchen(s) was conducted on 8/31/15, at 1:40 p.m. with the	F 441		

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F 441	Continued From page 21 director of dining (DD) and production coordinator. The following observations were noted: The Fireside One nourishment freezer contained seven small reusable gel ice packs, and eight blue reusable relief cold packs (approximately 10 inch wide by 15 inches long). No snacks were in the freezer at the time. The Fireside Two nourishment freezer contained one reusable relief cold pack stored with three opened boxes of ice cream treats and three ice cream cups. During the tour, the DD stated nursing staff were responsible for monitoring the nourishment refrigerators and freezers. During interview on 8/31/15, at 1:44 p.m. RN-A stated the patient use ice packs should not have been stored in the freezers with food. During interview on 8/31/15, at 1:50 p.m. RN-B stated the ice packs found in both Fireside nourishment freezers had always been stored there and if ice cream / food was in the freezer, nursing would make sure the ice packs and food did not touch. During interview on 9/1/15, at 1:45 p.m. licensed practical nurse (LPN)-A stated the ice packs were used for resident bumps and bruises and were taken from the freezer and put in a towel or pillowcase because they are too cold to put right on the skin, therefore, there was no specific instruction on how to clean the ice packs before placing them back in the freezer.	F 441		

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F 441	Continued From page 22 During interview on 9/2/15, at 8:23 a.m. the director of nursing (DON) stated the reusable ice packs should not have been stored in the resident nourishment freezers, and it was her expectation that staff put the cold pack in a towel or pillowcase, and when the resident was done with the ice pack, staff should wipe it down with a, "Sanitizing wipe." Review of the facility Standard Precautions Infection Control policy dated 7/1/09, indicated that reusable resident care equipment was not used for the care of another resident until it had been appropriately cleaned and disinfected. The procedure lacked direction on where resident reusable cold packs could be stored and to not store the cold packs together with food.	F 441		

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	245322	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/14/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Colonial Acres Health Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The Colonial Acres Health Care Center is made up of two buildings that are attached. The original building is 1 story without a basement and was constructed in 1961. It was determined to be of Type II(000) construction and is fully fire sprinkler protected. In 1982 an addition was built to the north of the original building, is a 1 story building without a basement. It was determined to be of Type V (111) construction, is fully fire sprinkler protected and is separated with at least a 2 hour fire barrier from the original building. This building house State Licensed only beds. This building had additions to it in 2000 of the same construction type and fully fire sprinkler protected. The buildings are divided into 5 smoke zones. The facility has a fire alarm system with smoke detection in the corridor system and in all common areas. The fire alarm system is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 88 beds and had a census of 71 at the time of the survey. Of these beds only 39 are	K 000		

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

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

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K 000	Continued From page 1 Medicaid/Medicare certified, 25 of these were occupied at the time of the survey. For this survey, only the 39 bed section (see sketch) and the associated exiting system are covered under this report as a single building. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On August 31, 2015, September 1st, 2nd, 3rd, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Compliance Monitoring, Licensing and Certification Program, 3333 West Division St, Suite 212, St Cloud, MN 56301. In addition, complaint investigation was also completed at the time of the recertification survey. An investigation of complaint H5322023 was completed. The complaint was unsubstantiated.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an	2 265		

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2 265	Continued From page 2 attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to notify the physician of the development of an unstageable pressure ulcer while in the facility for 1 of 1 resident (R43) reviewed with plans to discharge home with follow care. FINDINGS INCLUDE: R43's Admission Minimum Data Set (MDS) dated	2 265		

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2 265	Continued From page 3 4/28/15, indicated R43 was diagnosed with lung cancer, diabetes and peripheral neuropathy, had not pressure ulcers, was at risk for pressure ulcers, had intact cognition and required assist of one with bed mobility, transfers, dressing and personal hygiene. R43's Pressure Ulcer Care Area Assessment (CAA) dated 4/29/15, indicated R43 required extensive assist with bed mobility, was at risk for skin breakdown, was weak and frail related to chemotherapy and radiation treatment for metastatic lung cancer. R43's Care plan dated 5/7/15 identified R43 at risk of pressure ulcer, weight loss, poor appetite and diagnosis of cancer with metastasis. Interventions were to check skin for redness, skin tears, swelling, or pressure areas daily with cares. Updating MD as needed. Report any signs of skin breakdown. Review of R43's treatment record dated May 2015, indicated R43 had a stage one (red, non-blanchable) on the upper right buttock crease and barrier cream application to the area was started 5/11/15, twice a day. The record revealed the barrier cream treatment continued until discharge on 5/28/15. Review of R43's clinical progress notes revealed the following: R43's clinical progress note dated 5/27/15, identified a wound was noted to coccyx area which measured 1.0 cm X 1.0 cm, superficial,	2 265		

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2 265	Continued From page 4 scabbed over area. Surrounding skin is blanchable with 3.0 cm x 2.0 cm of pink colored skin. Surrounding skin is intact. Aquacel (moisture wicking) dressing applied for protection. R43's clinical progress note dated 5/29/15, included a summary of R43's coccyx pressure ulcer which identified the pressure ulcer was unstageable and measured 1.0 cm x 1.0 cm with a light brown scab over the area. The note further indicated Aquacel dressing was to be applied for protection. Additionally, the note indicated R43 was discharged to home on 5/28/15, with home care services. The note lacked evidence that R43's physician had been notified of the pressure ulcer and lacked any evidence of changes related to the care and treatment of the ulcer. Review of R43's physician orders revealed the following: R43's Physician Order's dated 4/28/15, directed the nurse to complete a weekly skin / pain assessment which included to document in nurses note if skin was intact or if new areas developed, compare it to previous notes and if new areas then do risk watch and initiate treatment if needed. The note also included the directive to monitor pain level. Physicians orders dated 5/27/15, indicated R43 was ok to discharge to home with physical therapy/occupational therapy and Registered nurse home health agency. The physician orders did not identify R43's newly developed unstageable pressure ulcer and lacked	2 265		

