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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NE4T

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00979

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245264**
2.STATE VENDOR OR MEDICAID NO.
(L2) **176622800**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA HCC OF APPLE VALLEY**
(L4) **14650 GARRETT AVENUE**
(L5) **APPLE VALLEY, MN** (L6) **55124**

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) **01/25/2006**

6. DATE OF SURVEY 11/24/2014 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **178** (L18)

13.Total Certified Beds **178** (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: * Code: **A*** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	178			
(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 :
Gayle Lantto, Supervisor 11/25/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 11/25/2014 (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
07/01/1983
(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
10/28/2014
(L33)

DETERMINATION APPROVAL

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,

Anne Kleppe

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

MINNESOTA MDH DEPARTMENT OF HEALTH

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, effective November 6, 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,

Anne Kleppe

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

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
245264	A. Building B. Wing	11/24/2014

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 **F0252** Reg. # **483.15(h)(1)** LSC	Correction Completed **11/06/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **11/06/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **11/06/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **11/06/2014**	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/AK	11/25/2014	15507	11/24/2014
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
10/2/2014			

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
245264	A. Building B. Wing **01 - MAIN BUILDING 01**	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**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0033		LSC K0064		LSC K0067	
ID Prefix	Correction Completed **11/06/2014**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0147		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/AK	11/25/2014	25822	11/10/2014
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
9/30/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NE4T

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00979

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245264**
2.STATE VENDOR OR MEDICAID NO.
(L2) **176622800**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA HCC OF APPLE VALLEY**
(L4) **14650 GARRETT AVENUE**
(L5) **APPLE VALLEY, MN** (L6) **55124**

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) **01/25/2006**
6. DATE OF SURVEY **10/02/2014** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **178** (L18)

13.Total Certified Beds **178** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	178			
(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 :
Lisa Hakanson, HPR-Dietary Specialist 10/22/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 10/27/2014 (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
07/01/1983
(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

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

Anne Kleppe

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain adequate water temperature for bathing for 1 of 2 residents (R249) who complained of cold bath water. This had the potential to affect approximately 55 out of 165 residents. Findings include: On 9/30/14, at 12:48 p.m. R249 revealed a concern about bathing in the tub with cold water, especially on the evening shift.	F 252	F252. It is the policy of Augustana Health Care Center of Apple Valley to ensure that our environment is safe, clean, comfortable and homelike for our residents. Inservices were conducted on Oct 8 and 10, 2014 regarding proper bathing techniques including monitoring for appropriate water temperature for bathing. Audits will be conducted of 5 residents per week X 3 months to determine if the water temperature was comfortable during their bath.	11/6/14

