DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			CENTERS FOR MED	ICARE & MEDICAID SEI	RVICES
	MEDICA	ARE/MEDICAI	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: NE4T	
	PART I -	TO BE COMPI	LETED BY T	THE STAT	FE SURVEY AGENCY	Facility ID:	00979
MEDICARE/MEDICAID PROVIDER (L1) 245264 2.STATE VENDOR OR MEDICAID NO		3. NAME AND AL (L3) AUGUSTAN (L4) 14650 GARI	A HCC OF A	PPLE VAI	LEY		rtification
(L2) 176622800		(L5) APPLE VAL		-	(L6) 55124	3. Termination4. CHO5. Validation6. Com7. On-Site Visit9. Othe	plaint
5. EFFECTIVE DATE CHANGE OF O (L9) 01/25/2006		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint	-
6. DATE OF SURVEY 11/22 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	L/2014 (L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: 09/30	(L35)
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		X A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:	
To (b):			equirements		2. Technical Personnel	6. Scope of Services Limit	i
12.Total Facility Beds	178 (L18)		e Based On: cceptable POC		 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code 	 7. Medical Director F)8. Patient Room Size 9. Beds/Room 	
13.Total Certified Beds	178 (L17)		pliance with Prog ents and/or Appli			(L12)	
14. LTC CERTIFIED BED BREAKDOW	VN	·			15. FACILITY MEETS		
18 SNF 18/19 SNF 178	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:	
Gayle Lantto, Supervisor		1	1/25/2014	(L19)	Anne Kleppe, Enforcen	nent Specialist 11	/25/2014 (L20)
PAR	T II - TO BE	COMPLETED I	BY HCFA RE	GIONAI	L OFFICE OR SINGLE S'		
 DETERMINATION OF ELIGIBILI _X_ 1. Facility is Eligible to Pa 			IPLIANCE WITH ITS ACT:	H CIVIL		cial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-151) :	3)
2. Facility is not Eligible	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	1ENT	26. TERMINATION ACTION:	(L30)	
OF PARTICIPATION 07/01/1983	BEGINNINC	6 DATE	ENDING DAT	ГЕ	VOLUNTARY 00 01-Merger, Closure 00	<u>INVOLUNTARY</u> 05-Fail to Meet Health	/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ment 06-Fail to Meet Agreer	nent
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	n <u>OTHER</u>	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Ch	ange
(L27)	B. Rescind Su	spension Date:	(L44)			00-Active	
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE			
	(L32)	10/28/2014		(L33)	DETERMINATION APPE	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 24-5264

Electronically Delivered: November 25, 2014

Mr. David Shaw, Administrator Augustana Healthcare Center of Apple Valley 14650 Garrett Avenue Apple Valley, Minnesota 55124

Dear Mr. Shaw:

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 November 6, 2014 the above facility is certified for:

178 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 178 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,

Ane Klegge

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



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: November 25, 2014

Mr. David Shaw, Administrator Augustana Healthcare Center of Apple Valley 14650 Garrett Avenue Apple Valley, Minnesota 55124

RE: Project Number S5264024

Dear Mr. Shaw:

On October 16, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 2, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 24, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 10, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 2, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 6, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 2, 2014 and therefore remedies outlined in our letter to you dated October 16, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Please feel free to call me with any questions about this electronic notice.

Sincerely,

Ane Kleene

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

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245264	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 11/24/2014
Name	e of Facility		Street Address, City, State, Zip Code	
AL	IGUSTANA HCC OF APPLE VALLEY		14650 GARRETT AVENUE APPLE VALLEY, MN 55124	

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	F0252	Correction Completed 11/06/2014	ID Prefix	F0282	Correction Completed 11/06/2014		ID Prefix	F0309		Correction Completed 11/06/2014
	483.15(h)(1)			483.20(k)(3)(ii)				483.25		
ID Prefix Reg. # LSC	483.65	Correction Completed 11/06/2014	Reg. #		Correction Completed	1				
ID Prefix Reg. # LSC						1	Reg. #			Correction Completed
Reg. #						i				
Reg. #			Reg. #			1	D //			
Reviewed I State Agen Reviewed I CMS RO	cy G	viewed By L/AK viewed By	Date: 11/25/20 Date:	14	of Surveyor: of Surveyor:		15	507	Date: 11/2 Date:	24/2014
Followup t	o Survey Comple 10/2/20				Uncorrected Det I Deficiencies (C				YES	NO

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

Provider / Supplier / CLIA / (Y2) Multiple C Identification Number A. Building 245264 B. Wing		N BUILDING 01	(Y3) Date of Revisit 11/10/2014
Name of Facility		Street Address, City, State, Zip Code	
AUGUSTANA HCC OF APPLE VALLEY		14650 GARRETT AVENUE APPLE VALLEY, MN 55124	

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		Correction Completed 11/06/2014	ID Prefix		Correction Completed 11/06/2014	ID Prefix		Correction Completed 11/06/2014
0	NFPA 101 K0033		0	NFPA 101 K0064		•	NFPA 101 K0067	
	NFPA 101 K0147	Correction Completed 11/06/2014	Reg. #		Correction Completed	D //		Correction Completed
ID Prefix Reg. # LSC		Correction Completed			Correction Completed	Reg. #		Correction Completed
Reg. #			_					
Reg. #			Reg. #			D "		
Reviewed B State Agen Reviewed B CMS RO		K	Date: 11/25/20 Date:	Signature of Sun 14 Signature of Sun	-	25822	2 Date 2 11/ Date	10/2014
Followup t	o Survey Completed 9/30/2014	l on:		Check for any Unco Uncorrected Defic				5 NO