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2 265	Continued From page 5 interventions for treatment. On 9/3/15, at 10:57 a.m. registered nurse (RN)-A verified R43 had developed an unstageable pressure ulcer while in the facility. RN-A also verified R43's physician had not been notified of the development and worsening of R43's coccyx pressure ulcer and had discharged to home on 5/28/15. RN-A stated she had informed the home care agency of R43's unstageable pressure ulcer, however, she had not notified R43's physician. On 9/3/15, at 12:57 p.m. the director of nurses (DON) stated R43 had developed an unstageable pressure ulcer in the facility and confirmed the facility's current policy. The DON stated she would expect staff to follow the policy and implement treatment. The facility's Pressure Ulcer Management form dated 9/1/10, directed staff to notify the physician and family when a pressure ulcer was identified, to implement a skin flow sheet and the ulcer monitoring tool in order to identify if the would changes over time / healing. The form further indicated the pressure ulcer should be re-assessed at least weekly or if the condition of resident or wound deteriorated. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could update policies and procedures and then educate staff on examples of when the physician should be notified. The DON or designee could perform audits of medical records to determine if the	2 265		

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COLONIAL ACRES HEALTH CARE CTR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

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2 265	Continued From page 6 physician had been notified appropriately. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 265		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and monitor a newly developed pressure ulcer for 1 of 1 resident who developed an unstageable pressure ulcer in the facility. Findings include:	2 900		

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2 900	Continued From page 7 R43's admission MDS dated 4/28/15, indicated R43 was diagnosed with lung cancer, diabetes and peripheral neuropathy. The MDS also indicated R43 had no pressure ulcers, was at risk for pressure ulcers and required one assist with bed mobility, transfers, dressing and personal hygiene. R43's Pressure Ulcer Care Area Assessment (CAA) dated 4/29/15, indicated R43 required extensive assist with bed mobility, was at risk for skin breakdown and was weak / frail related to chemotherapy and radiation treatment for metastatic lung cancer. R43's Care plan dated 5/7/15, indicated R43 was at risk of pressure ulcers related to weight loss, poor appetite and diagnosis of cancer with metastasis. The care plan directed staff to check R43's skin for redness, skin tears, swelling or pressure areas daily, with cares. The plan also directed staff to report signs of skin breakdown and update R43's physician as needed if there were changes. Review of R43's treatment record dated May 2015, indicated R43 had a stage one (red, non-blanchable) on the upper right buttock crease and barrier cream application to the area was started 5/11/15, twice a day. The record revealed the barrier cream treatment continued until discharge on 5/28/15. Review of R43's clinical progress notes (CPN) revealed the following: R43's CPN dated 5/27/15, indicated a superficial,	2 900		

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2 900	Continued From page 8 scabbed over (unstagable: full thickness tissue loss in which actual depth of the ulcer is obscured by slough and /or eschar) wound was noted to R43's coccyx area which measured 1.0 cm x 1.0 cm. The note further indicated the surrounding tissue was pink, blanchable and measured 3.0 cm x 2.0 cm. Aquacel (moisture wicking dressing) dressing applied for protection. R43's CPN dated 5/29/15, included a summary of R43's coccyx pressure ulcer which identified the pressure ulcer was unstageable and measured 1.0 cm x 1.0 cm with a light brown scab over the area. The note further indicated Aquacel was to be applied for protection. Additionally, the note indicated R43 was to be discharged to home on 5/28/15, with home care services. R43's clinical record identification and measurements of the coccyx when first observed on 5/11/15. However, R43's clinical record lacked documentation regarding any ongoing assessments or observations identifying changes to the pressure ulcer until the note on 5/27/15, which indicated the wound had worsened and was now unstageable. Review of R43's physician orders revealed the following: R43's Physician Order's dated 4/28/15, directed the nurse to complete a weekly skin / pain assessment which included to document in nurses note if skin was intact or if new areas developed, compare it to previous notes and if new areas then do risk watch and initiate treatment if needed. The note also included the directive to monitor pain level.	2 900		

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2 900	Continued From page 9 Physicians orders dated 5/27/15, indicated R43 was ok to discharge to home with physical therapy/occupational therapy and Registered nurse home health agency. The physician orders did not address R43's newly developed unstageable pressure ulcer and lacked orders for treatment On 9/3/15, at 10:57 a.m. RN-A verified R43 had developed an unstageable pressure ulcer while in the facility. RN-A confirmed a skin assessment had not been completed when the wound was identified on 5/11/15. In addition, RN-A verified R43's clinical record lacked evidence of monitoring of the pressure ulcer which had worsened from a stage one to a stage four (unstagable) pressure ulcer. RN-A also verified R43's physician had not been notified of the development and worsening of R43's coccyx pressure ulcer nor the presence of the ulcer on discharge. On 9/3/15, at 12:57 p.m. the DON stated R43 had developed an unstageable pressure ulcer in the facility and confirmed the facility's current policy. The DON also stated she would expect staff to follow the policy and implement treatment as directed. The facility's Pressure Ulcer Management form dated 9/1/10, directed staff to notify the physician and family when a pressure ulcer was identified, to implement a skin flow sheet and the ulcer monitoring tool in order to identify if the would changes over time / healing. The form further	2 900		

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2 900	Continued From page 10 indicated the pressure ulcer should be re-assessed at least weekly or if the condition of resident or wound deteriorated. The facility Pressure Ulcer Management policy and procedure reviewed on 1/2/15, indicated it was facility policy to ensure all residents received care for skin and skin related issues. Those who were admitted to the facility without pressure ulcers would remain free of pressure ulcers as was medically possible. Further, it is the policy to prevent all skin breakdown and /or infection as possible within the scope of the resident's condition and to provide treatment to all resident with skin related issues. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate staff regarding expectation for licensed staff monitoring of pressure ulcers including assessment of wound condition. The director of nursing or designee could develop auditing systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing	2 910		

