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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NUK3

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

Facility ID: 00740

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245275**
2.STATE VENDOR OR MEDICAID NO.
(L2) **964043600**

3. NAME AND ADDRESS OF FACILITY
(L3) **EDINA CARE & REHAB CENTER**
(L4) **6200 XERXES AVENUE SOUTH**
(L5) **RICHFIELD, MN** (L6) **55423**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/10/2015** (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)
**06/30**

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

12.Total Facility Beds **118** (L18)

13.Total Certified Beds **118** (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 |
|---|---|---|---|---|
| | 118 | | | |
| (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, HFE NEII 08/10/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/05/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
**05/01/1985**
(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
**08/11/2015** (L33)

DETERMINATION APPROVAL

*Protecting, Maintaining and Improving the Health of Minnesotans*

CMS Certification Number (CCN): 245275

October 4, 2015

Mr. John Doughty, Administrator
Edina Care & Rehabilitation Center
6200 Xerxes Avenue South
Richfield, Minnesota 55423

Dear Mr. Doughty:

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

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

Effective July 24, 2015 the above facility is certified for:

118 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 115 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.

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

August 10, 2015

Mr. Dennis Decosta, Administrator
Edina Care & Rehabilitation Center
6200 Xerxes Avenue South
Richfield, Minnesota 55423

RE: Project Number S5275025

Dear Mr. Decosta:

On July 10, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 25, 2015. 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 August 10, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 25, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 24, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 25, 2015, effective July 25, 2015 and therefore remedies outlined in our letter to you dated July 10, 2015, will not be imposed.

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

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

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

Sincerely,

Mark Meath

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

Enclosure(s)

cc: Licensing and Certification File

**Post-Certification Revisit Report**



| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245275 | A. Building<br>B. Wing | 8/10/2015 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| EDINA CARE & REHAB CENTER | 6200 XERXES AVENUE SOUTH<br>RICHFIELD, MN 55423 |

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 **F0156**<br>Reg. # **483.10(b)(5) - (10), 483.10(b)(1)**<br>LSC | Correction Completed **07/24/2015** | ID Prefix **F0246**<br>Reg. # **483.15(e)(1)**<br>LSC | Correction Completed **07/24/2015** | ID Prefix **F0279**<br>Reg. # **483.20(d), 483.20(k)(1)**<br>LSC | Correction Completed **07/24/2015** |
| ID Prefix **F0309**<br>Reg. # **483.25**<br>LSC | Correction Completed **07/242015** | ID Prefix **F0318**<br>Reg. # **483.25(e)(2)**<br>LSC | Correction Completed **07/24/2015** | ID Prefix **F0371**<br>Reg. # **483.35(i)**<br>LSC | Correction Completed **07/24/2015** |
| ID Prefix **F0428**<br>Reg. # **483.60(c)**<br>LSC | Correction Completed **07/24/2015** | ID Prefix **F0431**<br>Reg. # **483.60(b), (d), (e)**<br>LSC | Correction Completed **07/24/2015** | ID Prefix **F0441**<br>Reg. # **483.65**<br>LSC | Correction Completed **07/248015** |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| Reviewed By | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| State Agency | GL/mm | 08/10/2015 | 15507 | 08/10/2015 |
| Reviewed By<br>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 |
|---|---|---|---|
| 6/25/2015 | | | |

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** — ID: NUK3

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY** — Facility ID: 00740

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(L1) **245275**

2.STATE VENDOR OR MEDICAID NO.
(L2) **964043600**

3. NAME AND ADDRESS OF FACILITY
(L3) **EDINA CARE & REHAB CENTER**
(L4) **6200 XERXES AVENUE SOUTH**
(L5) **RICHFIELD, MN** (L6) **55423**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/25/2015** (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)
**06/30**

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

12.Total Facility Beds **118** (L18)

13.Total Certified Beds (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 |
|---|---|---|---|---|
| (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 :
Steven Douglas, HFE NEII — 07/24/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 08/10/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
**05/01/1985**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS
Posted 08/11/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7013 2250 0001 6357 1713

July 10, 2015

Mr. Dennis Decosta, Administrator
Edina Care & Rehabilitation Center
6200 Xerxes Avenue South
Richfield, Minnesota 55423

RE: Project Number S5275025

Dear Mr. Decosta:

On June 25, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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:

**Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**

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

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

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

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

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

**DEPARTMENT CONTACT**

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

**Gayle Lantto, Unit Supervisor**
**Metro D Survey Team**
**Licensing and Certification Program**
**Health Regulation Division**
**Minnesota Department of Health**
**85 East Seventh Place, Suite #220**
**P.O. Box 64900**
**Saint Paul, Minnesota 55164-0900**
**Email: gayle.lantto@state.mn.us**

**Phone: (651) 201-3794**
**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 August 4, 2015, 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 August 4, 2015 the following remedy will be imposed:

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

**PLAN OF CORRECTION (PoC)**

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

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

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

- Include signature of provider and date.

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

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

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

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

**PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

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

Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

### Original deficiencies not corrected

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

### Original deficiencies not corrected and new deficiencies found during the revisit

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

### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 25, 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 December 25, 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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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**
**444 Minnesota Street, Suite 145**
**St. Paul, Minnesota 55101-5145**

**Telephone: (651) 201-7205**
**Fax: (651) 215-0525**

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

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

RECEIVED
JUL 23 2015
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

PRINTED: 07/10/2015
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245275 | A. BUILDING _____ B. WING _____ | 06/25/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDINA CARE & REHAB CENTER | 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423 |

| (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<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance.<br><br>Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | This Credible Allegation of Compliance has been prepared and timely submitted. Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiency were correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator, or any employees, agents, or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness any conclusions set forth in this allegation by the survey agency.<br><br>Accordingly, we are submitting the Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of Deficiencies as a condition to participate in the Medicare & Medical Assistance Programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. | |
| F 156 SS=D | 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES<br><br>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.<br><br>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and | F 156<br><br>07/24/15 GL/mpm | **F 156**<br><br>• R4 and R21 have discharged from the facility.<br>• Policy for providing notice of right to request demand bill has been reviewed and revised as needed. | |

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

Constance A Anderson | Administrator | 7-23-15

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245275 | A. BUILDING _____ B. WING _____ | 06/25/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDINA CARE & REHAB CENTER | 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423 |

| (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 |
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| F 156 | Continued From page 1<br>inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.<br><br>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.<br><br>The facility must furnish a written description of legal rights which includes:<br>A description of the manner of protecting personal funds, under paragraph (c) of this section;<br><br>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.<br><br>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the | F 156 | • Education and review of facility policy and procedure process has been provided to MDS nurse, business office manager and any other staff responsible for informing residents of right to request a demand bill.<br>• Random audits to ensure applicable residents receive CMS Form 10123 at least 48 hours prior to end of service.<br>• ED is responsible.<br>• Audits will be reviewed at monthly QA meetings until IDT determines audits no longer necessary.<br>• Completion date is 7/24/15 | |

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| F 156 | Continued From page 2<br>facility, and non-compliance with the advance directives requirements.<br><br>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.<br><br>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review the facility failed to provide appropriate notice of the right to request a demand bill when Medicare benefits ended for 2 of 3 residents (R4, R21) reviewed for liability notice.<br><br>Findings include:<br><br>R4 was admitted to the facility on 4/20/15. R4 was discharged from Medicare non-coverage on 4/30/15, signed the notice of Medicare non-coverage form on 4/30/15, and was discharged from the facility on 5/1/15.<br><br>R21 was admitted to the facility on 12/22/14. R21 was discharged from Medicare non-coverage on 1/7/15, signed the notice of Medicare non-coverage form on 1/6/15, and was discharged from the facility on 1/8/15. | F 156 | | |