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

Electronically Signed | 10/22/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 1 R249's Minimum Data Set (MDS) dated 7/7/14, indicated R249 was cognitively intact. On 10/1/14, at 2:50 p.m. two out of the six spa rooms checked for hot water temperatures, revealed the hot water was cool to the touch. The 2 North hot water temperature was 98.7 degrees Fahrenheit (°F) and when rechecked 15 minutes later it was 99.6 °F. The sink water in the 2 North tub room was 113°F. The 1st floor North tub room water temperature when checked at 3:16 p.m. was 103°F. The maintenance director and assistant revealed there was no system in place to check the water temperatures. The maintenance assistant revealed the water temperatures should be between 105 to 115°F and that was "too cool." They both indicated if there was a problem the nursing staff should alert the maintenance department. On 10/1/14, at 4:10 p.m. nursing assistant (NA)-B was interviewed and revealed "You check the dial on tub machine and if it's between 90 to 92°F then that is a good temperature." NA-B explained if there had been a lot of water use it may be lowered to 90 to 92°F, but NA-B felt that was an acceptable temperature. On 10/1/14, at 4:20 p.m. NA-C was interviewed. NA-C revealed she would feel the water and ask the resident if it was ok. NA-C did not take water temperatures. NA-C added the temperature gauge never seemed to go into the red zone (which was over 100 degrees). She had heard some residents complain of water being too cool but had not informed anyone.	F 252	Maintenance will also be checking temperature of all 6 tubs bi-monthly for adequate temperatures. Unit manager is responsible for compliance. Results of the audits will be reviewed at the facility QI meetings to determine any recommended changes to the POC based on those results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 2 The policy and procedure titled Bath, revised 3/07, indicated to assure water temperature was comfortable for the resident.	F 252		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced 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. 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. The admission Minimum Data Set (MDS) dated 8/20/14, identified pain as being frequent with mild intensity and R102 was on scheduled pain medications. The MDS depicted R102 as having intact cognition. A pain assessment completed 8/19/14, indicated 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	F 282	F282 It is the policy of Augustana Health Care Center of Apple Valley to ensure that services provided by the facility are provided by qualified persons in accordance with each resident□s written plan of care. R 102 pain assessment was re-done on 10/5/14. The following adjustments were made to her pain management plan: Tramadol 50 mg was added on 10/10/14 due to lumbago and stiff legs. A follow up pain assessment was completed on 10/20/2014 which indicated improvement with pain with scheduled Tramadol. R 102 indicated occasionally having pain or hurting over the last 5 days with the worst pain intensity level of a 5 on a scale of 0-10. Patient feels her pain is being adequately managed at this time. Licensed staff will complete a learning packet regarding pain assessment and	11/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 3 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 and Tylenol ES (extra strength) 1000 mg three times a day (TID) both ordered on 6/1/14. Review of the September 2014 medication administration record noted the Capsaicin had not been used, the Tramadol had only been used once on 10/1/14, and the Tylenol ES was given at 8:00 a.m., 12:00 p.m. and 8:00 p.m. The plan of care dated 9/8/14, indicated pain due to functional dependence, depression/anxiety, and neuropathy. The care plan identified R102 was able to verbalize pain and was on scheduled pain medications along with as needed (PRN) medications. On 10/1/14, at 1:39 p.m. R102 stated she usually had back pain when she got up in the morning. On 10/2/14, at 11:52 a.m. licensed practical nurse (LPN)-B stated R102's pain seemed to be positional with Tylenol being effective. LPN-B stated R102 used the Tramadol on 10/1/14, for the first time and it was effective and verified Capsaicin had not been used. On 10/2/14, at 12:16 p.m. registered nurse (RN)-A stated R102's pain assessment was done	F 282	management. Random audits will be completed on 10% of pain observations completed per month X 3 months to ensure that the care plan regarding pain is followed. Unit manager is responsible for compliance. Results of audits will be reviewed at the facility QI meetings to determine any recommended changes to the POC based on those results.	

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F 282	Continued From page 4 quarterly. RN-A stated given the assessment completed on 8/19/14, "We should have documented her pain and utilize the PRN's and the Capsaicin to see if they were effective." RN-A verified the plan of care was not followed.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This 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 manage 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. On 10/1/14, at 12:45 p.m. R102 was observed in the dining room. R102 was observed to be eating and did not appear to be in pain. After lunch R102 was wheeled back to her room and did not appear in pain. At 1:30 p.m. R102 was observed to be seated in an oversized recliner. When	F 309	F309 It is the policy of Augustana Health Care Center of Apple Valley to ensure that services provided by the facility are provided by qualified persons in accordance with each resident□s written plan of care. R 102 pain assessment was re-done on 10/5/14. The following adjustments were made to her pain management plan: Tramadol 50 mg was added on 10/10/14 due to lumbago and stiff legs. A follow up pain assessment was completed on 10/20/2014 which indicated improvement with pain with scheduled Tramadol. R 102 indicated occasionally having pain or hurting over the last 5 days with the worst pain intensity level of a 5 on a scale of 0-10. Patient feels her pain is being adequately managed at this time.	11/6/14