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2 910	Continued From page 11 home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure medical justification for the continued use of an indwelling Foley catheter for 1 of 3 residents, (R121) who was admitted with a Foley catheter. Findings include: R121's physician note dated 8/31/15, indicated R121 had a developed a retroperiteanal bleed / hemorrhage while in the hospital receiving anticoagulation therapy for a blood clot. R121 was treated with a diuretic due to a 16 pound weight gain / fluid volume overload with edema, therefore, the Foley indwelling catheter was placed while in the hospital for diuresis as well as R121 requiring a mechanical total lift for transfers and lack of motivation to get out of bed. During interview on 9/3/15, at 12:46 p.m. social worker (SW)-A stated R121's admission Minimum Data Set (MDS) had not yet been	2 910		

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2 910	Continued From page 12 completed, however, on 8/20/15, and 8/27/15, SW-A completed a cognitive assessment which indicated R121 had intact cognition. R121's Park Nicollet Methodist Hospital discharge form dated 8/13/15, instructed staff to discontinue R121's Foley catheter within seven days. R121's Bladder Assessment Form dated 8/18/15, indicated R121 had an indwelling Foley catheter, however, the assessment did not include the medical justification for the ongoing use of the catheter. R121's Foley Catheter Assessment and Management form dated 8/21/15, indicated an indwelling catheter should only be used when there was valid medical justification. The document lacked indication of the medical justification for R121's continued indwelling catheter use. An External Facility Episodic Visit dated 8/27/15, indicated R121 continued to use a Foley catheter due to her immobility, R121's rash may worsen if it came into contact with urine and also because of diuretic therapy and urine output monitoring. There was no indication if an attempt at discontinuing the Foley catheter had been attempted. During observation 9/2/15, at 9:25 a.m. R121 was lying in bed watching television. A Foley catheter bag with urine was visible through R121's pant	2 910		

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2 910	Continued From page 13 leg. During interview on 9/2/15, at 1:34 p.m. nursing assistant (NA)-A stated R121 did not use the bathroom because she had an indwelling catheter and used a bed pan for bowel movements. During interview on 9/3/15, at 9:20 a.m. registered nurse (RN)-B verified R121's physician orders dated 8/21/15, did not have an appropriate diagnosis for the continued use of the Foley catheter. During interview on 9/3/15, at 10:03 a.m. R121 stated she believed she still had the Foley catheter because it was easier for staff so they did not need to come into her room and assist her to the toilet all the time. R121 stated the facility had not tried to remove the Foley catheter. The facility policy titled Bowel and Bladder Management dated 9/1/10, indicated if an indwelling catheter continued to be in place, the ongoing process was to ensure documentation of the justification for the continued use was in place. In addition, the policy indicated if the catheter use was not justified per assessment, the facility would initiate procedures for removal. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could inservice staff regarding the required medical justification for catheter use.	2 910		

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2 910	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 910		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required	21530		

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21530	Continued From page 15 by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility consulting pharmacist failed to ensure a prescribed antianxiety medication had adequate indication for use and behavior monitoring for 1 of 5 residents (R159) reviewed for unnecessary medications. Findings include: R159's face sheet dated 7/20/15, indicated R159's diagnoses included paralysis agitans (impairment of motor function), dementia without behavioral disturbances, hallucinations and depressive disorder. R159's admission Minimum Data Set (MDS) dated 7/29/15, identified R159 was cognitively intact and had no hallucinations and/ or delusions. R159's Care Area Assessment (CAA) for Psychotropic Drug Use dated 7/24/15, indicated R159 received Klonopin (antianxiety medication) for hallucinations and staff was to monitor for hallucinations and mood daily. R159's Care Plan dated 7/29/15, indicated R159	21530		

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21530	Continued From page 16	21530		

was receiving the antianxiety medication Klonopin for hallucinations and staff were instructed to record behavior on the Behavior Tracking Form and observe for episodes of anxiety and/or hallucinations.

R159's current Physician Orders dated 7/16/15, indicated Klonopin 0.5 milligrams (mg) tab, at bedtime for hallucinations.

R159's Physician Order Sheet dated and signed 8/6/15, included Klonopin 0.5 mg tablet, oral (by mouth). Although the physician order directed staff to monitor the resident for target behaviors for depression and psychotropic side effects, there was no indication to monitor target behaviors of hallucinations.

On 8/31/15, at 7:40 p.m. R159 was observed quietly sitting in his wheelchair in the dayroom.

During observation on 9/1/15, at 10:00 a.m. R159 appeared well groomed, was ambulating independently in his room and presented with a calm demeanor.

R159's current Medication Administration Record (MAR) dated 7/16/15, through 9/1/15, indicated R159 received Klonopin 0.5 mg orally (by mouth) one time a day.