DEPARTMENT OF HEALTH AND H	IUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDI	CAID SERVICES
Μ	EDICA	ARE/MEDICAII	O CERTIFIC	CATION	AND TRANSMITTAL		ID: NE4T
PA	RT I -	TO BE COMPL	ETED BY 1	THE STAT	FE SURVEY AGENCY		Facility ID: 00979
 MEDICARE/MEDICAID PROVIDER NO. (L1) 245264 STATE VENDOR OR MEDICAID NO. 		 NAME AND AD (L3) AUGUSTAN (L4) 14650 GARE 	A HCC OF A	PPLE VAI		 TYPE OF ACT Initial Termination 	ION: <u>2</u> (L8) 2. Recertification 4. CHOW
(L2) 176622800		(L5) APPLE VAL	LEY, MN		(L6) 55124	5. Validation	6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSH (L9) 01/25/2006		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey Aft	9. Other ter Complaint
6. DATE OF SURVEY 10/02/2014 8. ACCREDITATION STATUS:	(L34) L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR END 09/30	DING DATE: (L35)
	(L18)	1. Ad	nce With equirements e Based On: cceptable POC		And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	6. Scope of S 7. Medical D	Services Limit Director om Size
13.Total Certified Beds 178	(L17)	X B. Not in Com Requireme	pliance with Progents and/or Appli		* Code: B *	(L12)	
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS		
18 SNF 18/19 SNF 1 178	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMARKS (IF A	APPLICA	BLE SHOW LTC CA	NCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Lisa Hakanson, HPR-Dietary Spe	cialist	1	0/22/2014	(L19)	Anne Kleppe, Enforcer	nent Specialist	10/27/2014 (L20)
PART II - T	O BE (COMPLETED B	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S	TATE AGENCY	
 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible 	(L21)		PLIANCE WITH ITS ACT:	H CIVIL	 Statement of Fina Ownership/Contro Both of the Above 	ol Interest Disclosure Stn	
22. ORIGINAL DATE 23. LTC	AGREEN	MENT 24	. LTC AGREEN	/ENT	26. TERMINATION ACTION:		(L30)
	JINNING		ENDING DA		VOLUNTARY 00 01-Merger, Closure	<u>INVOLU</u>	JNTARY o Meet Health/Safety
(L24) (L41)		(L25)		02-Dissatisfaction W/ Reimburs		o Meet Agreement
25. LTC EXTENSION DATE: 27. ALT	ERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	OTHER	
A. S	uspension	of Admissions:			04-Other Reason for Withdrawal		der Status Change
(L27) B. Re	escind Su	spension Date:	(L44)			00-Activ	e
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		03001					
(L28)				(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE			
(L32)				(L33)	DETERMINATION APPI	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: October 16, 2014

Mr. David Shaw, Administrator Augustana Healthcare Center of Apple Valley 14650 Garrett Avenue Apple Valley, Minnesota 55124

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5264024

Dear Mr. Shaw:

The above facility was surveyed on September 29, 2014 through October 2, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

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

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Are Klegge

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			<u> </u>	<u>1B NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION (E SURVEY IPLETED
		245264	B. WING _			10/	02/2014
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE				650 GARRETT AVENUE		
A00001				AF	PPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 0	000			
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required first page of the CMS-2567 nic submission of the POC will tion of compliance.					
F 252 SS=E	on-site revisit of you validate that substa regulations has bee your verification. 483.15(h)(1)	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with IFORTABLE/HOMELIKE	F 2	252			11/6/14
	comfortable and ho	ovide a safe, clean, melike environment, allowing his or her personal belongings le.					
	by: Based on observat review, the facility fi- water temperature (R249) who compla had the potential to 165 residents. Findings include: On 9/30/14, at 12:4	NT is not met as evidenced ion, interview and document ailed to maintain adequate for bathing for 1 of 2 residents ined of cold bath water. This affect approximately 55 out of 8 p.m. R249 revealed a ing in the tub with cold water, vening shift.			F252. It is the policy of Augustana Health Care Center of Apple Valley t ensure that our environment is safe, clean, comfortable and homelike for residents. Inservices were conducte Oct 8 and 10, 2014 regarding proper bathing techniques including monito for appropriate water temperature for bathing. Audits will be conducted o residents per week X 3 months to determine if the water temperature w comfortable during their bath.	to our ed on r pring or f 5	
LABORATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

Electronically Signed

10/22/2014

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

PRINTED: 10/22/2014

		AND HUMAN SERVICES				FORM	10/22/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245264	B. WING			10/(02/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY			4650 GARRETT AVENUE PPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 252	Continued From pa	ge 1	F 2	252			
	indicated R249 was On 10/1/14, at 2:50	ata Set (MDS) dated 7/7/14, s cognitively intact. p.m. two out of the six spa hot water temperatures,			Maintenance will also be checking temperature of all 6 tubs bi-monthly adequate temperatures. Unit manager is responsible for compliance. Results of the audits will be reviewed		
	revealed the hot wa 2 North hot water te Fahrenheit (°F) and later it was 99.6 °F. tub room was 113°F	ater was cool to the touch. The emperature was 98.7 degrees d when rechecked 15 minutes The sink water in the 2 North F. The 1st floor North tub room when checked at 3:16 p.m.			the facility QI meetings to determin recommended changes to the POC on those results.	e any	
	there was no system temperatures. The revealed the water between 105 to 115 They both indicated	lirector and assistant revealed m in place to check the water maintenance assistant temperatures should be °F and that was "too cool." If there was a problem the alert the maintenance					
	was interviewed an on tub machine and then that is a good if there had been a	p.m. nursing assistant (NA)-B d revealed "You check the dial d if it's between 90 to 92°F temperature." NA-B explained lot of water use it may be °F, but NA-B felt that was an ature.					
	NA-C revealed she the resident if it was temperatures. NA-C gauge never seeme (which was over 10	p.m. NA-C was interviewed. would feel the water and ask s ok. NA-C did not take water C added the temperature ed to go into the red zone 0 degrees). She had heard nplain of water being too cool ed anyone.					