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F 309	Continued From page 5 asked about her pain, R102 stated she had no pain at the time, no pain while up in the wheelchair, or while in the recliner. R102 stated her pain occurred in the morning before getting out of bed. The admission Minimum Data Set (MDS) dated 8/20/14, identified pain as being frequent with mild intensity and R102 was on scheduled pain medications. The MDS depicted R102 as having intact cognition. A pain assessment completed 8/19/14, indicated 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 and Tylenol ES (extra strength) 1000 mg three times a day (TID) both ordered on 6/1/14. Review of the September 2014 medication administration record noted the Capsaicin had not been used, the Tramadol had only been used once on 10/1/14, and the Tylenol ES was given at 8:00 a.m., 12:00 p.m. and 8:00 p.m. The plan of care dated 9/8/14, indicated pain due to functional dependence, depression/anxiety,	F 309	Licensed staff will complete a learning packet regarding pain assessment and management. Random audits will be completed on 10% of pain observations completed per month X 3 months to ensure that the care plan regarding pain is followed. Unit manager is responsible for compliance.	

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F 309	Continued From page 6 and neuropathy. The care plan identified R102 was able to verbalize pain and was on scheduled pain medications along with as needed (PRN) medications. On 10/1/14, at 1:39 p.m. R102 stated she usually had back pain when she got up in the morning. On 10/2/14, at 11:52 a.m. licensed practical nurse (LPN)-B stated R102's pain seemed to be positional with Tylenol being effective. LPN-B stated R102 used the Tramadol on 10/1/14, for the first time and it was effective and verified Capsaicin had not been used. On 10/2/14, at 12:16 p.m. registered nurse (RN)-A stated R102's pain assessment was done quarterly. RN-A stated given the assessment completed on 8/19/14, "We should have documented her pain and utilize the PRN's and the Capsaicin to see if they were effective." RN-A verified R102 ' s pain was not being managed.	F 309		
F 441 SS=D	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	F 441		11/6/14

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F 441	Continued From page 7 (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. (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 follow their policy regarding how to prevent/minimize the potential spread of infections during dressing changes for 1 of 1 observed resident (R441). Findings include: On 10/1/14, at 9:21 a.m. LPN-B was observed completing a dressing change to R441's right forearm and doing wound care to an unstageable area on R441's left heel. Observations were as follows:	F 441	F441 It is the policy of Augustana Health Care Center of Apple Valley to 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. All licensed staff will complete a learning packet regarding hand hygiene including review of our dressing change policy. Random audits will be completed on 5 dressing changes a month X 3 months to	

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F 441	Continued From page 8 Before beginning wound care to R441's left heel, LPN-B was observed to cleanse her hands and then don gloves. LPN-B proceeded to cleanse the left heel wound with normal saline, then without changing the soiled gloves applied Betadine (an antiseptic and kills not only bacteria but healing cells within the wound) to the eschar tissue (a slough or piece of dead tissue that is cast off from the surface of the skin) of the left heel. Still without removing the soiled gloves and cleansing hands, LPN-B proceeded to open a skin prep packet and apply the skin prep wipe to the skin surround the wound. After completion of the left heel wound treatment LPN-B removed the gloves and washed their hands. LPN-B then proceeded to begin the right forearm dressing change and donned new gloves. The old dressing on the right forearm was removed and the adherent dressing was noted to stick to the wound, and the resident winced as the dressing was removed. The wound based was noted to be moist and yellow in color, the edges of the wound were noted to be red. Without changing the soiled gloves or cleansing their hands, LPN-B cleansed the wound with wound cleanser. Still without removing the soiled gloves or cleansing their hands, LPN-B applied Bacitracin (used topically to avoid infection) to three non-adherent dressings, applied the dressings to the open wound on the right forearm and then wrapped the forearm with gauze wrap. The gloves were not removed, and hands washed until the end of the dressing change. On 10/2/14, at 1:40 p.m. LPN-B stated that she did not change her gloves with the heel cleansing because there had not been a dressing on the	F 441	monitor for compliance with our policy. Unit manager is responsible for compliance. Results of audits will be reviewed at the facility QI meetings to determine any recommended changes to the POC based on those results.	