R159's Consulting Pharmacist Consultation Reports dated 8/1/15, through 8/6/15, and 9/2/15, indicated the consultant pharmacist had reviewed

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21530	Continued From page 17 R159's medications and indicated R159's medications contained no new irregularities and did not require the physician to review any concerns. During interview on 9/1/15, at 4:20 p.m. licensed practical nurse (LPN)-A stated the facility had not been monitoring R159 for hallucinations and stated, "I didn't know it [hallucinations]was an issue." LPN-A stated she believed R159 was always calm and had not been aware of the resident having hallucinations. During interview on 9/2/15, at 7:42 a.m. the consultant pharmacist (CP) stated the facility should have been monitoring R159 for hallucinations if that was the indication for use the physician had identified for use of the Klonopin. During interview on 9/3/15, at 12:35 p.m. registered nurse (RN)-A and CP stated there was no documentation, assessment, indication for use, or behavior monitoring for the use of Klonopin for R159. The facility policy titled Use of Psychotropic Medications dated 4/3/14, directed to assess and evaluate all residents for appropriate use of medications, and any resident prescribed a psychotropic medication will receive an assessment and evaluation prior to the start of the medication. The policy further directed all new admissions will be reviewed for psychotropic medication use, criteria for prescription and use, monitor for signs of response to the medication, as well as adverse reactions, and document	21530		

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21530	Continued From page 18 findings and recommendations. Review of the undated facility Omnicare Pharmacy Products, Services and Consultant Agreement indicated the consultant pharmacist would review the drug regimen of each resident on a monthly basis and report in writing any irregularity to the facility's administrator, medical director, director of nursing services, and resident's physician. SUGGESTED METHOD OF CORRECTION: The administrator, director of nurses, consultant pharmacist or designee could review and revise policy and procedures for identifying medication irregularities and ensuring adequate monitoring of medications. The administrator or designee could provide education on any revisions made. The administrator or designee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or	21535		

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21535	Continued From page 19 discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a prescribed antianxiety medication had adequate indication for use and behavior monitoring for 1 of 5 residents (R159) reviewed for unnecessary medications. Findings include: R159's face sheet dated 7/20/15, indicated R159's diagnoses included paralysis agitans (impairment of motor function), dementia without behavioral disturbances, hallucinations and depressive disorder. R159's Admission Minimum Data Set (MDS) dated 7/29/15, identified R159 was cognitively intact and had no hallucinations and/ or delusions.	21535		

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21535	Continued From page 20 R159's Care Area Assessment (CAA) for psychotropic drug use dated 7/24/15, indicated R159 received Klonopin (antianxiety medication) for hallucinations, and staff was to monitor for hallucinations and mood daily. R159's Care Plan dated 7/29/15, indicated R159 was receiving the antianxiety medication Klonopin for hallucinations, and staff were instructed to record behavior on the Behavior Tracking Form and observe for episodes of anxiety and/or hallucinations. R159's current Physician Orders dated 7/16/15, indicated Klonopin 0.5 milligram (mg) tab, at bedtime for hallucinations. R159's Physician Order Sheet dated and signed 8/6/15, included Klonopin 0.5 mg tablet, oral (by mouth). Although the physician order directed staff to monitor the resident for target behaviors for depression and psychotropic side effects, there was no indication to monitor target behaviors of hallucinations. On 8/31/15, at 7:40 p.m. R159 was observed quietly sitting in his wheelchair in the dayroom. During observation on 9/1/15, at 10:00 a.m. R159 appeared well groomed, was ambulating independently in his room, and presented with a calm demeanor.	21535		

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COLONIAL ACRES HEALTH CARE CTR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

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21535	Continued From page 21 R159's current Medication Administration Record (MAR) dated 7/16/15, through 9/1/15, indicated R159 received Klonopin 0.5 mg orally (by mouth) one time a day. R159's Consulting Pharmacist Consultation Reports dated 8/1/15, through 8/6/15, and 9/2/15, indicated the consultant pharmacist had reviewed R159's medications and indicated R159's medications contained no new irregularities and did not require the physician to review any concerns. During interview on 9/1/15, at 4:20 p.m. licensed practical nurse (LPN)-A stated the facility had not been monitoring R159 for hallucinations, and stated, "I didn't know it [hallucinations]was an issue." LPN-A stated she believed R159 was always calm and had not been aware of the resident having hallucinations. During interview on 9/2/15, at 7:42 a.m. the consultant pharmacist (CP) stated the facility should have been monitoring the resident for hallucinations if that is the indication for use the physician had identified for use of the Klonopin. During interview on 9/3/15, at 12:35 p.m. registered nurse (RN)-A and CP stated there was no documentation, assessment, indication for use or behavior monitoring for the use of Klonopin for R159. The facility policy titled Use of Psychotropic	21535		

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21535	Continued From page 22 Medications dated 4/3/14, directed to assess and evaluate all residents for appropriate use of medications, and any resident prescribed a psychotropic medication will receive an assessment and evaluation prior to the start of the medication. The policy further directed all new admissions will be reviewed for psychotropic medication use, criteria for prescription and use, monitor for signs of response to the medication, as well as adverse reactions, and document findings and recommendations. SUGGESTED METHOD OF CORRECTION: The administrator, director of nurses, consultant pharmacist or designee could review and revise policy and procedures to ensure the consultant pharmacist identified medication irregularities and ensured adequate monitoring of medications. The administrator or designee could provide education on any revisions made. The administrator or designee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21535		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced	21610		

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21610	Continued From page 23 by: Based on observation, interview and document review the facility failed to ensure only authorized personnel had access to the medication room. This lack in secure access to medications by facility personnel had the potential to affect all residents who received medication on the Morningside neighborhood. Findings include: During observation of medication administration on 9/1/15, at 11:10 a.m. registered nurse (RN)-F unlocked the medication storage room in the morningside neighborhood for maintenance supervisor (MS)-A. MS-A wheeled a cart into the medication storage room, and RN-F left MS-A in the medication room and closed the door. RN-F walked back to the medication cart and continued preparing medications for residents. MS-A was observed exiting the medication storage room approximately one to two minutes later with his cart, and left the unit. During interview on 9/1/15, at 11:15 a.m. RN-F stated she opens the door for maintance so they can collect medication and sharps container. During interview on 9/1/15, at 11:58 a.m. licensed practical nurse (LPN)-A stated nurses and nurse managers have access to the medication storage rooms, and maintenance staff take the sharps containers out, and housekeepers empty the trash. LPN-A stated when opening the door for staff that is not authorized to have access to the medication room, staff is expected to stay with them until they exit the medication room and it is secured. During interview on 9/1/15, at 11:59 a.m.	21610		