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| F 156 | Continued From page 3<br>On 6/25/15, at 3:15 p.m. the Centers of Medicare and Medicaid Services (CMS) form 10123 was reviewed for R4 and R21. The forms lacked documentation showing R4 and R21 had been provided a 48-hour notice as required before Medicare services ended.<br><br>On 6/25/15, at 3:25 p.m. the business office manager confirmed she should have given R4 and R21 the CMS form 10123 48-hrs prior to when services ended.<br><br>A policy and procedure for demand bill/liability notice was requested, but was not provided. | F 156 | | |
| F 246 SS=D | 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES<br><br>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to ensure call lights were within reach for 2 of 5 residents (R32, R44).<br><br>Findings include:<br><br>R32 was calling out for help when observed on 6/22/15, at 7:15 p.m. sitting in her wheelchair alone in her root. R32 then asked the surveyor, "Can you move me back into my chair? I'm sliding | F 246 | **F 246**<br>• R32 and R44 have call lights placed within reach when staff exit the room.<br>• All other residents with call lights will have call lights within reach.<br>• All nursing staff will be educated regarding placing call light within reach before exiting room.<br>• Random weekly audit will be done to ensure call lights are within reach.<br>• DNS/designee is responsible<br>• Audits will be reviewed at monthly QA meeting until IDT determines audits no longer necessary.<br>• Completion date 7/24/15 | |

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| F 246 | Continued From page 4<br>out of it." R32's call light cord was hanging down the wall behind the night stand out of the resident's reach. The surveyor activated the call light for R32 and a few minutes later two nursing assistants (NA)-A and NA-B entered the room. R32 asked NA-A and NA-B if they would move her back into her wheelchair, as she was sliding out of it. Both NA-A and NA-B verified R32 could not have reached her call light to request help.<br><br>Following the observation at 7:25 p.m. a registered nurse (RN)-A was brought to R32's room and explained how R32 was calling out for help and where her call light was positioned at the time. RN-A stated that R32's call light placement was unacceptable and should have been placed within her reach. RN-A explained that R32 was unable to use her call light. In addition, RN-A said R32 was at risk of sliding out of her wheelchair, and should not have been left alone in her room, but in view of the staff.<br><br>R32 was observed and interviewed on 6/24/15, at 10:30 a.m. She was lying in bed and the call light was clipped to the top sheet of her bed and her right arm was on top of the cord. When asked if she could use her call light to call for help she replied, "No." When asked if she knew where it was she again replied, "No."<br><br>R32's care plan dated 7/14/14, described the resident as being at risk for falling, had impaired cognition and required extensive assistance of two staff for transferring. Interventions included keeping the call light within reach and answering it in a timely manner, and providing positioning. R32's care plan lacked any indication she was unable to use her call light, and the nurse's report she should was not to be left alone in her room. | F 246 | | |

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| F 246 | Continued From page 5<br><br>R44's call light was on the floor between her bed and her roommate's bed during an initial tour on 6/22/15, at 4:20 p.m. The space between the two beds was approximately 18 inches, not wide enough for R44's wheelchair. NA-E was notified of the observation, and picked up the call light from the floor and placed it on top of the resident's bed. NA-E then stated, "The call light should be on top of her bed. She is able to use her call light and does use it."<br><br>The following morning at 7:56 a.m. R44's call light was placed in the far right upper corner of her bed to the right of the pillow. NA-F was called into R44's room and moved the call light to the left side of the bed where R44's wheelchair could fit so she could reach it. NA-F stated the call light was probably placed to the right of R44's pillow by the night staff because that was usually where it was placed when R44 was in bed. NA-F verified with the beds so close together R44's wheelchair could not have fit between the two beds, and the resident could not have reached the call light to summon help.<br><br>On 6/24/15, at 6:33 a.m. R44's call light was observed to the right of her pillow, and again out of her reach, however, R44 was not in her room at the time of the observation.<br><br>R44's care plan dated 5/13/15, indicated "[R44] is usually understood and usually understands others. Strength: Resident is able to make most needs known. Ensure/provide a safe environment: Call light in reach."<br><br>The director of nursing (DON) stated on 6/24/15, at 8:35 a.m. she expected call lights to be placed | F 246 | | |

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| F 246 | Continued From page 6<br>within the residents' reach.<br><br>Later that day at 1:12 p.m. the maintenance director stated call lights were checked for function, but maintenance staff did not check that they were kept in a resident's reach. The DON then stated, "I don't recall if nursing has any call light audits, but we can re-initiate." The administrator who was present at the time explained they had checked the whole house in the springtime for call light function, since the system was bulb-driven, however, the placement of call lights had not been audited.<br><br>A review of the resident council minutes dated 4/13/15, indicated one resident reported staff, "Need education for staff to keep call lights within reach."<br><br>The facility's 2006, Call Light, Use Of policy directed staff to, "Respond promptly to resident's call for assistance...Be sure call lights are placed within resident reach at all times, never on the floor or beside stand." | F 246 | | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. | F 279 | **F 279**<br><br>• R132 Care Plan has been updated with correct contact information, telephone number and address, of Dialysis Center. Clarification received regarding dialysis dressing and Care Plan and eTAR updated. | |

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| F 279 | Continued From page 7<br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure an accurate care plan was in place for 1 of 1 resident (R132) reviewed for dialysis.<br><br>Findings include:<br><br>R132's care plan dated 7/12/14, revealed the resident had impaired decision making abilities, needed assistance of one staff for dressing/grooming, had impaired vision, and received dialysis at DaVita on Mondays, Wednesdays, Fridays and Sundays. R132's care plan noted emergency protocols, as well as the telephone number to contact the dialysis center should concerns arise. However, the telephone number and location of the dialysis center were both incorrect.<br><br>R132's quarterly Minimum Data Set (MDS) dated 3/17/15, indicated R132's vision was highly impaired, was dependent on staff for cares and was receiving dialysis services.<br><br>A review of R132's ETAR's directed staff to check R132's dialysis access site for bruit/thrill | F 279 | • Audit of all other residents receiving dialysis to ensure correct dialysis center contact information and directions for shunt site dressings.<br>• Education to all licensed staff regarding appropriate dialysis care plan documentation and shunt site dressing care.<br>• Random audits of all residents receiving dialysis care to ensure correct contact information and shunt site dressing care are in place.<br>• DNS/designee is responsible<br>• Audits will be reviewed at monthly QA meeting until IDT determines audits no longer necessary.<br>• Completion date is 7/24/15 | |

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| F 279 | Continued From page 8<br>(checking to see the access site is still functioning by listening with a stethoscope and feeling for vibration) every day and evening shift for health monitoring. However, there was no direction for staff regarding checking or removing the dressing.<br><br>During an interview on 6/24/15, at 7:46 a.m. a registered nurse (RN)-D stated when R132 returned from dialysis, the access site was left covered until the following day, when the resident removed the dressing herself. RN-D explained that she checked R132's access site for burit/thrill daily, and charted the results under the electronic treatment administration records (ETAR). She did not document anything regarding when the dressing was removed. RN-D stated if she need to contact the dialysis center regarding R132, she would locate the telephone number for the clinic on the resident's care plan.<br><br>RN-C stated in an interview on 6/24/15, at 12:38 p.m. there was no specific place on the ETAR noting R132's dressing was removed after dialysis. RN-C explained nurses used "nursing judgement" regarding when to remove the dialysis dressings.<br><br>A telephone interview with R132's primary dialysis nurse on 6/24/15, at 2:13 p.m. revealed that with the start of a resident receiving dialysis treatment, the facility received instructions from the center on managing a dialysis site. The nurse then stated R132's dialysis dressings should have been removed four hours after the dialysis treatment. This was not noted on the resident's care plan.<br><br>In a follow-up interview on 6/25/15, at 1:39 p.m. | F 279 | | |

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| F 279 | Continued From page 9<br>RN-C stated 132's care plan indicated staff was to call the dialysis center if needed, at the number listed on the resident's care plan. However, when RN-C called the number listed, it was for another DaVita clinic, and not where R132 went for dialysis. RN-C also checked R132's dialysis referral forms sent with the resident after appointments, and confirmed the form lacked the clinic phone number.<br><br>The facility's 1/15/14, SNF [Skilled Nursing Facility] Outpatient Dialysis Services Agreement indicated "The end stage renal disease (ESRD) Dialysis Unit will provide the nursing facility information on all aspects of the management of the ESRD resident's care related to the provision of services, including directions on management of medical and non-medical emergencies, including, but not limited to, bleeding, infections and care of the dialysis access site." | F 279 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to coordinate dialysis services for 1 of 1 resident (R132) reviewed for dialysis. | F 309 | **F 309**<br>• R132 Care Plan has been updated with correct contact information, telephone number and address of Dialysis Center. Clarification received regarding dialysis dressing and Care plan and eTAR updated.<br>• Audit of all other residents receiving dialysis to ensure correct dialysis center contact information and director for shunt sitr dressings. | |