If continuation sheet Page 2 of 10

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		<u>. 0938-039</u> E SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COM	IPLETED
		245264	B. WING _		10/	02/2014
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COI	DE	
AUGUST	ANA HCC OF APPLE	VALLEY		14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 252	Continued From pa	age 2	F 25	2		
F 282 SS=D	3/07, indicated to a comfortable for the	RVICES BY QUALIFIED	F 28	2		11/6/14
	must be provided b	ded or arranged by the facility by qualified persons in ach resident's written plan of				
	by: Based on interview facility failed to imp 3 residents (R102) Findings include: On 9/29/14, at 2:25 and indicated lowe by pain medication worse lying in bed unable to move arc The admission Min 8/20/14, identified p mild intensity and F medications. The M intact cognition. A pain assessment the resident had vo	timum Data Set (MDS) dated pain as being frequent with R102 was on scheduled pain MDS depicted R102 as having t completed 8/19/14, indicated pocal complaints of (c/o) of pain.		F282 It is the policy of Augu Health Care Center of Apple V ensure that services provided facility are provided by qualifie accordance with each resider plan of care. R 102 pain ass was re-done on 10/5/14. The adjustments were made to he management plan: Tramadol added on 10/10/14 due to lum stiff legs. A follow up pain as was completed on 10/20/2014 indicated improvement with p scheduled Tramadol. R 102 i occasionally having pain or he the last 5 days with the worst intensity level of a 5 on a scal Patient feels her pain is being managed at this time.	/alley to by the ed persons in it s written essment e following er pain 50 mg was bbago and sessment 4 which ain with ndicated urting over pain e of 0-10.	
	making it hard to s	2 indicated frequent pain leep. She further indicated she ivities due to pain and rated the		Licensed staff will complete a packet regarding pain assess		

Facility ID: 00979

If continuation sheet Page 3 of 10

		AND HUMAN SERVICES				FORM	10/22/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		245264	B. WING			10/0	02/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, , , , , , , , , , , , , , , , , , , </u>	
AUGUST	ANA HCC OF APPLE	VALLEY			4650 GARRETT AVENUE PPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 3	F 2	282			
	Staff documented, plan developed." The Physician Orde further diagnoses o generalized pain. T indicated R102 had pain ordered: Caps pain prn (used sinc Tramadol 25 milligr and Tylenol ES (ext times a day (TID) b of the September 2 record noted the Ca the Tramadol had o	he worse imaginable pain). "Pain observed daily. Care er's dated 9/2/14, included of dementia, osteoporosis, and he Physician's Orders I the following medications for aicin topical apply to areas of e prior to admission); ams (mg) every six hours prn tra strength) 1000 mg three oth ordered on 6/1/14. Review 014 medication administration apsaicin had not been used, only been used once on denol ES was given at 8:00			Random audits will be completed or of pain observations completed per X 3 months to ensure that the care regarding pain is followed. Unit manager is responsible for compliance. Results of audits will be reviewed a facility QI meetings to determine ar recommended changes to the POC on those results.	r month plan it the iy	
	to functional depen- and neuropathy. The was able to verbaliz pain medications all medications. On 10/1/14, at 1:39 had back pain when On 10/2/14, at 11:5 (LPN)-B stated R102 positional with Tyler stated R102 used th	ated 9/8/14, indicated pain due dence, depression/anxiety, he care plan identified R102 ze pain and was on scheduled long with as needed (PRN) p.m. R102 stated she usually n she got up in the morning. 2 a.m. licensed practical nurse D2's pain seemed to be nol being effective. LPN-B he Tramadol on 10/1/14, for was effective and verified					
		6 p.m. registered nurse 2's pain assessment was done					

If continuation sheet Page 4 of 10

		& MEDICAID SERVICES	0.00			0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · ·	E SURVEY PLETED
		245264	B. WING		10/	02/2014
AME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
UGUST	ANA HCC OF APPLE	VALLEY		14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 282	quarterly. RN-A stat completed on 8/19/ documented her pa the Capsaicin to se	ted given the assessment 14, "We should have in and utilize the PRN's and e if they were effective." RN-A	F 28	2		
F 309 SS=D		care was not followed. CARE/SERVICES FOR EING	F 30	9		11/6/14
	provide the necess or maintain the high mental, and psycho	receive and the facility must ary care and services to attain nest practicable physical, psocial well-being, in e comprehensive assessment				
	by: Based on observatives the services, the facility factors and services the residents (R102) resident for the service services and indicated lower by pain medication, worse lying in bed a unable to move aro On 10/1/14, at 12:4 the dining room. R1 and did not appear was wheeled back appear in pain. At 1	p.m. R102 was interviewed back pain, not totally relieved R102 revealed the pain was and when in bed she was		F309 It is the policy of Augustar Health Care Center of Apple Valley ensure that services provided by th facility are provided by qualified pe accordance with each resident s w plan of care. R 102 pain assessm was re-done on 10/5/14. The follo adjustments were made to her pain management plan: Tramadol 50 m added on 10/10/14 due to lumbago stiff legs. A follow up pain assess was completed on 10/20/2014 whice indicated improvement with pain w scheduled Tramadol. R 102 indicated occasionally having pain or hurting the last 5 days with the worst pain intensity level of a 5 on a scale of 0 Patient feels her pain is being adeo managed at this time.	to te rsons in written ent owing g was o and ment ch ith tted over 0-10.	

Facility ID: 00979

If continuation sheet Page 5 of 10

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MILLET	PLE CONSTRUCTION	(Y2) DAT	E SURVEY
	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
		245264	B. WING		10/	02/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY		14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 309	Continued From pa	age 5	F 30	9		
		ain, R102 stated she had no				
		pain while up in the				
		e in the recliner. R102 stated n the morning before getting		Licensed staff will complete a le packet regarding pain assessme management.		
	8/20/14, identified p mild intensity and F medications. The N intact cognition.	imum Data Set (MDS) dated bain as being frequent with R102 was on scheduled pain IDS depicted R102 as having		Random audits will be complete of pain observations completed X 3 months to ensure that the corregarding pain is followed. Unit manager is responsible for compliance.	per month	
	the resident had vo When asked, R102 making it hard to sl had limited her acti pain as a 6, on a so pain and 10 being t	completed 8/19/14, indicated ocal complaints of (c/o) of pain. 2 indicated frequent pain leep. She further indicated she vities due to pain and rated the cale of 1 to 10 (with 0 being no the worse imaginable pain). "Pain observed daily. Care				
	further diagnoses of generalized pain. T indicated R102 had pain ordered: Caps pain prn (used sind Tramadol 25 milligr and Tylenol ES (ex times a day (TID) b of the September 2 record noted the Ca the Tramadol had of	er's dated 9/2/14, included of dementia, osteoporosis, and The Physician's Orders d the following medications for caicin topical apply to areas of ee prior to admission); rams (mg) every six hours prn tra strength) 1000 mg three both ordered on 6/1/14. Review 2014 medication administration apsaicin had not been used, only been used once on denol ES was given at 8:00 nd 8:00 p.m.				