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21610	Continued From page 24 registered nurse (RN)-A stated housekeeping and maintenance personnel need to enter the medication storage room at times, however, the nurses is expected to stay with them while they are in the medication room. During interview on 9/1/15, at 1:40 p.m. MS-A stated he goes into each medication storage room once per week and removes the full sharps containers, weighs and emptied the black box if needed, takes out the non-narcotic pharmaceuticals that have been discontinued, and transports them to an area in the maintenance area where a contracted company picks them up and disposes of them. MS-A stated the nurses do not always stay with him when he is collecting the medication and sharps containers in the medication storage room. During interview on 9/1/15, at 3:50 p.m., director of nursing (DON) stated when maintenance needs access to the medication storage room a nurse is expected to stay with them. A review of the facility's Storage of Medications policy dated 7/1/09, lacked information regarding secured access to the medication storage rooms. SUGGESTED METHOD OF CORRECTION: The administrator, director of nurses, consultant pharmacist or designee could review and revise policy and procedures for safe drug storage and accessibility. The administrator or designee could provide education on any revisions made. The administrator or designee could do random audits to ensure compliance with safe storage of medications. TIME PERIOD FOR CORRECTION: Twenty One	21610		

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21610	Continued From page 25 (21) days.	21610		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On August 31, 2015, September 1st, 2nd, 3rd, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000	10/1/15 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.	

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2 000	Continued From page 1 Compliance Monitoring, Licensing and Certification Program, 3333 West Division St, Suite 212, St Cloud, MN 56301. In addition, complaint investigation was also completed at the time of the recertification survey. An investigation of complaint H5322023 was completed. The complaint was unsubstantiated.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an	2 265		

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2 265	Continued From page 2 attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to notify the physician of the development of an unstageable pressure ulcer while in the facility for 1 of 1 resident (R43) reviewed with plans to discharge home with follow care. FINDINGS INCLUDE: R43's Admission Minimum Data Set (MDS) dated	2 265		

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2 265	Continued From page 3 4/28/15, indicated R43 was diagnosed with lung cancer, diabetes and peripheral neuropathy, had not pressure ulcers, was at risk for pressure ulcers, had intact cognition and required assist of one with bed mobility, transfers, dressing and personal hygiene. R43's Pressure Ulcer Care Area Assessment (CAA) dated 4/29/15, indicated R43 required extensive assist with bed mobility, was at risk for skin breakdown, was weak and frail related to chemotherapy and radiation treatment for metastatic lung cancer. R43's Care plan dated 5/7/15 identified R43 at risk of pressure ulcer, weight loss, poor appetite and diagnosis of cancer with metastasis. Interventions were to check skin for redness, skin tears, swelling, or pressure areas daily with cares. Updating MD as needed. Report any signs of skin breakdown. Review of R43's treatment record dated May 2015, indicated R43 had a stage one (red, non-blanchable) on the upper right buttock crease and barrier cream application to the area was started 5/11/15, twice a day. The record revealed the barrier cream treatment continued until discharge on 5/28/15. Review of R43's clinical progress notes revealed the following: R43's clinical progress note dated 5/27/15, identified a wound was noted to coccyx area which measured 1.0 cm X 1.0 cm, superficial,	2 265		

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2 265	Continued From page 4 scabbed over area. Surrounding skin is blanchable with 3.0 cm x 2.0 cm of pink colored skin. Surrounding skin is intact. Aquacel (moisture wicking) dressing applied for protection. R43's clinical progress note dated 5/29/15, included a summary of R43's coccyx pressure ulcer which identified the pressure ulcer was unstageable and measured 1.0 cm x 1.0 cm with a light brown scab over the area. The note further indicated Aquacel dressing was to be applied for protection. Additionally, the note indicated R43 was discharged to home on 5/28/15, with home care services. The note lacked evidence that R43's physician had been notified of the pressure ulcer and lacked any evidence of changes related to the care and treatment of the ulcer. Review of R43's physician orders revealed the following: R43's Physician Order's dated 4/28/15, directed the nurse to complete a weekly skin / pain assessment which included to document in nurses note if skin was intact or if new areas developed, compare it to previous notes and if new areas then do risk watch and initiate treatment if needed. The note also included the directive to monitor pain level. Physicians orders dated 5/27/15, indicated R43 was ok to discharge to home with physical therapy/occupational therapy and Registered nurse home health agency. The physician orders did not identify R43's newly developed unstageable pressure ulcer and lacked	2 265		

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2 265	Continued From page 5 interventions for treatment. On 9/3/15, at 10:57 a.m. registered nurse (RN)-A verified R43 had developed an unstageable pressure ulcer while in the facility. RN-A also verified R43's physician had not been notified of the development and worsening of R43's coccyx pressure ulcer and had discharged to home on 5/28/15. RN-A stated she had informed the home care agency of R43's unstageable pressure ulcer, however, she had not notified R43's physician. On 9/3/15, at 12:57 p.m. the director of nurses (DON) stated R43 had developed an unstageable pressure ulcer in the facility and confirmed the facility's current policy. The DON stated she would expect staff to follow the policy and implement treatment. The facility's Pressure Ulcer Management form dated 9/1/10, directed staff to notify the physician and family when a pressure ulcer was identified, to implement a skin flow sheet and the ulcer monitoring tool in order to identify if the would changes over time / healing. The form further indicated the pressure ulcer should be re-assessed at least weekly or if the condition of resident or wound deteriorated. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could update policies and procedures and then educate staff on examples of when the physician should be notified. The DON or designee could perform audits of medical records to determine if the	2 265		