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| F 309 | Continued From page 10<br><br>Findings include:<br><br>R132 had a dressing on her left arm on 6/23/15, at 2:56 p.m. R132 explained the dressing was from a dialysis treatment, which she independently removed the day after her dialysis treatments.<br><br>On 6/25/15, at 8:48 a.m. R132 was interviewed, at which time she was picking at, and attempting to remove her dialysis dressing. She reported her dialysis treatment had gone well the previous day and said, "I'm trying to take off this dressing because it makes me look like I have been wounded." R132 explained she had poor vision which made it hard for her to see the tape.<br><br>R132's quarterly Minimum Data Set (MDS) dated 3/17/15, indicated R132's vision was highly impaired, was dependent on staff for cares and was receiving dialysis services.<br><br>R132's care plan dated 7/12/14, revealed the resident had impaired decision making abilities, needed assistance of one staff for dressing/grooming, had impaired vision, and received dialysis at DaVita on Mondays, Wednesdays, Fridays and Sundays. R132's care plan noted emergency protocols, as well as the telephone number to contact the dialysis center should concerns arise. However, the telephone number and location of the dialysis center were both incorrect.<br><br>A review of R132's ETAR's directed staff to check R132's dialysis access site for bruit/thrill (checking to see the access site is still functioning by listening with a stethoscope and feeling for | F 309 | • Education to all licensed staff regarding appropriate dialysis care plan documentation and shunt site dressing care.<br>• Random audits of all residents receiving dialysis care to ensure correct conta t information and shunt site dressing care are in place.<br>• DON/designee is responsible.<br>• Audits will be reviewed at monthly QA meetings until IDT determines audits no longer necessary.<br>• Completion date is 7/24/15. | |

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| F 309 | Continued From page 11<br>vibration) every day and evening shift for health monitoring. However, there was no direction for staff regarding checking or removing the dressing.<br><br>During an interview on 6/24/15, at 7:46 a.m. a registered nurse (RN)-D stated when R132 returned from dialysis, the access site was left covered until the following day, when the resident removed the dressing herself. RN-D explained that she checked R132's access site for burit/thrill daily, and charted the results under the electronic treatment administration records (ETAR). She did not document anything regarding when the dressing was removed. RN-D stated if she need to contact the dialysis center regarding R132, she would locate the telephone number for the clinic on the resident's care plan.<br><br>RN-C stated in an interview on 6/24/15, at 12:38 p.m. there was no specific place on the ETAR noting R132's dressing was removed after dialysis. RN-C explained nurses used "nursing judgement" regarding when to remove the dialysis dressings.<br><br>A telephone interview with R132's primary dialysis nurse on 6/24/15, at 2:13 p.m. revealed that with the start of a resident receiving dialysis treatment, the facility received instructions from the center on managing a dialysis site. The nurse then stated R132's dialysis dressings should have been removed four hours after the dialysis treatment.<br><br>In a follow-up interview on 6/25/15, at 1:39 p.m. RN-C stated 132's care plan indicated staff was to call the dialysis center if needed, at the number listed on the resident's care plan. However, when | F 309 | | |

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| F 309 | Continued From page 12<br>RN-C called the number listed, it was for another DaVita clinic, and not where R132 went for dialysis. RN-C also checked R132's dialysis referral forms sent with the resident after appointments, and confirmed the form lacked the clinic phone number.<br><br>The facility's 2006 Dialysis Program Guidelines policy indicated the purpose was to "Provide quality care and treatment services to the resident who requires dialysis...Comprehensive Care Plan...monitor for complications, monitor for access site for signs of infection, potential for bleeding and monthly assessments and care plan...Nursing Management...remove dressing to access site four hours after discharge form dialysis and access bleeding post dialysis."<br><br>The facility's 1/15/14, SNF [Skilled Nursing Facility] Outpatient Dialysis Services Agreement indicated "The end stage renal disease (ESRD) Dialysis Unit will provide the nursing facility information on all aspects of the management of the ESRD resident's care related to the provision of services, including directions on management of medical and non-medical emergencies, including, but not limited to, bleeding, infections and care of the dialysis access site." The agreement was by both the facility and ESRD on 1/15/14. | F 309 | | |
| F 318 SS=D | 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further | F 318 | **F318**<br>• R5 has order for Physical Therapy to evaluate and treat for ROM and splint. | |

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| F 318 | Continued From page 13<br>decrease in range of motion.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services for 1 of 3 residents (R5) reviewed for ROM.<br><br>Findings include:<br><br>R5 was observed and interviewed on 6/23/15, at 3:18 p.m. R5 was lying in bed with her left hand curled into a fist with all of her fingers bent toward the palm of her hand. When asked if she could open up her left hand, R5 was able to lift all of her fingers a few inches with the exception of the third finger on her left hand. R5 reported, "It's not painful, just stiff." When asked if she would like to have had ROM exercises she replied, "Yes."<br><br>R5 was observed on 6/24/15, at 9:26 a.m. receiving morning cares from two nursing assistants (NA)-C and (NA)-H. R5's left hand remained in a fist throughout the cares. NA-C stated R5's left hand did not open all the way, and nursing staff had been putting a rolled up wash cloth in R5's palm left hand a while ago, but R5 refused and fought anyone who tried to do it.<br><br>R5's care plan dated 4/24/15, indicted the resident had a memory deficit with impaired judgment and decision making, as well as reliance on staff for self-care related to dementia, requiring two staff to assist her with personal hygiene. R5's care plan lacked direction for staff to provide ROM services or any interventions to | F 318 | • IDT Morning Start-Up now includes review of any residents with change in mobility; ROM. Tracking form developed and implemented for Therapy recommendations to nursing.<br>• Any residents with change in mobility or ROM will have an assessment to determine if that individual would benefit from restorative and/or device application.<br>• Random audits during observation week to determine if ROM services were implemented when needed.<br>• DON/designee is responsible.<br>• Audits will be reviewed at monthly QA meetings until IDT determines audits no longer necessary.<br>• Completion date is 7/24/15 | |

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| F 318 | Continued From page 14<br>minimize the risk for further decline in ROM in R5's hand.<br><br>A nursing note dated 5/20/15, read "Hospice provided a hand splint for resident's left hand. Unfortunately resident was unable to tolerate d/t [due to] pain and wash cloth placement has been unsuccessful in the past. Will f/u [follow-up] with therapy for other suggestions." Nursing notes reviewed from 4/15 to 6/15 lacked any notations that a trial of washcloths or a splint had been tried and the resident's refusal for ROM and/or a device.<br><br>A registered nurse (RN)-A stated in an interview on 6/23/15, at approximately 4:30 p.m. R5 had been on hospice from 3/28/14 to 5/26/15. Hospice staff had ordered splints for R5's left hand, but she refused to wear the splint, therefore it was discontinued. RN-A stated staff did not provide any ROM services for R5. RN-A explained that nursing had attempted to place a rolled up wash cloth into the palm of her hand, but it was too painful for the resident. In a follow-up interview on 6/24/15, at 11:01 a.m. RN-A stated R5 was unable to open her fingers on her left hand due to pain and not rigidity. RN-A said "When hospice ordered the splint, I was personally in the room when [R5] refused to have it on." RN-A stated she did not write a nursing note documenting the times R5 refused to utilize the splint or washcloth. Regarding the nursing note dated 5/20/15, RN-A explained that it was only brought up at morning nursing meetings via word of mouth. and had not been directly brought to the attention of therapy staff for suggestions regarding ROM.<br><br>In an interview on 6/24/15, at 9:01 a.m. with the | F 318 | | |

