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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: O292

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245322**

2.STATE VENDOR OR MEDICAID NO.
(L2)

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

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/27/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
01/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jennifer Bahr, HFE NE II 09/27/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 10/12/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 10/21/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/09/2016
(L33)

DETERMINATION APPROVAL

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective 09/26/2016, the facility is certified for 38 skilled nursing facility beds.

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245322
October 12, 2016

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

Dear Mr. Carsen:

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

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

Effective September 26, 2016 the above facility is certified for or recommended for:

38 Skilled Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 12, 2016

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

RE: Project Number S5322025

Dear Mr. Carsen:

On August 19, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 3, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On September 27, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 3, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 26, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 3, 2016, effective September 26, 2016 and therefore remedies outlined in our letter to you dated August 19, 2016, 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.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245322 Y1	A. Building B. Wing Y2	9/27/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0157	Correction	ID Prefix F0242	Correction	ID Prefix F0282	Correction
Reg. # 483.10(b)(11)	Completed	Reg. # 483.15(b)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	09/26/2016	LSC	09/26/2016	LSC	09/26/2016
ID Prefix F0312	Correction	ID Prefix F0314	Correction	ID Prefix	Correction
Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(c)	Completed	Reg. #	Completed
LSC	09/26/2016	LSC	09/26/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) PK/KJ	DATE 10/12/2016	SIGNATURE OF SURVEYOR 35575	DATE 09/27/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 8/3/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: O292

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(L1) **245322**
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(L2)

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(L3) **COLONIAL ACRES HEALTH CARE CTR**
(L4) **5825 ST CROIX AVENUE**
(L5) **GOLDEN VALLEY, MN** (L6) **55422**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/03/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
01/31

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

12.Total Facility Beds **88** (L18)
13.Total Certified Beds **38** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Jennifer Bahr, HFE NE II — 08/31/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 09/01/2016 (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
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: **00** (L30)

VOLUNTARY
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 09/08/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 19, 2016

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

RE: Project Number S5322025

Dear Mr. Carsen:

On August 4, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), 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;

Electronic 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:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Email: Teresa.Ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

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 September 13, 2016, 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 September 13, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 3, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 3, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING _____ B. WING _____	08/03/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as	F 157		8/26/16

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

Electronically Signed | 08/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING _____ B. WING _____	08/03/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician in a timely manner following the development of a stage 2 pressure ulcer (partial thickness skin loss involving the epidermis and or dermis, presenting as an abrasion, blister or shallow crater) for 1 of 3 residents (R71) reviewed for pressure ulcers. Findings include: R71's quarterly Minimum Data Set (MDS) dated 5/26/16, identified diagnoses that included diabetes. The MDS also indicated R71 was cognitively intact, and was at risk for developing pressure ulcers. A progress note dated 7/6/16, at 6:43 p.m. identified R71 had developed a blister to the right foot. The progress notes indicated the physician was notified on 7/20/16, 14 days after the development of the pressure ulcer, and the physician ordered a treatment on that time. When interviewed on 8/3/16, at at 9:47 a.m. registered nurse (RN)-A stated when a new skin area develops the physician was to be notified. RN-A stated the nursing notes would indicate if	F 157	F157: Notify of changes In order to remain in compliance, the facility submits the following: Corrective action for resident found to be affected by alleged deficient practice: R-71s physician was notified of resident change in condition. R71 continues to be a resident at facility. She enrolled in Hospice on 8/15/16. Primary physician/NP and Hospice physician/Nurse and others as appropriate will continue to be notified of any changes in resident□s condition. IDENTIFY OTHERS POTENTIALLY AFFECTED: Interviewed licensed staff during licensed nurse in serving regarding current resident population and criteria for notification of resident change in condition. Reviewed clinical records of current resident population to identify possible change in condition not identified. No other case discovered. Measures put into place or systemic changes: Licensed Nurse in servicing was	

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F 157	Continued From page 2 the physician had been notified. When interviewed on 8/3/16, at 2:44 p.m. the director of nursing (DON) stated that the nurse manager, herself, and the physician should have been notified of the development of the stage 2 pressure ulcer. The facility policy Change in a resident's Condition or Status dated 7/1/09, directed staff to notify the residents attending physician when there were changes in the resident's medical/ mental condition and or status.	F 157	conducted on August 22, 24 & 25th, 2016. Agenda included review of policy and procedure regarding notification of physician and/or legal representation/interested family member related to significant change in health status. Staff member that failed to report incident with R71 identified, counseled and re-educated regarding the need for immediate notification to physician, legal representative, interested family member and supervisor when there is a significant change in the resident□s physical, mental, or psychosocial status (i.e. deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications. Clinical staff orientation check list reviewed and updated as needed to ensure reporting and documentation standards are clearly presented and understood. MONITOR: Random weekly audits will be conducted on 20% of residents residing in Medicare Distinctive Unit for 60 days then monthly x's 1 month and as directed by QAPI/QA committee to ensure proper reporting and notification of physicians and/or legal representation/interested family member when there is a significant change or life-threatening conditions or clinical complication. Results will be presented to QAPI/QA committee with review for additional recommendations. DATES OF COMPLETION: August 26, 2016	