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2 265	Continued From page 6 physician had been notified appropriately. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 265		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and monitor a newly developed pressure ulcer for 1 of 1 resident who developed an unstageable pressure ulcer in the facility. Findings include:	2 900		

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2 900	Continued From page 7 R43's admission MDS dated 4/28/15, indicated R43 was diagnosed with lung cancer, diabetes and peripheral neuropathy. The MDS also indicated R43 had no pressure ulcers, was at risk for pressure ulcers and required one assist with bed mobility, transfers, dressing and personal hygiene. R43's Pressure Ulcer Care Area Assessment (CAA) dated 4/29/15, indicated R43 required extensive assist with bed mobility, was at risk for skin breakdown and was weak / frail related to chemotherapy and radiation treatment for metastatic lung cancer. R43's Care plan dated 5/7/15, indicated R43 was at risk of pressure ulcers related to weight loss, poor appetite and diagnosis of cancer with metastasis. The care plan directed staff to check R43's skin for redness, skin tears, swelling or pressure areas daily, with cares. The plan also directed staff to report signs of skin breakdown and update R43's physician as needed if there were changes. Review of R43's treatment record dated May 2015, indicated R43 had a stage one (red, non-blanchable) on the upper right buttock crease and barrier cream application to the area was started 5/11/15, twice a day. The record revealed the barrier cream treatment continued until discharge on 5/28/15. Review of R43's clinical progress notes (CPN) revealed the following: R43's CPN dated 5/27/15, indicated a superficial,	2 900		

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2 900	Continued From page 8 scabbed over (unstagable: full thickness tissue loss in which actual depth of the ulcer is obscured by slough and /or eschar) wound was noted to R43's coccyx area which measured 1.0 cm x 1.0 cm. The note further indicated the surrounding tissue was pink, blanchable and measured 3.0 cm x 2.0 cm. Aquacel (moisture wicking dressing) dressing applied for protection. R43's CPN dated 5/29/15, included a summary of R43's coccyx pressure ulcer which identified the pressure ulcer was unstageable and measured 1.0 cm x 1.0 cm with a light brown scab over the area. The note further indicated Aquacel was to be applied for protection. Additionally, the note indicated R43 was to be discharged to home on 5/28/15, with home care services. R43's clinical record identification and measurements of the coccyx when first observed on 5/11/15. However, R43's clinical record lacked documentation regarding any ongoing assessments or observations identifying changes to the pressure ulcer until the note on 5/27/15, which indicated the wound had worsened and was now unstageable. Review of R43's physician orders revealed the following: R43's Physician Order's dated 4/28/15, directed the nurse to complete a weekly skin / pain assessment which included to document in nurses note if skin was intact or if new areas developed, compare it to previous notes and if new areas then do risk watch and initiate treatment if needed. The note also included the directive to monitor pain level.	2 900		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 9 Physicians orders dated 5/27/15, indicated R43 was ok to discharge to home with physical therapy/occupational therapy and Registered nurse home health agency. The physician orders did not address R43's newly developed unstageable pressure ulcer and lacked orders for treatment On 9/3/15, at 10:57 a.m. RN-A verified R43 had developed an unstageable pressure ulcer while in the facility. RN-A confirmed a skin assessment had not been completed when the wound was identified on 5/11/15. In addition, RN-A verified R43's clinical record lacked evidence of monitoring of the pressure ulcer which had worsened from a stage one to a stage four (unstagable) pressure ulcer. RN-A also verified R43's physician had not been notified of the development and worsening of R43's coccyx pressure ulcer nor the presence of the ulcer on discharge. On 9/3/15, at 12:57 p.m. the DON stated R43 had developed an unstageable pressure ulcer in the facility and confirmed the facility's current policy. The DON also stated she would expect staff to follow the policy and implement treatment as directed. The facility's Pressure Ulcer Management form dated 9/1/10, directed staff to notify the physician and family when a pressure ulcer was identified, to implement a skin flow sheet and the ulcer monitoring tool in order to identify if the would changes over time / healing. The form further	2 900		

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	00183	A. BUILDING: _____ B. WING _____	09/03/2015

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2 900	Continued From page 10 indicated the pressure ulcer should be re-assessed at least weekly or if the condition of resident or wound deteriorated. The facility Pressure Ulcer Management policy and procedure reviewed on 1/2/15, indicated it was facility policy to ensure all residents received care for skin and skin related issues. Those who were admitted to the facility without pressure ulcers would remain free of pressure ulcers as was medically possible. Further, it is the policy to prevent all skin breakdown and /or infection as possible within the scope of the resident's condition and to provide treatment to all resident with skin related issues. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate staff regarding expectation for licensed staff monitoring of pressure ulcers including assessment of wound condition. The director of nursing or designee could develop auditing systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing	2 910		

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2 910	Continued From page 11 home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure medical justification for the continued use of an indwelling Foley catheter for 1 of 3 residents, (R121) who was admitted with a Foley catheter. Findings include: R121's physician note dated 8/31/15, indicated R121 had a developed a retroperiteanal bleed / hemorrhage while in the hospital receiving anticoagulation therapy for a blood clot. R121 was treated with a diuretic due to a 16 pound weight gain / fluid volume overload with edema, therefore, the Foley indwelling catheter was placed while in the hospital for diuresis as well as R121 requiring a mechanical total lift for transfers and lack of motivation to get out of bed. During interview on 9/3/15, at 12:46 p.m. social worker (SW)-A stated R121's admission Minimum Data Set (MDS) had not yet been	2 910		