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| F 318 | Continued From page 15<br>director of rehabilitation, she reported R5 had never been assessed by a therapist regarding her left hand contracture, nor had therapy staff been asked to assess the resident.<br><br>RN-B explained on 6/24/15, at 10:02 a.m. that when R5 was admitted to the facility, she was able to play the piano, but now was unable to open her fingers on her left hand. Although "months ago" nursing staff tried to put a wrap around R5's hand, she asked staff to "'stop that.'" RN-B said, "I feel like it was causing her more pain when we would change the wraps than if we just left it alone."<br><br>On 6/24/15 11:15 a.m. RN-A and the surveyor looked at R5's hand. When RN-A attempted to reach for R5's hand to open her fingers, the resident pulled away. However, when RN-A asked R5 if she could open her fingers by herself, she was able to perform the same movement as observed by the surveyor on 6/23/15. No verbal or physical signs of pain were observed. R5 stated again it was not painful, but when RN-A tried to move her ring finger on her left hand upward R5 pulled away and stated, "That hurts." RN-A said, "We should have been asking her daily for her to move her fingers by herself and document any refusals."<br><br>A facility policy on ROM was requested, but was not provided. | F 318 | | |
| F 371 SS=F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local | F 371 | **F371**<br><br>• Deeply grooved cutting boards have been replaced. All cutting boards are thoroughly cleaned in hot, soapy water, rinsed and sanitized after each use. Cutting boards will be replaced when surfaces are gouged. Ice machine has been thoroughly cleaned. | |

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| F 371 | Continued From page 16<br>authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to maintain cutting boards and ice machines in sanitary manner to minimize the possibility of foodborne illness. This had the potential to affect all 90 residents were served food from the kitchen.<br><br>Finding include:<br><br>An initial tour was conducted in the kitchen on 6/22/15, at 12:05 p.m. with the dietary manager (DM)-A. Three of nine large plastic cutting boards stored for use were deeply grooved and contained dried food debris. DM-A was able to scrape the dry food debris from the boards with a fingernail. DM-A verified the cutting boards should not have been stored with food debris and stated the boards should have been disposed of and replaced. In addition, the ice machine had a metal ledge and a long plastic guard located inside the ice machine that had a significant build-up of white crusty lime deposits along the entire length of both the metal ledge and plastic guard.<br><br>The director of environmental services (DES) explained on 6/25/15, at 7:42 a.m. that he cleaned the ice machine monthly. The DES verified the white crusty substance on the metal ledge and plastic guard inside the ice machine | F 371 | Plastic guard on the ice machine has been replaced.<br>• Education to all dietary regarding cleaning and replacement of cutting boards. Education to dietary staff and maintenance regarding cleaning of ice machine.<br>• Random weekly audits of cutting boards and ice machine.<br>• Dietary/Maintenance Directors responsible<br>• Audits will be reviewed at monthly QA until IDT determines audits no longer necessary.<br>• Completion date is 7/24/15 | |

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| F 371 | Continued From page 17<br>was indeed lime deposits. The DES scraped some of the deposits with a fingernail down to the metal, and said the plastic guard could have been replaced with a new one. The DES verified the lime build-up on the metal and plastic should not have been there, and could have easily been removed with a wire brush. The ice machine may have required more frequent cleaning than monthly, according to the DES.<br><br>A 6/15, Preventative Maintenance schedule indicated the ice machine had been de-limed and compressors cleaned on 6/15/15.<br><br>Review of the facilities Policy and Procedure titled Cleaning Instructions: Cutting Boards undated, indicated for staff to wash cutting boards in hot soapy water, rinse and sanitize after each use. Cutting boards will be replaced when surfaces are gouged. | F 371 | | |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the | F 428 | **F428**<br>• R126 has non-pharmacological interventions in place.<br>• All residents with PRN medications have non-pharmacological interventions in place.<br>• Education to all licensed staff regarding non-pharmacological interventions.<br>• Random weekly audits to ensure use of non-pharmacological interventions.<br>• DON/designee is responsible.<br>• Audits will re reviewed at monthly QA meetings until IDT determines audits no longer necessary.<br>• Completion date is 7/24/15 | |

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| F 428 | Continued From page 18<br>facility failed to ensure timely follow up on pharmacy recommendations for 1 of 1 resident (R126) for whom a drug irregularity was noted with anti-anxiety medication use.<br><br>Findings include:<br><br>R126's monthly Medication Regimen Review dated 5/19/15 read, "With any Ativan PRN [as needed] use, please ensure documenting non-drug interventions attempted."<br><br>R126's diagnostic list included dementia, bipolar disorder, and depression, and current physician orders included Ativan was prescribed for anxiety. A review of R126's medical record, however, revealed a lack documentation of non-pharmacological interventions in the resident's care plan, as well as on the treatment records.<br><br>During an interview on 6/25/15, at 2:55 p.m. a registered nurse (RN)-A stated regarding the Ativan and follow up to the pharmacist's recommendation, "Could we seriously not have the anti-anxiety non-pharmacological interventions? We missed that. I will put it in there right now." | F 428 | | |
| F 431 SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically | F 431 | **F431**<br>• No expired medications are being administered to R158. All expired medications have been removed from carts/medication room storage.<br>• Random weekly audits of medication carts, storage rooms to ensure all expired medications are removed. | |

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| F 431 | Continued From page 19<br>reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure expired medication was not administered for 1 of 6 residents (R158) reviewed for medication administration, and to ensure expired medications were not stored for use in 2 of 4 medication carts/rooms reviewed.<br><br>Findings include: | F 431 | • Education to all licensed staff regarding removing expired medications from medication carts/storage rooms.<br>• DNS/designee is responsible.<br>• Audits will be reviewed by IDT at monthly QA meetings until IDT determines audits no longer necessary.<br>• Completion date 7/24/15 | |

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| F 431 | Continued From page 20<br>R158's medication administration was observed on 6/24/15, at 8:26 a.m. with a registered nurse (RN)-D. RN-D prepared R158's medication including aspirin enteric coated (EC) 325 milligrams (mg) (used to treat or prevent heart attacks/strokes). The aspirin EC had an expiration date of 3/15. After preparing the medication, RN-D brought the medication to R158's room. RN-D was stopped right before handing the cup of pills to R158 by surveyor and was brought to the medication cart. RN-D verified that the aspirin EC was expired. On interview, RN-D stated that she should have checked the expiration dated prior to dispensing the medication.<br><br>When interviewed on 6/24/15, at 9:04 a.m. the registered nurse (RN)-C stated that they audit medication carts every week to check for expired medication. RN-C stated that her expectations is that nurses should be checking expiration dates before dispensing medication to residents. RN-C further stated that, "that medication should not have been in the medication cart".<br><br>R158's signed physician orders directed staff to administer aspirin EC tablet delayed release 325 miligrams (mg) by mouth in the morning for brokine [sic] ankle.<br><br>On 6/23/15, at 11:18 a.m. the first floor medication room was observed for medication storage with a licensed practical nurse (LPN)-B. A box of Compro (prochlorperazine)(medication used to prevent nausea) 25 mg suppository rectal for R80 was located in the refrigerator with an expiration date of 02/15. LPN-B verified that the medication was expired. On interview, LPN-B stated that she does not know who is supposed | F 431 | | |

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| F 431 | Continued From page 21<br>to be checking for expired medications.<br><br>On 6/22/15, at 1:11 p.m. the second floor medication room was observed for medication storage with a registered nurse (RN)-E. A bottle of sodium docusate (medication used for constipation) 100 mg capsule, house stock, was located in the medication storage with expiration date of 3/15. RN-E verified that medication was expired and stated that, "the medication should not be here".<br><br>The Disposal/Destruction of Expired or Discontinued Medications policy dated 1/1/13 directed that, "Facility should place all discontinued or out-dated medications in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction". | F 431 | | |
| F 441 SS=F | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections. | F 441 | **F441**<br><br>• Employee Absence Report form includes tracking of symptoms. Sharps are being disposed of in the correct sharps disposal containers. Glucose monitors are being cleaned per protocol.<br>• Staff authorized to accept employee call-ins have been educated regarding infection control tracking via Absence Report form. Licensed nurses have been educated regarding proper disposal of sharps and blood glucose monitor cleaning. | |