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F 441	Continued From page 9 area, and there had been no drainage from the wound. Regarding the arm dressing change, LPN-B verified she had not changed her gloves and cleansed her hands after removing the old dressing and before applying the new dressing. The facility's policy on Equipment and Supplies for a Dressing Change dated as revised on 8/13, directed after a dressing was removed, the individual doing the dressing change was to remove their gloves and sanitize their hands, before putting on disposable gloves and cleansing the wound as ordered by the physician.	F 441		

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	245264	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/30/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Augustana Health Care Center of Apple Valley, was found not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

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

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K 000	Continued From page 1	K 000		

By email to: Marian.Whitney@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Augustana Health Care Center of Apple Valley is a 3-story building with a full basement. The building was constructed in 1983, and was determined to be of Type II(222) construction.

The building is fully fire sprinkler protected. The facility has a complete fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility chooses to have battery operated single station smoke alarms in all resident rooms.

The facility has a licensed capacity of 178 beds and had a census of 165 at the time of the survey.

The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:

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K 033	Continued From page 2	K 033		
K 033 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a fire resistance rating of at least one hour in the exit component accordance with the following requirements of 2000 NFPA 101, Section 19.3.1.1, 8.2.5.2. This could effect 40 out of 165 residents. Findings include: On facility tour between 8:00 AM and 11:30 AM, observation revealed that the Basement - Stairwell A, has open penetration around sprinkler line and around cables. Check all stairwells for this deficiency This deficient practice was confirmed by the Facility Maintenance Director (RC) at the time of discovery.	K 033	K33 Basement □ Stairwell A: Open Penetration around sprinkler line, (2) More 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 check this biannually	11/6/14
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all	K 064		11/6/14

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K 064	Continued From page 3 health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to maintain portable fire extinguisher in accordance with NFPA 101-2000 edition, Section 9.7.4.1 and NFPA 10. This deficient practice could affect 10 out of 165 residents. Findings include: On facility tour between 8:00 AM and 11:30 AM, observation reveal that the following was found: 1. Basement - elevator equipment: fire extinguisher has not been annual inspected since 2/2013 2. Basement - room # N-7: Fire extinguisher monthly inspection was missed for July & August 2014 This deficient practice was confirmed by the Facility Maintenance Director (RC) at the time of discovery.	K 064	K64 1. Basement elevator equipment room: Fire Extinguisher was not inspected on its annual inspection schedule. Augustana Apple Valley will notify fire extinguisher inspection contractor of their Error and make certain we receive a check list that is completed after each yearly inspection.	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A,	K 067		11/6/14

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K 067	Continued From page 4 19.5.2.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, that the facility's general ventilating and air conditioning system (HVAC) was not maintained in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 3-4.7. A noncompliant HVAC system could affect all 165 residents. Findings include: On facility tour between 8:00 AM and 11:30 AM, documentation review for fire damper testing for the past 4 years revealed, that the fire/smoke dampers have not been tested with-in a 4 years period. Tests were conducted on 02/17/10 and 07/18/14. This deficient practice was confirmed by the Facility Maintenance Director (RC) at the time of discovery.	K 067	K67 fire smoke dampers were not inspected within a four year period 2/17-10/18-14. Augustana Apple Valley has put the dates of inspections for this into its preventive maintenance software, this inspection will inform our vender that this need to be done two weeks prior of due date.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical supply in accordance with the requirements of 2000 NFPA	K 147	K147 Found power strips connected to each other at the following locations: 1. Basement room □S-4	11/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/30/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 5 101 - 9.1.2, 1999 NFPA 70, and 2007 Minnesota State Fire Code 605.4 .2. This could effect 10 out of 165 residents. Findings include: On facility tour between 8:00 AM and 11:30 AM, observation revealed that the following relocatable power strips are interconnected to each other: 1. Basement - S-4 2. Basement - Occupational therapy room 3. Basement - Physical therapy room Check the entire facility for this deficiency This deficient practice was confirmed by the Facility Maintenance Director (RC) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 147	2. Basement room □ O.T. room 3. Basement room -P.T. room Augustana Apple Valley will correct this deficiency, and will notify and retrain staff on this improper usage of power strips.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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: gloria.derfus@state.mn.us
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:
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.