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2 910	Continued From page 12 completed, however, on 8/20/15, and 8/27/15, SW-A completed a cognitive assessment which indicated R121 had intact cognition. R121's Park Nicollet Methodist Hospital discharge form dated 8/13/15, instructed staff to discontinue R121's Foley catheter within seven days. R121's Bladder Assessment Form dated 8/18/15, indicated R121 had an indwelling Foley catheter, however, the assessment did not include the medical justification for the ongoing use of the catheter. R121's Foley Catheter Assessment and Management form dated 8/21/15, indicated an indwelling catheter should only be used when there was valid medical justification. The document lacked indication of the medical justification for R121's continued indwelling catheter use. An External Facility Episodic Visit dated 8/27/15, indicated R121 continued to use a Foley catheter due to her immobility, R121's rash may worsen if it came into contact with urine and also because of diuretic therapy and urine output monitoring. There was no indication if an attempt at discontinuing the Foley catheter had been attempted. During observation 9/2/15, at 9:25 a.m. R121 was lying in bed watching television. A Foley catheter bag with urine was visible through R121's pant	2 910		

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2 910	Continued From page 13 leg. During interview on 9/2/15, at 1:34 p.m. nursing assistant (NA)-A stated R121 did not use the bathroom because she had an indwelling catheter and used a bed pan for bowel movements. During interview on 9/3/15, at 9:20 a.m. registered nurse (RN)-B verified R121's physician orders dated 8/21/15, did not have an appropriate diagnosis for the continued use of the Foley catheter. During interview on 9/3/15, at 10:03 a.m. R121 stated she believed she still had the Foley catheter because it was easier for staff so they did not need to come into her room and assist her to the toilet all the time. R121 stated the facility had not tried to remove the Foley catheter. The facility policy titled Bowel and Bladder Management dated 9/1/10, indicated if an indwelling catheter continued to be in place, the ongoing process was to ensure documentation of the justification for the continued use was in place. In addition, the policy indicated if the catheter use was not justified per assessment, the facility would initiate procedures for removal. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could inservice staff regarding the required medical justification for catheter use.	2 910		

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2 910	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 910		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required	21530		

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21530	Continued From page 15 by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility consulting pharmacist failed to ensure a prescribed antianxiety medication had adequate indication for use and behavior monitoring for 1 of 5 residents (R159) reviewed for unnecessary medications. Findings include: R159's face sheet dated 7/20/15, indicated R159's diagnoses included paralysis agitans (impairment of motor function), dementia without behavioral disturbances, hallucinations and depressive disorder. R159's admission Minimum Data Set (MDS) dated 7/29/15, identified R159 was cognitively intact and had no hallucinations and/ or delusions. R159's Care Area Assessment (CAA) for Psychotropic Drug Use dated 7/24/15, indicated R159 received Klonopin (antianxiety medication) for hallucinations and staff was to monitor for hallucinations and mood daily. R159's Care Plan dated 7/29/15, indicated R159	21530		

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21530	Continued From page 16 was receiving the antianxiety medication Klonopin for hallucinations and staff were instructed to record behavior on the Behavior Tracking Form and observe for episodes of anxiety and/or hallucinations. R159's current Physician Orders dated 7/16/15, indicated Klonopin 0.5 milligrams (mg) tab, at bedtime for hallucinations. R159's Physician Order Sheet dated and signed 8/6/15, included Klonopin 0.5 mg tablet, oral (by mouth). Although the physician order directed staff to monitor the resident for target behaviors for depression and psychotropic side effects, there was no indication to monitor target behaviors of hallucinations. On 8/31/15, at 7:40 p.m. R159 was observed quietly sitting in his wheelchair in the dayroom. During observation on 9/1/15, at 10:00 a.m. R159 appeared well groomed, was ambulating independently in his room and presented with a calm demeanor. R159's current Medication Administration Record (MAR) dated 7/16/15, through 9/1/15, indicated R159 received Klonopin 0.5 mg orally (by mouth) one time a day. R159's Consulting Pharmacist Consultation Reports dated 8/1/15, through 8/6/15, and 9/2/15, indicated the consultant pharmacist had reviewed	21530		

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21530	Continued From page 17 R159's medications and indicated R159's medications contained no new irregularities and did not require the physician to review any concerns. During interview on 9/1/15, at 4:20 p.m. licensed practical nurse (LPN)-A stated the facility had not been monitoring R159 for hallucinations and stated, "I didn't know it [hallucinations]was an issue." LPN-A stated she believed R159 was always calm and had not been aware of the resident having hallucinations. During interview on 9/2/15, at 7:42 a.m. the consultant pharmacist (CP) stated the facility should have been monitoring R159 for hallucinations if that was the indication for use the physician had identified for use of the Klonopin. During interview on 9/3/15, at 12:35 p.m. registered nurse (RN)-A and CP stated there was no documentation, assessment, indication for use, or behavior monitoring for the use of Klonopin for R159. The facility policy titled Use of Psychotropic Medications dated 4/3/14, directed to assess and evaluate all residents for appropriate use of medications, and any resident prescribed a psychotropic medication will receive an assessment and evaluation prior to the start of the medication. The policy further directed all new admissions will be reviewed for psychotropic medication use, criteria for prescription and use, monitor for signs of response to the medication, as well as adverse reactions, and document	21530		

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21530	Continued From page 18 findings and recommendations. Review of the undated facility Omnicare Pharmacy Products, Services and Consultant Agreement indicated the consultant pharmacist would review the drug regimen of each resident on a monthly basis and report in writing any irregularity to the facility's administrator, medical director, director of nursing services, and resident's physician. SUGGESTED METHOD OF CORRECTION: The administrator, director of nurses, consultant pharmacist or designee could review and revise policy and procedures for identifying medication irregularities and ensuring adequate monitoring of medications. The administrator or designee could provide education on any revisions made. The administrator or designee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or	21535		

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21535	Continued From page 19 discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a prescribed antianxiety medication had adequate indication for use and behavior monitoring for 1 of 5 residents (R159) reviewed for unnecessary medications. Findings include: R159's face sheet dated 7/20/15, indicated R159's diagnoses included paralysis agitans (impairment of motor function), dementia without behavioral disturbances, hallucinations and depressive disorder. R159's Admission Minimum Data Set (MDS) dated 7/29/15, identified R159 was cognitively intact and had no hallucinations and/ or delusions.	21535		