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| F 441 | Continued From page 22<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to include tracking of employee infections to minimize the spread of infection, potentially affecting all residents residing in the facility. Additionally, the facility failed to ensure a used sharp/needle was properly disposed and a glucometer was properly sanitized for 1 of 1 resident (R132) observed, having the potential to affect three additional residents who received glucose testing with the shared glucometer.<br><br>Findings include:<br><br>During interview with a licensed practical nurse | F 441 | • Random weekly audits of employee Absence Report to ensure facility tracking for infection control. Random weekly observation audits to ensure nurses are disposing of sharps in the proper manner and that blood glucose monitors are being cleaned correctly.<br>• DON/designee is responsible.<br>• Audits will be reviewed at monthly QA meetings until IDT determines audits no longer necessary.<br>• Completion date 7/24/15 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245275 | A. BUILDING _____ B. WING _____ | 06/25/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| EDINA CARE & REHAB CENTER | 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423 |

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| F 441 | Continued From page 23<br>(LPN)-C on 6/24/15, at 9:57 a.m. she explained that she had taken over some of the infection control duties, as the registered nurse (RN) who had been overseeing the infection control program resigned about a month prior. LPN-C further stated, "The director of nursing (DON) is now overseeing me. It's in our quality assurance [QA program] that we will be working on the infection control together." LPN-C went on to further explain that when an employee stayed home ill, an absence report was filled out by the staff coordinator Monday through Friday, and by a supervisor on the weekends. LPN-C stated the absence slips were kept in the staff coordinator book. She stated that although she looked at the slips, she did not perform any tracking or trending of employee illnesses.<br><br>The 4/15 Monthly Infection Report provided by the facility lacked any information regarding employee infections. A policy related to employee illness tracking was requested on 6/25/15, but was not provided.<br><br>R132's blood glucose testing was observed on 6/22/15, at 5:46 p.m. by LPN-A. LPN-A donned gloves, wiped R132's finger with an alcohol wipe and then poked the resident's finger. LPN-A then threw the used lancet into the waste basket that was adjacent to R132. LPN-A took a sample of blood from R132 using a glucose test strip, and obtained the reading, detached the test strip from the blood glucose machine and then threw the used glucose test strip in the waste basket adjacent to R132.<br><br>After the testing was completed, LPN-A removed the gloves and placed the glucometer in the basket, and washed her hands. LPN-A then | F 441 | | |

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| F 441 | Continued From page 24<br>donned gloves and wiped the glucometer with a germicidal wipe for approximately 10 seconds.<br><br>Immediately after leaving R132's room, LPN-A was interviewed regarding the lack of disposing of a used sharp/needle properly. LPN-A verified that she threw the used lancet and glucose test strip in a waste basket. LPN-A stated, "I should have placed the used needles in the sharps container [designed to prevent needle misuse/re-use]. I shouldn't have thrown it in the trash can." LPN-A also verified that she did not clean the glucometer machine per the policy. LPN-A stated that she's supposed to wipe the machine for at least 2 minutes with wet disinfecting wipes, but "I didn't do it". LPN-A stated, "I should have wiped it for 2 minutes or wrapped the machine with the wet wipes for 2 minutes".<br><br>During an interview on 6/22/15, at 7:20 p.m. the RN-C explained that the expectations was that all used sharps/needles "must go" in sharps container. RN-C further stated that glucometer machines should be cleaned according to the policy.<br><br>During an interview on 6/23/15, at 11:25 a.m. director of nursing (DON) explained that the expectations was that all used sharps/needles "must go" in the sharps container. The DON stated, "no sharps should go into a waste basket". DON further explained that there is a policy on how to clean glucometer after use, and that her expectations is nurses to follow the policy.<br><br>R132's physician orders dated 6/17/15, directed staff to test blood glucose three times per day before meals at 7:30 a.m., 11:30 a.m., and 5:30 | F 441 | | |

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| F 441 | Continued From page 25<br>p.m.<br><br>An undated "Infection Control Bloodborne Pathogen Exposure Control Plan" reminded staff that used needles will not be recapped or removed by hand or bent, broken or manipulated by hand. It further stated that, "all procedures involving blood or other potentially infectious materials will be performed in a manner that minimizes splashing, spraying, spattering and generation of droplets of these substances".<br><br>The facility's 3/20/12, Disinfecting Blood Glucose Meters policy directed staff to wipe all surfaces of the glucometer ensuring the device remained wet for two minutes to ensure it was effective against tuberculosis, bacterial and viral organisms. Staff was to "wrap the glucometer with germicidal wipe to ensure adequate disinfecting." The germicidal wipe (PSS Select Disinfectant) manufacturer container directed cleaning shared devices for two minutes to ensure cleaning was effective against tuberculosis, bacterial and viral organisms. | F 441 | | |

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| | 245275 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **06/25/2015** |

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| **EDINA CARE & REHAB CENTER** | **6200 XERXES AVENUE SOUTH<br>RICHFIELD, MN 55423** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire marshal Division on June 25, 2015. At the time of this survey, Edina Care Center was found in 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.<br><br>This 3-story building was determined to be of Type II (222) construction. It has a full basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 125 beds and had a census of 91 at the time of the survey. | K 000 | | |

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

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7013 2250 0001 6357 1713

July 10, 2015

Mr. Dennis Decosta, Administrator
Edina Care & Rehabilitation Center
6200 Xerxes Avenue South
Richfield, Minnesota 55423

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5275025

Dear Mr. Decosta:

The above facility was surveyed on June 22, 2015 through June 25, 2015 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, Health Regulation 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

When all orders are corrected, the order form should be signed and returned to this office at:

**Gayle Lantto, Unit Supervisor**
**Metro D Survey Team**
**Licensing and Certification Program**
**Health Regulation Division**
**Minnesota Department of Health**
**85 East Seventh Place, Suite #220**
**P.O. Box 64900**
**Saint Paul, Minnesota 55164-0900**
**Email: gayle.lantto@state.mn.us**
**Phone: (651) 201-3794 Fax: (651) 215-9697**

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 Gayle Lantto at the phone number or email detailed above**.

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

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

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

Sincerely,

Mark Meath

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

Enclosure(s)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00740 | A. BUILDING: _____ B. WING _____ | 06/25/2015 |

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| EDINA CARE & REHAB CENTER | 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423 |

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On June 22 through June 25, 2015, surveyors of this Department's staff visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to: | 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<br>Minnesota Department of Health<br>Health Regulation Division<br>Licensing and Certification Program<br>PO Box 64900<br>St. Paul, MN 55164-0900 | 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | |
| 2 560 | MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents<br><br>Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan | 2 560 | | |

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| 2 560 | Continued From page 2<br>required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure an accurate care plan was in place for 1 of 1 resident (R132) reviewed for dialysis.<br><br>Findings include:<br><br>R132's care plan dated 7/12/14, revealed the resident had impaired decision making abilities, needed assistance of one staff for dressing/grooming, had impaired vision, and received dialysis at DaVita on Mondays, Wednesdays, Fridays and Sundays. R132's care plan noted emergency protocols, as well as the telephone number to contact the dialysis center should concerns arise. However, the telephone number and location of the dialysis center were both incorrect.<br><br>R132's quarterly Minimum Data Set (MDS) dated 3/17/15, indicated R132's vision was highly impaired, was dependent on staff for cares and was receiving dialysis services.<br><br>A review of R132's ETAR's directed staff to check R132's dialysis access site for bruit/thrill (checking to see the access site is still functioning by listening with a stethoscope and feeling for vibration) every day and evening shift for health monitoring. However, there was no direction for staff regarding checking or removing the dressing.<br><br>During an interview on 6/24/15, at 7:46 a.m. a registered nurse (RN)-D stated when R132 | 2 560 | | |