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: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Anne Kleppe

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

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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 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	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 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 electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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.	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.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced	2 565		11/6/14

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2 565	Continued From page 2 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. 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. The admission Minimum Data Set (MDS) dated 5/29/14, identified pain as mild intensity and R102 was on scheduled pain medications. A pain assessment completed 8/19/14, indicated 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 and Tylenol ES (extra strength) 1000 mg three times a day (TID) both ordered on 6/1/14. Review of the September 2014 medication administration record noted the Capsaicin had not been used, the Tramadol had only been used once on 10/1/14, and the Tylenol ES was given at 8:00	2 565	F282 It is the policy of Augustana Health Care Center of Apple Valley to ensure that services provided by the facility are provided by qualified persons in accordance with each resident□s written plan of care. R 102 pain assessment was re-done on 10/5/14. The following adjustments were made to her pain management plan: Tramadol 50 mg was added on 10/10/14 due to lumbago and stiff legs. A follow up pain assessment was completed on 10/20/2014 which indicated improvement with pain with scheduled Tramadol. R 102 indicated occasionally having pain or hurting over the last 5 days with the worst pain intensity level of a 5 on a scale of 0-10. Patient feels her pain is being adequately managed at this time. Licensed staff will complete a learning packet regarding pain assessment and management. Random audits will be completed on 10% of pain observations completed per month X 3 months to ensure that the care plan regarding pain is followed. Unit manager is responsible for compliance. Results of audits will be reviewed at the facility QI meetings to determine any recommended changes to the POC based on those results.	

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2 565	Continued From page 3 a.m., 12:00 p.m. and 8:00 p.m. The plan of care dated 9/8/14, indicated pain due to functional dependence, depression/anxiety, and neuropathy. The care plan identified R102 was able to verbalize pain and was on scheduled pain medications along with as needed (PRN) medications. On 10/1/14, at 1:39 p.m. R102 stated she usually had back pain when she got up in the morning. On 10/2/14, at 11:52 a.m. licensed practical nurse (LPN)-B stated R102's pain seemed to be positional with Tylenol being effective. LPN-B stated R102 used the Tramadol on 10/1/14, for the the first time and it was effective and verified Capsaicin had not been used. On 10/2/14, at 12:16 p.m. registered nurse (RN)-A stated R102's pain assessment was done quarterly. RN-A stated given the assessment completed on 8/19/14, "We should have documented her pain and utilize the PRN's and the Capsaicin to see if they were effective." RN-A verified the plan of care was not followed. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to ensure all care plans interventions are followed according to individualized needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 565		

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2 830	Continued From page 4	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to 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. On 10/1/14, at 12:45 p.m. R102 was observed in the dining room. R102 was observed to be eating and did not appear to be in pain. After lunch R102 was wheeled back to her room and did not appear in pain. At 1:30 p.m. R102 was observed to be seated in an oversized recliner. When asked about her pain, R102 stated she had no	2 830	F282 It is the policy of Augustana Health Care Center of Apple Valley to ensure that services provided by the facility are provided by qualified persons in accordance with each resident□s written plan of care. R 102 pain assessment was re-done on 10/5/14. The following adjustments were made to her pain management plan: Tramadol 50 mg was added on 10/10/14 due to lumbago and stiff legs. A follow up pain assessment was completed on 10/20/2014 which indicated improvement with pain with scheduled Tramadol. R 102 indicated occasionally having pain or hurting over the last 5 days with the worst pain intensity level of a 5 on a scale of 0-10. Patient feels her pain is being adequately managed at this time.	11/6/14