Facility ID: 00979

If continuation sheet Page 6 of 10

		AND HUMAN SERVICES				FORM	10/22/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE	E SURVEY IPLETED
		245264	B. WING	B. WING			02/2014
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	TANA HCC OF APPLE	VALLEY			4650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309 F 441 SS=D	and neuropathy. Th was able to verbaliz pain medications al medications. On 10/1/14, at 1:39 had back pain wher On 10/2/14, at 11:52 (LPN)-B stated R102 positional with Tyler stated R102 used th the first time and it Capsaicin had not to On 10/2/14, at 12:11 (RN)-A stated R102 quarterly. RN-A state completed on 8/19/ documented her pathe the Capsaicin to se verified R102 's pathe 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and of to help prevent the of disease and infect (a) Infection Contro The facility must es Program under whit (1) Investigates, con in the facility; (2) Decides what pr	 a care plan identified R102 a pain and was on scheduled long with as needed (PRN) a p.m. R102 stated she usually in she got up in the morning. 2 a.m. licensed practical nurse 02's pain seemed to be not being effective. LPN-B the Tramadol on 10/1/14, for was effective and verified been used. 6 p.m. registered nurse 2's pain assessment was done ted given the assessment ta4, "We should have an and utilize the PRN's and e if they were effective." RN-A in was not being managed. I CONTROL, PREVENT A contrable environment and development and transmission ction. A Program tablish an Infection Control 	F 4	309			11/6/14

Facility ID: 00979

If continuation sheet Page 7 of 10

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				PRINTED FORM OMB NC					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED			
		245264	B. WING	;		10/	02/2014			
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE					
AUGUST	ANA HCC OF APPLE	VALLEY			4650 GARRETT AVENUE .PPLE VALLEY, MN 55124					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETION DATE			
F 441	actions related to in (b) Preventing Spre (1) When the Infect determines that a r prevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each di hand washing is ind professional practic (c) Linens Personnel must ha	ord of incidents and corrective ifections. ead of Infection tion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. t require staff to wash their irect resident contact for which dicated by accepted	F	441						
	by: Based on observative review, the facility for spread of infections 1 of 1 observed rest Findings include: On 10/1/14, at 9:21 completing a dress forearm and doing	NT is not met as evidenced tion, interview and document ailed to follow their policy revent/minimize the potential s during dressing changes for sident (R441). a.m. LPN-B was observed ing change to R441's right wound care to an unstageable heel. Observations were as			F441 It is the policy of Augustar Health Care Center of Apple Valle establish and maintain an infection program designed to provide a sa sanitary and comfortable environm to help prevent the development a transmission of disease and infect All licensed staff will complete a le packet regarding hand hygiene interview of our dressing change pol Random audits will be completed dressing changes a month X 3 mo	y to n control fe, nent and and tion. earning cluding icy. on 5				

Facility ID: 00979

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PRINTED: 10/22/2014

		& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · /	E SURVEY IPLETED
		245264	B. WING _		10/	02/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
AUGUST	ANA HCC OF APPLE	VALLEY		14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 441	Continued From pa	age 8	F 44	41		
	LPN-B was observe then don gloves. Lf left heel wound with changing the soiled antiseptic and kills cells within the wou slough or piece of of the surface of the s without removing th hands, LPN-B proc packet and apply th surround the wound heel wound treatme and washed their h LPN-B then proceed dressing change and dressing on the right the adherent dress wound, and the res was removed. The moist and yellow in were noted to be re- gloves or cleansing the wound with wour removing the soiled hands, LPN-B appl to avoid infection) to dressings, applied to wound on the right forearm with gauze removed, and hand dressing change.	eded to begin the right forearm and donned new gloves. The old ht forearm was removed and ing was noted to stick to the sident winced as the dressing wound based was noted to be color, the edges of the wound ed. Without changing the soiled a their hands, LPN-B cleansed and cleanser. Still without d gloves or cleansing their ied Bacitracin (used topically o three non-adherent the dressings to the open forearm and then wrapped the e wrap. The gloves were not ds washed until the end of the		monitor for compliance with Unit manager is responsible compliance. Results of audits will be revie facility QI meetings to determ recommended changes to th on those results.	for ewed at the nine any	
	did not change her	p.m. LPN-B stated that she gloves with the heel cleansing not been a dressing on the				

If continuation sheet Page 9 of 10

		AND HUMAN SERVICES				FORM	: 10/22/2014 APPROVED . 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245264	B. WING	i		10/	/02/2014	
NAME OF	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE			
AUGUST	ANA HCC OF APPLE	VALLEY			4650 GARRETT AVENUE APPLE VALLEY, MN 55124			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 441	wound. Regarding t LPN-B verified she and cleansed her h dressing and before The facility's policy for a Dressing Char directed after a drea individual doing the remove their gloves before putting on di	inge 9 It been no drainage from the the arm dressing change, had not changed her gloves ands after removing the old e applying the new dressing. on Equipment and Supplies nge dated as revised on 8/13, ssing was removed, the dressing change was to a and sanitize their hands, isposable gloves and d as ordered by the physician.	F	441				

Facility ID: 00979

If continuation sheet Page 10 of 10

		AND HUMAN SERVICES	7.	F5264023	FORM	: 10/23/2014 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245264	B. WING		09/	/30/2014
NAME OF F	PROVIDER OR SUPPLIER	<i>h</i>		STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY		14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE
K 000	INITIAL COMMENT	rs	K 0	000		
	FIRE SAFETY					
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.		i i		
N	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departm Fire Marshal Divisio Augustana Health C was found not in su requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),				
	DEFICIENCIES (K-TAGS) TO:	R THE FIRE SAFETY		EPOC		
	Health Care Fire In: State Fire Marshal 445 Minnesota St., St Paul, MN 55101-	Division Suite 145				
		ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Electron	ically Signed					10/22/2014