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| 2 560 | Continued From page 3<br>returned from dialysis, the access site was left covered until the following day, when the resident removed the dressing herself. RN-D explained that she checked R132's access site for burit/thrill daily, and charted the results under the electronic treatment administration records (ETAR). She did not document anything regarding when the dressing was removed. RN-D stated if she need to contact the dialysis center regarding R132, she would locate the telephone number for the clinic on the resident's care plan.<br><br>RN-C stated in an interview on 6/24/15, at 12:38 p.m. there was no specific place on the ETAR noting R132's dressing was removed after dialysis. RN-C explained nurses used "nursing judgement" regarding when to remove the dialysis dressings.<br><br>A telephone interview with R132's primary dialysis nurse on 6/24/15, at 2:13 p.m. revealed that with the start of a resident receiving dialysis treatment, the facility received instructions from the center on managing a dialysis site. The nurse then stated R132's dialysis dressings should have been removed four hours after the dialysis treatment. This was not noted on the resident's care plan.<br><br>In a follow-up interview on 6/25/15, at 1:39 p.m. RN-C stated 132's care plan indicated staff was to call the dialysis center if needed, at the number listed on the resident's care plan. However, when RN-C called the number listed, it was for another DaVita clinic, and not where R132 went for dialysis. RN-C also checked R132's dialysis referral forms sent with the resident after appointments, and confirmed the form lacked the clinic phone number. | 2 560 | | |

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| 2 560 | Continued From page 4<br><br>The facility's 1/15/14, SNF [Skilled Nursing Facility] Outpatient Dialysis Services Agreement indicated "The end stage renal disease (ESRD) Dialysis Unit will provide the nursing facility information on all aspects of the management of the ESRD resident's care related to the provision of services, including directions on management of medical and non-medical emergencies, including, but not limited to, bleeding, infections and care of the dialysis access site."<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that appropriate care plans are created for residents requiring dialysis and range of motion; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 560 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>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. | 2 830 | | |

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| 2 830 | Continued From page 5<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to coordinate dialysis services for 1 of 1 resident (R132) reviewed for dialysis.<br><br>Findings include:<br><br>R132 had a dressing on her left arm on 6/23/15, at 2:56 p.m. R132 explained the dressing was from a dialysis treatment, which she independently removed the day after her dialysis treatments.<br><br>On 6/25/15, at 8:48 a.m. R132 was interviewed, at which time she was picking at, and attempting to remove her dialysis dressing. She reported her dialysis treatment had gone well the previous day and said, "I'm trying to take off this dressing because it makes me look like I have been wounded." R132 explained she had poor vision which made it hard for her to see the tape.<br><br>R132's quarterly Minimum Data Set (MDS) dated 3/17/15, indicated R132's vision was highly impaired, was dependent on staff for cares and was receiving dialysis services.<br><br>R132's care plan dated 7/12/14, revealed the resident had impaired decision making abilities, needed assistance of one staff for dressing/grooming, had impaired vision, and received dialysis at DaVita on Mondays, Wednesdays, Fridays and Sundays. R132's care plan noted emergency protocols, as well as the telephone number to contact the dialysis center | 2 830 | | |

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| 2 830 | Continued From page 6<br>should concerns arise. However, the telephone number and location of the dialysis center were both incorrect.<br><br>A review of R132's ETAR's directed staff to check R132's dialysis access site for bruit/thrill (checking to see the access site is still functioning by listening with a stethoscope and feeling for vibration) every day and evening shift for health monitoring. However, there was no direction for staff regarding checking or removing the dressing.<br><br>During an interview on 6/24/15, at 7:46 a.m. a registered nurse (RN)-D stated when R132 returned from dialysis, the access site was left covered until the following day, when the resident removed the dressing herself. RN-D explained that she checked R132's access site for burit/thrill daily, and charted the results under the electronic treatment administration records (ETAR). She did not document anything regarding when the dressing was removed. RN-D stated if she need to contact the dialysis center regarding R132, she would locate the telephone number for the clinic on the resident's care plan.<br><br>RN-C stated in an interview on 6/24/15, at 12:38 p.m. there was no specific place on the ETAR noting R132's dressing was removed after dialysis. RN-C explained nurses used "nursing judgement" regarding when to remove the dialysis dressings.<br><br>A telephone interview with R132's primary dialysis nurse on 6/24/15, at 2:13 p.m. revealed that with the start of a resident receiving dialysis treatment, the facility received instructions from the center on managing a dialysis site. The nurse then stated R132's dialysis dressings should have | 2 830 | | |

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| 2 830 | Continued From page 7<br>been removed four hours after the dialysis treatment.<br><br>In a follow-up interview on 6/25/15, at 1:39 p.m. RN-C stated 132's care plan indicated staff was to call the dialysis center if needed, at the number listed on the resident's care plan. However, when RN-C called the number listed, it was for another DaVita clinic, and not where R132 went for dialysis. RN-C also checked R132's dialysis referral forms sent with the resident after appointments, and confirmed the form lacked the clinic phone number.<br><br>The facility's 2006 Dialysis Program Guidelines policy indicated the purpose was to "Provide quality care and treatment services to the resident who requires dialysis...Comprehensive Care Plan...monitor for complications, monitor for access site for signs of infection, potential for bleeding and monthly assessments and care plan...Nursing Management...remove dressing to access site four hours after discharge form dialysis and access bleeding post dialysis."<br><br>The facility's 1/15/14, SNF [Skilled Nursing Facility] Outpatient Dialysis Services Agreement indicated "The end stage renal disease (ESRD) Dialysis Unit will provide the nursing facility information on all aspects of the management of the ESRD resident's care related to the provision of services, including directions on management of medical and non-medical emergencies, including, but not limited to, bleeding, infections and care of the dialysis access site." The agreement was by both the facility and ESRD on 1/15/14.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and | 2 830 | | |

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| 2 830 | Continued From page 8<br>revise policies and procedures related to dialysis access site assessments, monitoring and care, and could provide staff education related to the care of residents related to dialysis access sites. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 830 | | |
| 2 895 | MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion<br><br>Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:<br><br>B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to ensure call lights were within reach for 2 of 5 residents (R32, R44).<br><br>Findings include:<br><br>R32 was calling out for help when observed on 6/22/15, at 7:15 p.m. sitting in her wheelchair | 2 895 | | |

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| 2 895 | Continued From page 9 | 2 895 | | |

alone in her root. R32 then asked the surveyor, "Can you move me back into my chair? I'm sliding out of it." R32's call light cord was hanging down the wall behind the night stand out of the resident's reach. The surveyor activated the call light for R32 and a few minutes later two nursing assistants (NA)-A and NA-B entered the room. R32 asked NA-A and NA-B if they would move her back into her wheelchair, as she was sliding out of it. Both NA-A and NA-B verified R32 could not have reached her call light to request help.

Following the observation at 7:25 p.m. a registered nurse (RN)-A was brought to R32's room and explained how R32 was calling out for help and where her call light was positioned at the time. RN-A stated that R32's call light placement was unacceptable and should have been placed within her reach. RN-A explained that R32 was unable to use her call light. In addition, RN-A said R32 was at risk of sliding out of her wheelchair, and should not have been left alone in her room, but in view of the staff.

R32 was observed and interviewed on 6/24/15, at 10:30 a.m. She was lying in bed and the call light was clipped to the top sheet of her bed and her right arm was on top of the cord. When asked if she could use her call light to call for help she replied, "No." When asked if she knew where it was she again replied, "No."

R32's care plan dated 7/14/14, described the resident as being at risk for falling, had impaired cognition and required extensive assistance of two staff for transferring. Interventions included keeping the call light within reach and answering it in a timely manner, and providing positioning. R32's care plan lacked any indication she was unable to use her call light, and the nurse's report

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| 2 895 | Continued From page 10<br>she should was not to be left alone in her room.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and receive policies and procedures related to ensure residents with ROM deficits receive assessments, monitoring and care, and could provide staff education related to the care of resident related to ROM. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 895 | | |
| 21015 | MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi<br><br>Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to maintain cutting boards and ice machines in sanitary manner to minimize the possibility of foodborne illness. This had the potential to affect all 90 residents were served food from the kitchen.<br><br>Finding include:<br><br>An initial tour was conducted in the kitchen on 6/22/15, at 12:05 p.m. with the dietary manager (DM)-A. Three of nine large plastic cutting boards stored for use were deeply grooved and | 21015 | | |

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| 21015 | Continued From page 11 | 21015 | | |

contained dried food debris. DM-A was able to scrape the dry food debris from the boards with a fingernail. DM-A verified the cutting boards should not have been stored with food debris and stated the boards should have been disposed of and replaced. In addition, the ice machine had a metal ledge and a long plastic guard located inside the ice machine that had a significant build-up of white crusty lime deposits along the entire length of both the metal ledge and plastic guard.