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2 830	Continued From page 5 pain at the time, no pain while up in the wheelchair, or while in the recliner. R102 stated her pain occurred in the morning before getting out of bed. The admission Minimum Data Set (MDS) dated 5/29/14, identified pain as mild intensity and R102 was on scheduled pain medications. A pain assessment completed 8/19/14, indicated 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 and Tylenol ES (extra strength) 1000 mg three times a day (TID) both ordered on 6/1/14. Review of the September 2014 medication administration record noted the Capsaicin had not been used, the Tramadol had only been used once on 10/1/14, and the Tylenol ES was given at 8:00 a.m., 12:00 p.m. and 8:00 p.m. The plan of care dated 9/8/14, indicated pain due to functional dependence, depression/anxiety, and neuropathy. The care plan identified R102 was able to verbalize pain and was on scheduled pain medications along with as needed (PRN) medications.	2 830	Licensed staff will complete a learning packet regarding pain assessment and management. Random audits will be completed on 10% of pain observations completed per month X 3 months to ensure that the care plan regarding pain is followed. Unit manager is responsible for compliance. Results of audits will be reviewed at the facility QI meetings to determine any recommended changes to the POC based on those results.	

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2 830	Continued From page 6 On 10/1/14, at 1:39 p.m. R102 stated she usually had back pain when she got up in the morning. On 10/2/14, at 11:52 a.m. licensed practical nurse (LPN)-B stated R102's pain seemed to be positional with Tylenol being effective. LPN-B stated R102 used the Tramadol on 10/1/14, for the the first time and it was effective and verified Capsaicin had not been used. On 10/2/14, at 12:16 p.m. registered nurse (RN)-A stated R102's pain assessment was done quarterly. RN-A stated given the assessment completed on 8/19/14, "We should have documented her pain and utilize the PRN's and the Capsaicin to see if they were effective." RN-A verified the plan of care was not followed. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop polices and procedures regarding assessing and monitoring of pain. The Director of Nursing or her designee could educate staff on the policies and procedures. The Director of Nursing or her designee could develop a monitoring system to ensure residents receive the appropriate care. TIME FRAME FOR CORRECTION: Twenty-One (21) Days.	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		11/6/14

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21375	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow their policy regarding how to prevent/minimize the potential spread of infections during dressing changes for 1 of 1 observed resident (R441). Findings include: On 10/1/14, at 9:21 a.m. LPN-B was observed completing a dressing change to R441's right forearm and doing wound care to an unstageable area on R441's left heel. Observations were as follows: Before beginning wound care to R441's left heel, LPN-B was observed to cleanse her hands and then don gloves. LPN-B proceeded to cleanse the left heel wound with normal saline, then without changing the soiled gloves applied Betadine (an antiseptic and kills not only bacteria but healing cells within the wound) to the eschar tissue (a slough or piece of dead tissue that is cast off from the surface of the skin) of the left heel. Still without removing the soiled gloves and cleansing hands, LPN-B proceeded to open a skin prep packet and apply the skin prep wipe to the skin surround the wound. After completion of the left heel wound treatment LPN-B removed the gloves and washed their hands. LPN-B then proceeded to begin the right forearm dressing change and donned new gloves. The old dressing on the right forearm was removed and the adherent dressing was noted to stick to the wound, and the resident winced as the dressing was removed. The wound based was noted to be moist and yellow in color, the edges of the wound	21375	F441 It is the policy of Augustana Health Care Center of Apple Valley to 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. All licensed staff will complete a learning packet regarding hand hygiene including review of our dressing change policy. Random audits will be completed on 5 dressing changes a month X 3 months to monitor for compliance with our policy. Unit manager is responsible for compliance. Results of audits will be reviewed at the facility QI meetings to determine any recommended changes to the POC based on those results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	10/02/2014