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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/23/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 6 01 - MAIN BUILDING 01		E SURVEY PLETED
		245264	B. WING			09/	30/2014
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY			14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 1	K	000			
	By email to: Marian	.Whitney@state.mn.us					
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:	-				
	1. A description of v to correct the deficient	what has been, or will be, done ency.					
	2. The actual, or pro	oposed, completion date.					
		r title of the person rection and monitoring to ence of the deficiency.					
	a 3-story building w building was constr	Care Center of Apple Valley is ith a full basement. The ucted in 1983, and was f Type II(222) construction.					
	facility has a comple corridor smoke dete corridor that is mon department notifica	fire sprinkler protected. The ete fire alarm system with full ection and spaces open to the itored for automatic fire tion. The facility chooses to ted single station smoke nt rooms.					
		censed capacity of 178 beds of 165 at the time of the					
	The requirement at NOT MET as evide	42 CFR Subpart 483.70(a) is nced by:					

Facility ID: 00979

If continuation sheet Page 2 of 6

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ATE SURVEY OMPLETED
		245264	B. WING	0	9/30/2014
	PROVIDER OR SUPPLIER	VALLEY	1	STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
K 033 K 033 SS=D	NFPA 101 LIFE SA Exit components (s enclosed with cons resistance rating of arranged to provide and provide protect	ge 2 FETY CODE STANDARD uch as stairways) are truction having a fire at least one hour, are a continuous path of escape, ion against fire or smoke from uilding. 8.2.5.2, 19.3.1.1	K 033 K 033		11/6/14
	Based on observation facility failed to main facility failed to main at least one hour in accordance with the 2000 NFPA 101, Secould effect 40 out Findings include: On facility tour between the second seco	veen 8:00 AM and 11:30 AM,		K33 Basement Stairwell A: Open Penetration around sprinkler line, (2) Mo around cables, Check all stairwells foe deficiency. Augustana Apple Valley will inspect all stairwells for this deficiency, maintenance staff will also add this into their maintenance preventive software to che this biannually	е
	observation revealed	ed that the Basement - en penetration around sprinkler bles.			
K 064 SS=D	Facility Maintenance discovery.	ice was confirmed by the e Director (RC) at the time of FETY CODE STANDARD	K 064	L.	11/6/14

Event ID: NE4T21

PRINTED: 10/23/2014

		AND HUMAN SERVICES			M APPROVE 0. 0938-039
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED
		245264	B. WING	0	9/30/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
AUGUST	ANA HCC OF APPLE	VALLEY		4650 GARRETT AVENUE APPLE VALLEY, MN 55124	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
K 064		ncies in accordance with	K 064		
	Based on observation determined that the portable fire extingent NFPA 101-2000 ed	s not met as evidenced by: tion and staff interview, it was a facility failed to maintain uisher in accordance with ition, Section 9.7.4.1 and cient practice could affect 10 s.		K64 1. Basement elevator equipment room: Fire Extinguisher was not inspecte on its annual inspection schedule. Augustana Apple Valley will notify fire extinguisher inspection contractor of the Error and make certain we receive a check list that is completed after each yearly inspection.	
	 observation reveal 1. Basement - eleve extinguisher has no 2/2013 2. Basement - root 	ween 8:00 AM and 11:30 AM, that the following was found: ator equipment: fire of been annual inspected since m # N-7: Fire extinguisher			
K 067 SS=F	2014 This deficient pract Facility Maintenanc discovery. NFPA 101 LIFE SA Heating, ventilating with the provisions in accordance with	was missed for July & August ice was confirmed by the se Director (RC) at the time of FETY CODE STANDARD , and air conditioning comply of section 9.2 and are installed the manufacturer's 9.5.2.1, 9.2, NFPA 90A,	K 067		11/6/14

Facility ID: 00979

If continuation sheet Page 4 of 6

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		AND HUMAN SERVICES			FORM APP OMB NO. 093	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245264	B. WING_		09/30/2	014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY		14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COM	(X5) MPLETIO DATE
K 067	Continued From pa 19.5.2.2	ge 4	К 06	37		
	Based on docume interview, that the fair conditioning sys maintained in accor 19.5.2.1 and NFPA	s not met as evidenced by: ntation review and staff acility's general ventilating and tem (HVAC) was not rdance with the LSC, Section 90A, Section 3-4.7. A C system could affect all 165		K67 fire smoke dampers were n inspected within a four year perio 2/17-10/18-14. Augustana Apple Valley has put t of inspections for this into its prev maintenance software, this inspe inform our vender that this need done two weeks prior of due date	nd the dates ventive ection will to be	
	documentation revi the past 4 years rev dampers have not l	veen 8:00 AM and 11:30 AM, ew for fire damper testing for vealed, that the fire/smoke been tested with-in a 4 years conducted on 02/17/10 and				
K 147 SS=D	Facility Maintenanc discovery. NFPA 101 LIFE SA Electrical wiring and	ice was confirmed by the e Director (RC) at the time of FETY CODE STANDARD d equipment is in accordance ional Electrical Code. 9.1.2	K 14	17	11/	6/14
	Based on observation facility failed to main	s not met as evidenced by: tion and staff interview, the ntain electrical supply in e requirements of 2000 NFPA		K147 Found power strips conne- each other at the following location 1. Basement room □S-4		

ŗ.

Facility ID: 00979

If continuation sheet Page 5 of 6

PRINTED: 10/23/2014

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01		E SURVEY PLETED
		245264	B. WING		09/	30/2014
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
UGUST	ANA HCC OF APPLE	VALLEY				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
K 147	State Fire Code 60 of 165 residents. Findings include: On facility tour betwo observation revealed relocatable power seach other: 1. Basement - S-4 2. Basement - Occ 3. Basement - Physic Check the entire face	NFPA 70, and 2007 Minnesota 15.4 .2. This could effect 10 out ween 8:00 AM and 11:30 AM, ed that the following strips are interconnected to	K 14	 Basement room □ O.T. room Basement room -P.T. room Augustana Apple Valley will corredeficiency, and will notify and reion this improper usage of power 	ect this train staff	
	TEAM COMPOSI Gary Schroeder, L	TION ife Safety Code Spc.				