The director of environmental services (DES) explained on 6/25/15, at 7:42 a.m. that he cleaned the ice machine monthly. The DES verified the white crusty substance on the metal ledge and plastic guard inside the ice machine was indeed lime deposits. The DES scraped some of the deposits with a fingernail down to the metal, and said the plastic guard could have been replaced with a new one. The DES verified the lime build-up on the metal and plastic should not have been there, and could have easily been removed with a wire brush. The ice machine may have required more frequent cleaning than monthly, according to the DES.

A 6/15, Preventative Maintenance schedule indicated the ice machine had been de-limed and compressors cleaned on 6/15/15.

Review of the facilities Policy and Procedure titled Cleaning Instructions: Cutting Boards undated, indicated for staff to wash cutting boards in hot soapy water, rinse and sanitize after each use. Cutting boards will be replaced when surfaces are gouged.

SUGGESTED METHOD OF CORRECTION:
The dietitian could develop/revise, and implement policies and procedures to ensure that equipment

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| 21015 | Continued From page 12<br>related to food consumption was maintained in a sanitary manner; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days. | 21015 | | |
| 21426 | MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control<br><br>(a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.<br><br>(b) Written compliance with this subdivision must be maintained by the nursing home.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to ensure mantoux were | 21426 | | |

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| 21426 | Continued From page 13<br>completed according to prevention guidelines for 5 of 5 residents (R49, R146, R158, 184, R199) and 4 of 5 employees (E1, E2, E3, E4) reviewed for tuberculosis testing.<br><br>Findings include:<br><br>During interview with licensed practical nurse (LPN-C) on 6/24/15, at 9:57 a.m. stated the employees receive a mantoux for tuberculosis testing upon hire and a second step mantoux 7-21 days later. And if the employee is not back within 72 hours to have the mantoux read, the employee must start the process all over and repeat the mantoux testing. LPN-C further stated, "It is important to know the time when the mantoux was given and read to be within the 48-72 hours. The time is important for that."<br><br>The tuberculosis testing documents from the employee files were reviewed for employees E1, E2, E3, E4, and E5. The review indicated E1 hired 3/23/15, had no copy of a chest x-ray in her file. The review also indicated E2 also hired 3/23/15, had only a preliminary chest x-ray completed with no copy of the final results. E3 hired 5/18/15, record indicated her first mantoux dated 5/8/15, had not been read, her second mantoux dated 5/19/15, (to repeat the first mantoux having not been read) indicated the time had not been marked down when the mantoux was given or read. E3's third mantoux dated 6/1/15, also indicated the time had not been marked on the form when the mantoux was given or read, making the tests for tuberculosis for E3 ineffective. E4 hired 6/1/15, record indicated E4 had had a positive mantoux but with no indurations in mm (millimeters) measured as prevention guidelines directed. | 21426 | | |

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| 21426 | Continued From page 14<br><br>LPN-C stated on 6/24/15, at 9:57 a.m. that the screening for tuberculosis starts when an employee is in prehire and that Human Resources (HR) does the screening part and that will determine if some employees will show positive on the mantoux testing or need a chest x-ray or not. LPN-C also stated there was a mantoux book on the floor so if employees do come in they can have their mantoux read. LPN-C further stated on the first day of orientation she made sure the first step mantoux was given to the new employee and she put little reminders on the message board for when the second mantoux was to be completed. LPN-C verified that the paper mantoux forms that the facility was using did not designate a place for the manufacturer of the tubersol to be recorded and additionally did not designate a place for the time the mantoux was given and the time the mantoux was read to be recorded. LPN-C reported it was a standard form the facility used and and that the form needed revising.<br><br>The following day at 10:00 a.m. LPN-C stated she had called the clinic where E2's chest x-ray had been taken and they were sending a copy of the final results. LPN-C also stated a copy of E1's chest x-ray was being sent over. LPN-C further stated she was going to redo E3's mantoux as the mantoux process for E3 needed to start over due to the mantoux not having been recorded with time given or time read.<br><br>Later that day at 2:44 p.m. LPN-C stated the person taking the sick calls had just been marking the employee illness on an individual employee record kept with the staff coordinator and that she was going to now start tracking and trending employee illnesses. | 21426 | | |

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| 21426 | Continued From page 15<br><br>On 6/24/15, and 6/25/15, during the review of records for residents' tuberculosis testing R49's October 2015, treatment administration record (TAR) indicated R49 admitted 10/24/14, had her first mantoux read 10/27/14. The TAR did not reveal the times the mantoux was given or when the mantoux was read. The TAR also did not indicate the indurations in mm (millimeters) when read as prevention guidelines dictate. R49's second mantoux given 11/8/14, and read on 11/10/14, also did not indicate the indurations in mm and the times given and read. R146 admitted 3/3/15, record indicated no mantoux had been given, neither first or second step. R158 admitted 3/10/15, her March 2015, TAR indicated R158's second mantoux given 3/26/15, the time was not documented that the mantoux was given and also indicated that R158's mantoux had not been read. R199 admitted 5/4/15, her May 2015, TAR indicated R199 had refused the first step mantoux on 5/5/15, and then again refused the mantoux 5/19/15. No other documents were provided revealing any indication of any other mantoux given or any further testing completed for R199. R184 admitted 3/25/15, his March 2015, TAR indicated R184's mantoux were read on 3/2/15, and 3/17/15, without the times documented when the mantoux was given and when the mantoux was read.<br><br>While showing LPN-C on 6/25/15, at 10:00 a.m. the residents' mantoux records which surveyor had reviewed LPN-C verified the residents' mantoux were incomplete and stated the floor nurses track the residents' mantoux. LPN-C further stated that between the nurses on the floor and the nurse managers they take care of the residents' mantoux.<br><br>In the afternoon at 2:11 p.m. the director of | 21426 | | |

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nursing (DON) stated, "Those two residents [R146, R158] you mentioned were a problem, we got the order [physicians] in, and will start giving them [mantoux] now." DON also stated the facility was going to start auditing new admission residents' mantoux going forward. DON gave surveyor a copy of the physician orders for the two residents R146 and R158.

When questioning registered nurse (RN)-C at 3:00 p.m. who was a nurse manager RN-C answered she had not been aware that R199 had refused her mantoux. When asked what she would have done if she would have known R199 had refused her mantoux she stated she would have reapproached R199 and reapproached her possibly with a different staff.

DON came up to surveyor at 3:11 p.m. and handed surveyor a paper (template titled Resident/Patient Mantoux Audit) and stated, "We now have a system for the nurse managers to audit the residents' mantoux."