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21535	Continued From page 20 R159's Care Area Assessment (CAA) for psychotropic drug use dated 7/24/15, indicated R159 received Klonopin (antianxiety medication) for hallucinations, and staff was to monitor for hallucinations and mood daily. R159's Care Plan dated 7/29/15, indicated R159 was receiving the antianxiety medication Klonopin for hallucinations, and staff were instructed to record behavior on the Behavior Tracking Form and observe for episodes of anxiety and/or hallucinations. R159's current Physician Orders dated 7/16/15, indicated Klonopin 0.5 milligram (mg) tab, at bedtime for hallucinations. R159's Physician Order Sheet dated and signed 8/6/15, included Klonopin 0.5 mg tablet, oral (by mouth). Although the physician order directed staff to monitor the resident for target behaviors for depression and psychotropic side effects, there was no indication to monitor target behaviors of hallucinations. On 8/31/15, at 7:40 p.m. R159 was observed quietly sitting in his wheelchair in the dayroom. During observation on 9/1/15, at 10:00 a.m. R159 appeared well groomed, was ambulating independently in his room, and presented with a calm demeanor.	21535		

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21535	Continued From page 21 R159's current Medication Administration Record (MAR) dated 7/16/15, through 9/1/15, indicated R159 received Klonopin 0.5 mg orally (by mouth) one time a day. R159's Consulting Pharmacist Consultation Reports dated 8/1/15, through 8/6/15, and 9/2/15, indicated the consultant pharmacist had reviewed R159's medications and indicated R159's medications contained no new irregularities and did not require the physician to review any concerns. During interview on 9/1/15, at 4:20 p.m. licensed practical nurse (LPN)-A stated the facility had not been monitoring R159 for hallucinations, and stated, "I didn't know it [hallucinations]was an issue." LPN-A stated she believed R159 was always calm and had not been aware of the resident having hallucinations. During interview on 9/2/15, at 7:42 a.m. the consultant pharmacist (CP) stated the facility should have been monitoring the resident for hallucinations if that is the indication for use the physician had identified for use of the Klonopin. During interview on 9/3/15, at 12:35 p.m. registered nurse (RN)-A and CP stated there was no documentation, assessment, indication for use or behavior monitoring for the use of Klonopin for R159. The facility policy titled Use of Psychotropic	21535		

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21535	Continued From page 22 Medications dated 4/3/14, directed to assess and evaluate all residents for appropriate use of medications, and any resident prescribed a psychotropic medication will receive an assessment and evaluation prior to the start of the medication. The policy further directed all new admissions will be reviewed for psychotropic medication use, criteria for prescription and use, monitor for signs of response to the medication, as well as adverse reactions, and document findings and recommendations. SUGGESTED METHOD OF CORRECTION: The administrator, director of nurses, consultant pharmacist or designee could review and revise policy and procedures to ensure the consultant pharmacist identified medication irregularities and ensured adequate monitoring of medications. The administrator or designee could provide education on any revisions made. The administrator or designee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21535		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced	21610		

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21610	Continued From page 23 by: Based on observation, interview and document review the facility failed to ensure only authorized personnel had access to the medication room. This lack in secure access to medications by facility personnel had the potential to affect all residents who received medication on the Morningside neighborhood. Findings include: During observation of medication administration on 9/1/15, at 11:10 a.m. registered nurse (RN)-F unlocked the medication storage room in the morningside neighborhood for maintenance supervisor (MS)-A. MS-A wheeled a cart into the medication storage room, and RN-F left MS-A in the medication room and closed the door. RN-F walked back to the medication cart and continued preparing medications for residents. MS-A was observed exiting the medication storage room approximately one to two minutes later with his cart, and left the unit. During interview on 9/1/15, at 11:15 a.m. RN-F stated she opens the door for maintance so they can collect medication and sharps container. During interview on 9/1/15, at 11:58 a.m. licensed practical nurse (LPN)-A stated nurses and nurse managers have access to the medication storage rooms, and maintenance staff take the sharps containers out, and housekeepers empty the trash. LPN-A stated when opening the door for staff that is not authorized to have access to the medication room, staff is expected to stay with them until they exit the medication room and it is secured. During interview on 9/1/15, at 11:59 a.m.	21610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00183	A. BUILDING: _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL ACRES HEALTH CARE CTR	5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422

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21610	Continued From page 24 registered nurse (RN)-A stated housekeeping and maintenance personnel need to enter the medication storage room at times, however, the nurses is expected to stay with them while they are in the medication room. During interview on 9/1/15, at 1:40 p.m. MS-A stated he goes into each medication storage room once per week and removes the full sharps containers, weighs and emptied the black box if needed, takes out the non-narcotic pharmaceuticals that have been discontinued, and transports them to an area in the maintenance area where a contracted company picks them up and disposes of them. MS-A stated the nurses do not always stay with him when he is collecting the medication and sharps containers in the medication storage room. During interview on 9/1/15, at 3:50 p.m., director of nursing (DON) stated when maintenance needs access to the medication storage room a nurse is expected to stay with them. A review of the facility's Storage of Medications policy dated 7/1/09, lacked information regarding secured access to the medication storage rooms. SUGGESTED METHOD OF CORRECTION: The administrator, director of nurses, consultant pharmacist or designee could review and revise policy and procedures for safe drug storage and accessibility. The administrator or designee could provide education on any revisions made. The administrator or designee could do random audits to ensure compliance with safe storage of medications. TIME PERIOD FOR CORRECTION: Twenty One	21610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21610	Continued From page 25 (21) days.	21610		