Facility ID: 00979

If continuation sheet Page 6 of 6



Protecting, Maintaining and Improving the Health of Minnesotans Electronically Delivered: October 16, 2014

Mr. David Shaw, Administrator Augustana Healthcare Center of Apple Valley 14650 Garrett Avenue Apple Valley, Minnesota 55124

RE: Project Number S5264024

Dear Mr. Shaw:

On October 2, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

<u>Electronic 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;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and <u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

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:

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

Email: <u>gloria.derfus@state.mn.us</u> Telephone: (651) 201-3792 Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 11, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 11, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the

facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following 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 ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 January 2, 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 April 2, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC 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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division

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

Feel free to contact me if you have questions about this electronic notice.

Sincerely,

Ane Klegge

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

	ILTIPLE CONSTRUCTION (X3)	DATE SURVEY COMPLETED
00979 B. WIN	G	10/02/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, O	CITY, STATE, ZIP CODE	
AUGUSTANA HCC OF APPLE VALLEY 14650 GARRETT APPLE VALLEY,		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		
2 000 Initial Comments 2 000		
*****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 September 29th, and 30th and October 1st, and 2nd, 2014, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softw Tag numbers have been assigned to Minnesota state statutes/rules for Nur Homes.	
Minnesota Department of Health _ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 10/22/14

Electronically Signed

6899

If continuation sheet 1 of 12

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		SURVEY LETED	
		00979	B. WING	10		/02/2014	
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	Health Information http://www.health.s obul.htm The Sta delineated on the a Department of Hea electronically. Alth necessary for State the word "corrected Then indicate in th process, under the date your orders w	Minnesota Department of al Bulletin 14-01, available at state.mn.us/divs/fpc/profinfo/inf te licensing orders are attached Minnesota alth orders being submitted hough no plan of correction is e Statutes/Rules, please enter d" in the box available for text. e electronic State licensure e heading completion date, the fill be corrected prior to hitting to the Minnesota alth.		The assigned tag number ap far left column entitled "ID P The state statute/rule number corresponding text of the sta out of compliance is listed in "Summary Statement of Defi column and replaces the "To portion of the correction order column also includes the fir are in violation of the state sta statement, "This Rule is not evidenced by." Following th findings are the Suggested M Correction and the Time Per Correction. PLEASE DISREGARD THE THE FOURTH COLUMN WH STATES, "PROVIDER'S PLA CORRECTION." THIS APPL FEDERAL DEFICIENCIES C WILL APPEAR ON EACH PA THERE IS NO REQUIREME SUBMIT A PLAN OF CORRECTIONS OF MINNESC	refix Tag." r and the te statute/rule the ciencies" Comply" er. This ndings which atute after the met as e surveyors Aethod of iod For HEADING OF HICH N OF IES TO DNLY. THIS AGE. NT TO ECTION FOR		
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565	STATUTES/RULES.		11/6/14	
	Subp. 3. Use. A c	comprehensive plan of care Il personnel involved in the It.					
	This MN Requirem	nent is not met as evidenced					

14650 GARRETT AVENUE	SHOULD BE COMPL
AUGUSTANA HCC OF APPLE VALLEY 14650 GARRETT AVENUE APPLE VALLEY, MN 55124 (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 COR (EACH CORRECTIVE ACTION) 2 565 Continued From page 2 2 565 by: Based on interview and document review the facility failed to implement the plan of care for 1 of 3 residents (R102) identified with pain. F282 It is the policy of Augu Care Center of Apple Valley to services provided by the faci provided by qualified persons accordance with each reside plan of care. R 102 pain ass re-done on 10/5/14. The fol adjustments were made to h management plan: Tramadoi added on 10/10/14 due to lur stiff legs. A follow up pain as worse lying in bed and when in bed she was unable to move around that well. The admission Minimum Data Set (MDS) dated 5/29/14, identified pain as mild intensity and R102 was on scheduled pain medications. Atoms of the worst	SHOULD BE COMPL
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 the resident had vocal complaints of (c/o) of pain. When asked, R102 indicated frequent pain making it hard to sleep. She further indicated she had limited her activities due to pain and rated the pain as a 6, on a scale of 1 to 10 (with 0 being no pain and 10 being the worse imaginable pain). Staff documented, "Pain observed daily. Care plan developed." The Physician Order's dated 9/2/14, included further diagnoses of dementia, osteoporosis, and generalized pain. The Physician's Orders indicated R102 had the following medications for pain ordered: Capsaicin topical apply to areas of pain prn (used since prior to admission); Tramadol 25 milligrams (mg) every six hours prn 	to ensure that illity are us in ent s written issessment was illowing her pain of 50 mg was imbago and assessment 14 which pain with 2 indicated hurting over ist pain intensity 0. Patient uately a learning issment and oleted on 10% eted per month he care plan e for ewed at the