Policy provided by the facility dated 2013 "Infection Control Resident Immunizations and Vaccinations" indicated 'Tuberculin Skin Test (TST) 1. For all new admissions a tuberculin skin test will be done within 72 hours after admission if there is no documented TST result from within 3 months prior to admission. 2. The 2-step Tuberculin Test (TST) method will be performed using 5 units (0.1 ml) of purified protein derivative tuberculin given intracutaneously. a. The first step must be performed within 72 hours of admission. b. If the first step is non-reactive, the second test will be administered one to three weeks later. 5. Tuberculin Skin Test (TST) results will be documented in the resident's medical record. a. Skin test results will be documented in millimeters

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| 21426 | Continued From page 17<br>of indurations rather than stating results is "positive" or "negative".'<br><br>Policy provided by the facility dated 2013 "Infection Control Tuberculosis Screening -- Employees" indicated 'It is the policy of this facility that all healthcare workers be tested for tuberculosis upon hire and yearly thereafter, unless contraindicated. Initial testing will be a two-step procedure with the first dose given prior to beginning work and the second "booster" dose given 7-21 days after the first, if the first dose is negative along with an employee risk screening tool. 1. Tuberculin Skin Test (TST): 2. New employees with a known, documented positive skin test will not receive a repeat Tuberculin Skin Test (TST) but will undergo a Chest X-ray if they do not have a documented negative CXR [chest x-ray] after Tuberculin skin tested positive. 4. Tuberculin Skin Test (TST) results will be documented in the employee's medical record. a. Skin test results will be documented in millimeters of indurations rather than stating result is "positive" or negative". b. The tuberculin manufacturer and lot number will be recorded'<br><br>Policy provided by the facility dated 2015 "Infection Control TB [Tuberculosis] Exposure Plan" indicated 'It is the policy of this facility to institute an effective Tuberculosis (TB) Control Plan that includes early detection of latent TB infection, screening for infectious TB disease, follow-up where necessary, appropriate transfer and isolation of infectious TB, and treatment of persons with non-infectious TB.'<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop or revise, and implement policies and procedures to ensure that residents and | 21426 | | |

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| 21426 | Continued From page 18<br>employees receive the required TB screening, and educate all staff. Then develop or revise monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21426 | | |
| 21530 | MN Rule 4658.1310 A.B.C Drug Regimen Review<br><br>A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change.<br>B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician.<br>C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending | 21530 | | |

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| 21530 | Continued From page 19<br>physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure timely follow up on pharmacy recommendations for 1 of 1 resident (R126) for whom a drug irregularity was noted with anti-anxiety medication use.<br><br>Findings include:<br><br>R126's monthly Medication Regimen Review dated 5/19/15 read, "With any Ativan PRN [as needed] use, please ensure documenting non-drug interventions attempted."<br><br>R126's diagnostic list included dementia, bipolar disorder, and depression, and current physician orders included Ativan was prescribed for anxiety. A review of R126's medical record, however, revealed a lack documentation of non-pharmacological interventions in the resident's care plan, as well as on the treatment records.<br><br>During an interview on 6/25/15, at 2:55 p.m. a registered nurse (RN)-A stated regarding the Ativan and follow up to the pharmacist's recommendation, "Could we seriously not have | 21530 | | |

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| 21530 | Continued From page 20<br>the anti-anxiety non-pharmacological interventions? We missed that. I will put it in there right now."<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for offering required nonpharmacological interventions. Nursing staff could be educated as necessary. The DON along with the pharmacist, could audit MARs, care plans and pharmacy medication reviews on a regular basis to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21530 | | |
| 21800 | MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who | 21800 | | |

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| 21800 | Continued From page 21<br>speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review the facility failed to provide appropriate notice of the right to request a demand bill when Medicare benefits ended for 2 of 3 residents (R4, R21) reviewed for liability notice.<br><br>Findings include:<br><br>R4 was admitted to the facility on 4/20/15. R4 was discharged from Medicare non-coverage on 4/30/15, signed the notice of Medicare non-coverage form on 4/30/15, and was discharged from the facility on 5/1/15.<br><br>R21 was admitted to the facility on 12/22/14. R21 was discharged from Medicare non-coverage on 1/7/15, signed the notice of Medicare non-coverage form on 1/6/15, and was discharged from the facility on 1/8/15.<br><br>On 6/25/15, at 3:15 p.m. the Centers of Medicare and Medicaid Services (CMS) form 10123 was reviewed for R4 and R21. The forms lacked documentation showing R4 and R21 had been provided a 48-hour notice as required before | 21800 | | |

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| 21800 | Continued From page 22<br>Medicare services ended.<br><br>On 6/25/15, at 3:25 p.m. the business office manager confirmed she should have given R4 and R21 the CMS form 10123 48-hrs prior to when services ended.<br><br>A policy and procedure for demand bill/liability notice was requested, but was not provided.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents receive the required Medicare denial and appeal rights notices; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days. | 21800 | | |
| 21810 | MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources.<br><br>This MN Requirement is not met as evidenced by: | 21810 | | |

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| 21810 | Continued From page 23<br><br>Based on observation, interview and document review the facility failed to ensure call lights were within reach for 2 of 5 residents (R32, R44).<br><br>Findings include:<br><br>R32 was calling out for help when observed on 6/22/15, at 7:15 p.m. sitting in her wheelchair alone in her root. R32 then asked the surveyor, "Can you move me back into my chair? I'm sliding out of it." R32's call light cord was hanging down the wall behind the night stand out of the resident's reach. The surveyor activated the call light for R32 and a few minutes later two nursing assistants (NA)-A and NA-B entered the room. R32 asked NA-A and NA-B if they would move her back into her wheelchair, as she was sliding out of it. Both NA-A and NA-B verified R32 could not have reached her call light to request help.<br><br>Following the observation at 7:25 p.m. a registered nurse (RN)-A was brought to R32's room and explained how R32 was calling out for help and where her call light was positioned at the time. RN-A stated that R32's call light placement was unacceptable and should have been placed within her reach. RN-A explained that R32 was unable to use her call light. In addition, RN-A said R32 was at risk of sliding out of her wheelchair, and should not have been left alone in her room, but in view of the staff.<br><br>R32 was observed and interviewed on 6/24/15, at 10:30 a.m. She was lying in bed and the call light was clipped to the top sheet of her bed and her right arm was on top of the cord. When asked if she could use her call light to call for help she replied, "No." When asked if she knew where it was she again replied, "No." | 21810 | | |

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| 21810 | Continued From page 24<br><br>R32's care plan dated 7/14/14, described the resident as being at risk for falling, had impaired cognition and required extensive assistance of two staff for transferring. Interventions included keeping the call light within reach and answering it in a timely manner, and providing positioning. R32's care plan lacked any indication she was unable to use her call light, and the nurse's report she should was not to be left alone in her room.<br><br>R44's call light was on the floor between her bed and her roommate's bed during an initial tour on 6/22/15, at 4:20 p.m. The space between the two beds was approximately 18 inches, not wide enough for R44's wheelchair. NA-E was notified of the observation, and picked up the call light from the floor and placed it on top of the resident's bed. NA-E then stated, "The call light should be on top of her bed. She is able to use her call light and does use it."<br><br>The following morning at 7:56 a.m. R44's call light was placed in the far right upper corner of her bed to the right of the pillow. NA-F was called into R44's room and moved the call light to the left side of the bed where R44's wheelchair could fit so she could reach it. NA-F stated the call light was probably placed to the right of R44's pillow by the night staff because that was usually where it was placed when R44 was in bed. NA-F verified with the beds so close together R44's wheelchair could not have fit between the two beds, and the resident could not have reached the call light to summon help.<br><br>On 6/24/15, at 6:33 a.m. R44's call light was observed to the right of her pillow, and again out of her reach, however, R44 was not in her room at the time of the observation. | 21810 | | |

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| 21810 | Continued From page 25<br><br>R44's care plan dated 5/13/15, indicated "[R44] is usually understood and usually understands others. Strength: Resident is able to make most needs known. Ensure/provide a safe environment: Call light in reach."<br><br>The director of nursing (DON) stated on 6/24/15, at 8:35 a.m. she expected call lights to be placed within the residents' reach.<br><br>Later that day at 1:12 p.m. the maintenance director stated call lights were checked for function, but maintenance staff did not check that they were kept in a resident's reach. The DON then stated, "I don't recall if nursing has any call light audits, but we can re-initiate." The administrator who was present at the time explained they had checked the whole house in the springtime for call light function, since the system was bulb-driven, however, the placement of call lights had not been audited.<br><br>A review of the resident council minutes dated 4/13/15, indicated one resident reported staff, "Need education for staff to keep call lights within reach."<br><br>The facility's 2006, Call Light, Use Of policy directed staff to, "Respond promptly to resident's call for assistance...Be sure call lights are placed within resident reach at all times, never on the floor or beside stand."<br><br>SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents have call lights placed within reach; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality | 21810 | | |

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| 21810 | Continued From page 26<br>Assurance Committee.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 21810 | | |