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21375	Continued From page 8 were noted to be red. Without changing the soiled gloves or cleansing their hands, LPN-B cleansed the wound with wound cleanser. Still without removing the soiled gloves or cleansing their hands, LPN-B applied Bacitracin (used topically to avoid infection) to three non-adherent dressings, applied the dressings to the open wound on the right forearm and then wrapped the forearm with gauze wrap. The gloves were not removed, and hands washed until the end of the dressing change. On 10/2/14, at 1:40 p.m. LPN-B stated that she did not change her gloves with the heel cleansing because there had not been a dressing on the area, and there had been no drainage from the wound. Regarding the arm dressing change, LPN-B verified she had not changed her gloves and cleansed her hands after removing the old dressing and before applying the new dressing. The facility's policy on Equipment and Supplies for a Dressing Change dated as revised on 8/13, directed after a dressing was removed, the individual doing the dressing change was to remove their gloves and sanitize their hands, before putting on disposable gloves and cleansing the wound as ordered by the physician. SUGGESTED METHOD OF CORRECTION: The DON or designee could train staff and perform audits to ensure infection control techniques are being followed. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21375		
21710	MN Rule 4658.1415 Subp. 7 Plant Housekeeping, Operation, & Maintenance	21710		11/6/14

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21710	Continued From page 9 Subp. 7. Hot water temperature. Hot water supplied to sinks and bathing fixtures must be maintained within a temperature range of 105 degrees Fahrenheit to115 degrees Fahrenheit at the fixtures. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain adequate water temperature for bathing for 1 of 2 residents (R249) who complained of cold bath water. This had the potential to affect approximately 55 out of 165 residents. Findings include: On 9/30/14, at 12:48 p.m. R249 revealed a concern about bathing in the tub with cold water, especially on the evening shift. R249's Minimum Data Set (MDS) dated 7/7/14, indicated R249 was cognitively intact. On 10/1/14, at 2:50 p.m. two out of the six spa rooms checked for hot water temperatures, revealed the hot water was cool to the touch. The 2 North hot water temperature was 98.7 degrees Fahrenheit (°F) and when rechecked 15 minutes later it was 99.6 °F. The sink water in the 2 North tub room was 113°F. The 1st floor North tub room water temperature when checked at 3:16 p.m. was 103°F. The maintenance director and assistant revealed there was no system in place to check the water temperatures. The maintenance assistant revealed the water temperatures should be between 105 to 115°F and that was "too cool."	21710	F252. It is the policy of Augustana Health Care Center of Apple Valley to ensure that our environment is safe, clean, comfortable and homelike for our residents. Inservices were conducted on Oct 8 and 10, 2014 regarding proper bathing techniques including monitoring for appropriate water temperature for bathing. Audits will be conducted of 5 residents per week X 3 months to determine if the water temperature was comfortable during their bath. Maintenance will also be checking temperature of all 6 tubs bi-monthly for adequate temperatures. Unit manager is responsible for compliance. Results of the audits will be reviewed at the facility QI meetings to determine any recommended changes to the POC based on those results.	

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21710	Continued From page 10 They both indicated if there was a problem the nursing staff should alert the maintenance department. On 10/1/14, at 4:10 p.m. nursing assistant (NA)-B was interviewed and revealed "You check the dial on tub machine and if it's between 90-92°F then that is a good temperature." NA-B explained if there had been a lot of water use it may be lowered to 90 to 92°F, but NA-B felt that was an acceptable temperature. On 10/1/14, at 4:20 p.m. NA-C was interviewed. NA-C revealed she would feel the water and ask the resident if it was ok. NA-C did not take water temperatures. NA-C added the temperature gauge never seemed to go into the red zone (which was over 100 degrees). She had heard some residents complain of water being too cool but had not informed anyone. The policy and procedure titled Bath, revised 3/07, indicated to assure water temperature was comfortable for the resident. SUGGESTED METHOD OF CORRECTION: The facility maintenance supervisor, administrator and/or a designee could develop policies and procedures related to management of comfortable water temperatures for resident accessible fixtures. Maintenance employees could be educated on new policies and procedures. A monitoring system could be implemented and reviewed by the facility's quality assessment and assurance committee to ensure ongoing compliance with comfortable water temperatures. TIME PERIOD FOR CORRECTION: Seven (7) days.	21710		

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