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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	a.m., 12:00 p.m. ar	nd 8:00 p.m.				
	to functional depen and neuropathy. The was able to verbali	ated 9/8/14, indicated pain due indence, depression/anxiety, he care plan identified R102 ze pain and was on scheduled long with as needed (PRN)				
		9 p.m. R102 stated she usually n she got up in the morning.				
	(LPN)-B stated R102 positional with Tylen stated R102 used th	52 a.m. licensed practical nurse 02's pain seemed to be nol being effective. LPN-B the Tramadol on 10/1/14, for nd it was effective and verified been used.	•			
	(RN)-A stated R10. quarterly. RN-A sta completed on 8/19 documented her pa the Capsaicin to se	16 p.m. registered nurse 2's pain assessment was done ated given the assessment /14, "We should have ain and utilize the PRN's and ee if they were effective." RN-A care was not followed.				
	The director of nur staff to ensure all of followed according monitoring program to assure ongoing	THOD FOR CORRECTION: sing or designee could direct care plans interventions are to individualized needs. A n could be established in order and effective care plan sponse to resident care needs.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty one				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			X3) DATE S COMPL	
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custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t resident must rema	supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident				
by: Based on observati review the facility fa care and services to residents (R102) re Findings include: On 9/29/14, at 2:25 and indicated lower by pain medication, worse lying in bed a unable to move aro On 10/1/14, at 12:4 the dining room. R1 and did not appear	ion, interview, and document ailed to provide the necessary o mange pain for 1 of 3 eviewed for pain. 5 p.m. R102 was interviewed back pain, not totally relieved R102 revealed the pain was and when in bed she was bund that well. 5 p.m. R102 was observed in 102 was observed to be eating to be in pain. After lunch R102		Care Center of Apple Valley to ensu services provided by the facility are provided by qualified persons in accordance with each resident s w plan of care. R 102 pain assessme re-done on 10/5/14. The following adjustments were made to her pain management plan: Tramadol 50 mg added on 10/10/14 due to lumbago stiff legs. A follow up pain assessme was completed on 10/20/2014 which indicated improvement with pain wit scheduled Tramadol. R 102 indicated occasionally having pain or hurting of	re that ritten ent was and hent h ed over ntensity	
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa MN Rule 4658.0524 Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t resident must rema prefers to remain in This MN Requirema by: Based on observati review the facility fa care and services t residents (R102) re Findings include: On 9/29/14, at 2:25 and indicated lower by pain medication, worse lying in bed a unable to move arc On 10/1/14, at 12:4 the dining room. R ² and did not appear	OF CORRECTION IDENTIFICATION NUMBER: 00979 00979 PROVIDER OR SUPPLIER STREET AD ANA HCC OF APPLE VALLEY 14650 GA APPLE VALLEY SUMMARY STATEMENT OF DEFICIENCIENCIENCY SUMMARY STATEMENT OF DEFICIENCIENCIENCY SUMMARY STATEMENT OF DEFICIENCIENCIENCY Continued From page 4 MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide the necessary care and services to mange pain for 1 of 3 residents (R102) reviewed for pain. Findings include: On 9/29/14, at 2:25 p.m. R102 was interviewed and indicated lower back pain, not totally relieved by pain medication. R102 revealed the pain was worse lying in bed and when in bed she was unable to move around that well.	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING. 00979 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, I ANA HCC OF APPLE VALLEY 14650 GARRETT AVE APPLE VALLEY, MN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 4 2 830 MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General 2 830 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.04005. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. 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A follow up pain assessmi was completed on 10/20214 which indicated improvement with pain wit scheduled Tramadol 5. R02 20214 which indicated inprovement with pain wit scheduled Tramadol. R 102 indicato indicated inprovement with pain wit scheduled Tramadol. R 102 indic	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPL NOVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10/02 ANA HCC OF APPLE VALLEY 14650 GARETT AVENUE APPLE VALLEY, MN 55124 10/02 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DIENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ATION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) Continued From page 4 2 830 2 830 NN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care, General 2 830 Subpart 1. Care in general. 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R 102 uncitated occasionally having pain or thuring over othe last 5 days with the worst pain intensity

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	wheelchair, or while	pain while up in the e in the recliner. R102 stated n the morning before getting		Licensed staff will complete packet regarding pain asse management.		
	The admission Minimum Data Set (MDS) dated 5/29/14, identified pain as mild intensity and R102 was on scheduled pain medications.			Random audits will be com of pain observations compl X 3 months to ensure that t regarding pain is followed.	eted per month	
	the resident had vo When asked, R102 making it hard to sl had limited her acti pain as a 6, on a so pain and 10 being t	completed 8/19/14, indicated cal complaints of (c/o) of pain. eep. She further indicated she vities due to pain and rated the cale of 1 to 10 (with 0 being no he worse imaginable pain). "Pain observed daily. Care	,	Unit manager is responsible compliance. Results of audits will be rev facility QI meetings to deter recommended changes to on those results.	viewed at the mine any	
	further diagnoses of generalized pain. T indicated R102 had pain ordered: Caps pain prn (used sinc Tramadol 25 milligr and Tylenol ES (exi times a day (TID) b of the September 2 record noted the Ca the Tramadol had of	er's dated 9/2/14, included of dementia, osteoporosis, and the Physician's Orders If the following medications for vaicin topical apply to areas of e prior to admission); rams (mg) every six hours prn tra strength) 1000 mg three oth ordered on 6/1/14. Review 2014 medication administration apsaicin had not been used, only been used once on thenol ES was given at 8:00 ad 8:00 p.m.				
	to functional depen and neuropathy. Th was able to verbalize	ated 9/8/14, indicated pain due dence, depression/anxiety, ne care plan identified R102 ze pain and was on scheduled long with as needed (PRN)				

Minnesota Department of Health						
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00979	B. WING		10/0	2/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY	ALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 6	2 830			
		p.m. R102 stated she usually n she got up in the morning.				
	(LPN)-B stated R10 positional with Tyler stated R102 used t	2 a.m. licensed practical nurse 02's pain seemed to be nol being effective. LPN-B he Tramadol on 10/1/14, for d it was effective and verified been used.				
	(RN)-A stated R102 quarterly. RN-A stat completed on 8/19/ documented her pat the Capsaicin to se	6 p.m. registered nurse 2's pain assessment was done ted given the assessment 14, "We should have in and utilize the PRN's and e if they were effective." RN-A care was not followed.				
	Director of Nursing polices and proced monitoring of pain. designee could edu procedures. The Di designee could dev	THOD OF CORRECTION: The or her designee could develop ures regarding assessing and The Director of Nursing or her acate staff on the policies and rector of Nursing or her relop a monitoring system to acceive the appropriate care.				
	TIME FRAME FOR (21) Days.	CORRECTION: Twenty-One				
21375	MN Rule 4658.0800 Program	0 Subp. 1 Infection Control;	21375			11/6/14
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
Vinnesota D	epartment of Health					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	
		00979	B. WING		10/0	2/2014
	PROVIDER OR SUPPLIER	14650 GA	DRESS, CITY, RRETT AVE ALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLE DATE
21375	Continued From pa	age 7	21375			
	by: Based on observat review, the facility f regarding how to p spread of infections 1 of 1 observed res Findings include: On 10/1/14, at 9:21 completing a dress forearm and doing area on R441's left follows: Before beginning w LPN-B was observ then don gloves. L left heel wound witt changing the soiled antiseptic and kills cells within the wou slough or piece of the surface of the s without removing th hands, LPN-B proc packet and apply th surround the woun heel wound treatm and washed their h LPN-B then proces dressing on the rig the adherent dress wound, and the res was removed. The	I a.m. LPN-B was observed sing change to R441's right wound care to an unstageable heel. Observations were as yound care to R441's left heel, ed to cleanse her hands and PN-B proceeded to cleanse the h normal saline, then without d gloves applied Betadine (an not only bacteria but healing und) to the eschar tissue (a dead tissue that is cast off from skin) of the left heel. Still he soiled gloves and cleansing seeded to open a skin prep he skin prep wipe to the skin d. After completion of the left ent LPN-B removed the gloves		F441 It is the policy of Augu Care Center of Apple Valley to and maintain an infection con designed to provide a safe, sa comfortable environment and prevent the development and of disease and infection. All licensed staff will complete packet regarding hand hygien review of our dressing change Random audits will be complete dressing changes a month X monitor for compliance with o Unit manager is responsible f compliance. Results of audits will be review facility QI meetings to determ recommended changes to the on those results.	 be establish trol program anitary and to help transmission be a learning he including policy. beted on 5 conthes to ur policy. or wed at the ine any 	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00979	B. WING		10/02/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	1	
AUGUST	ANA HCC OF APPLE	ναιιεγ	ARRETT AVEN /ALLEY, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATTEL A ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 8	21375			
	gloves or cleansing the wound with wour removing the soiled hands, LPN-B appl to avoid infection) t dressings, applied t wound on the right forearm with gauze removed, and hand dressing change. On 10/2/14, at 1:40 did not change her because there had area, and there had area, and there had area, and there had and cleansed her h	ed. Without changing the soiled their hands, LPN-B cleansed und cleanser. Still without d gloves or cleansing their ied Bacitracin (used topically o three non-adherent the dressings to the open forearm and then wrapped the e wrap. The gloves were not ds washed until the end of the 0 p.m. LPN-B stated that she gloves with the heel cleansing not been a dressing on the d been no drainage from the the arm dressing change, had not changed her gloves hands after removing the old e applying the new dressing.	•			
	for a Dressing Cha directed after a dre individual doing the remove their gloves before putting on d cleansing the woun SUGGESTED MET	on Equipment and Supplies nge dated as revised on 8/13, ssing was removed, the e dressing change was to s and sanitize their hands, isposable gloves and nd as ordered by the physician. THOD OF CORRECTION: nee could train staff and				
	perform audits to e techniques are beir	nsure infection control				
	(21) days.					
21710	MN Rule 4658.141 Housekeeping, Op		21710			11/6/14

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00979	B. WING		10/02/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	ναιιεγ	ARRETT AVE /ALLEY, MN			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLET DATE
21710	Continued From pa	age 9	21710			
	supplied to sinks an maintained within a	r temperature. Hot water nd bathing fixtures must be a temperature range of 105 t to115 degrees Fahrenheit at				
	by: Based on observat review, the facility f water temperature (R249) who compla	ent is not met as evidenced ion, interview and document failed to maintain adequate for bathing for 1 of 2 residents ained of cold bath water. This affect approximately 55 out of		F252. It is the policy of Augustar Care Center of Apple Valley to en our environment is safe, clean, comfortable and homelike for our residents. Inservices were condu Oct 8 and 10, 2014 regarding pro bathing techniques including mon for appropriate water temperature	sure that icted on per itoring	
	concern about bath especially on the end R249's Minimum D	ata Set (MDS) dated 7/7/14,		bathing. Audits will be conducted residents per week X 3 months to determine if the water temperatur comfortable during their bath. Maintenance will also be checking temperature of all 6 tubs bi-month) e was g	
	rooms checked for revealed the hot wa 2 North hot water to Fahrenheit (°F) and later it was 99.6 °F tub room was 113°	s cognitively intact.) p.m. two out of the six spa hot water temperatures, ater was cool to the touch. The emperature was 98.7 degrees d when rechecked 15 minutes . The sink water in the 2 North F. The 1st floor North tub roon when checked at 3:16 p.m.		adequate temperatures. Unit manager is responsible for compliance. Results of the audits will be review the facility QI meetings to determ recommended changes to the PC on those results.	ine any	
	there was no syste temperatures. The revealed the water	director and assistant revealed m in place to check the water maintenance assistant temperatures should be 5°F and that was "too cool."				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00979	B. WING		10/02/2014	
NAME OF PROVIDER OR SUPPLIER STREET.			DDRESS, CITY, ST	TATE, ZIP CODE	10/	02/2014
UGUST	ANA HCC OF APPLE	14650 G	ARRETT AVEN /ALLEY, MN 5	IUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	AFFLE V ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21710	Continued From pa	age 10	21710			
		d if there was a problem the d alert the maintenance				
	was interviewed an on tub machine and that is a good temp there had been a lo) p.m. nursing assistant (NA)-E ad revealed "You check the dia d if it's between 90-92°F then berature." NA-B explained if ot of water use it may be 2°F, but NA-B felt that was an ature.				
	NA-C revealed she the resident if it wa temperatures. NA-0 gauge never seem (which was over 10	 p.m. NA-C was interviewed. would feel the water and ask s ok. NA-C did not take water C added the temperature ed to go into the red zone d degrees). She had heard mplain of water being too cool ed anyone. 				
		cedure titled Bath, revised ssure water temperature was resident.				
	The facility mainter and/or a designee of procedures related comfortable water to accessible fixtures. could be educated procedures. A mor implemented and re assessment and as	THOD OF CORRECTION: nance supervisor, administrato could develop policies and to management of temperatures for resident . Maintenance employees on new policies and nitoring system could be eviewed by the facility's quality ssurance committee to ensure e with comfortable water	,			
	TIME PERIOD FOI days.	R CORRECTION: Seven (7)				

Minnesota Department of Health								
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED			
		00979	B. WING		10/02/2014			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE				
AUGUST	ANA HCC OF APPLE		ARRETT AVE					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE			
Vinnesota D	epartment of Health							