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F 157	Continued From page 3	F 157	RESPONSIBLE: Director of Nursing/designee	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to offer and/or accommodate resident choices regarding bathing preferences and bathing frequency for 2 of 3 residents (R71, R3) reviewed for choices. Findings include: R71's admission Minimum Data Set (MDS) dated 3/2/16, indicated R71 had moderate cognitive impairment and required physical help with bathing. The MDS also indicated it was very important for R71 to have the choice between a tub bath, shower, bed bath or sponge bath. During interview on 8/1/16, at 6:46 p.m. R71 stated she preferred a tub bath but was frequently receiving a shower. R71 further stated staff did not offer her a choice between a shower and a tub bath. An undated nursing assistant (NA) task sheet	F 242	F242 Self-Determination □ Right to Make Choices In order to remain in compliance, the facility submits the following: Corrective action for resident found to be affected by alleged deficient practice: R71□s bathing choice has been updated on her caregiver □Group Sheet□ to include offering □choice□ with every bathing event. Resident has since had both a tub bath and a shower per her choice. Care plan updated to reflect resident choice. R3 has been offered additional frequency with his bathing schedule, however, he has not wanted additional bathing at this point. Staff will continue to offer and honor his choice. IDENTIFY OTHERS POTENTIALLY	8/26/16

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F 242	Continued From page 4 indicated R71 received bathing assistance on Wednesday mornings, but did not specify a bathing preference. R71 was observed on 8/3/16, at 7:43 a.m. while NA-B wheeled R71 via wheelchair to the tub room. The tub room was observed to have a spa tub and a shower available. NA-B walked over to the shower, started the water, and got R71 ready for a shower. NA-B did not offer R71 a choice regarding whether she would prefer a tub bath or shower. NA-B proceeded to give R71 a shower. During interview on 8/3/16, at 7:51 a.m. NA-B stated that she never offered R71 a choice between a tub bath and a shower because "she just always gets a shower." NA-B verified R71's task sheet did not specify the resident's choice of a tub bath or shower, but rather just indicated the day and shift R71 was to be bathed. During interview on 8/3/16, at 1:09 p.m. registered nurse (RN)-B stated staff should be asking if a resident prefers a tub bath or shower unless it is contraindicated. RN-B said if a staff member is not sure whether a bath is contraindicated, they should ask a nurse. RN-B also stated she felt the nursing assistants probably gave showers because a shower is quicker than a tub bath. During interview on 8/3/16, at 2:44 p.m. the director of nursing (DON) stated that residents should always be offered a choice regarding their bathing preferences.	F 242	AFFECTED: All residents residing in the Medicare Distinictive Unit were interviewed regarding their preferred method and frequency of personal hygiene (bath vs. shower). Caregiver group sheets revised to include 'choice' of bathing preference on 'bath day'. Staff re-educated regarding offering resident choice with every bathing event as resident may change preference from bath to shower depending on preference on any given day. Measures put into place or systemic changes: Caregiver (Licensed nurse/NAR) in servicing conducted on August 17 □ August 25, 2016 which included review of facility protocol regarding resident□s right to make choices about aspects of their life that is significant to them. Orientation shift routine expectation reviewed and revised to highlight resident choice. MONITOR: Random weekly interviews will be conducted by RN Managers/designee for 20% of residents residing on the Medicare Distinctive Unit for 60 days then monthly x's 1 month and then as directed by QAPI/QA to ensure residents are being offered a choice in their personal hygiene style (bath vs. shower) and bathing frequency. Results of interviews will be presented to QAPI/QA committee with review for additional recommendations. DATES OF COMPLETION: August 26, 2016	

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F 242	Continued From page 5	F 242	RESPONSIBLE: Director of Nursing/Nurse managers/supervisors	

R3's admission MDS dated 5/28/16, indicated R3 was cognitively intact, it was very important for R3 to choose bathing preferences, and R3 required physical help and set up with showering.

During interview on 8/3/16, at 8:20 a.m. R3 stated he only received one shower a week on Monday evenings and would like to shower more often. When asked how staff responded to his requests for more showers R3 stated, "they say they can't do it."

R3's current care plan dated 5/23/16, identified a problem of self care deficit, and indicated R3 required supervision with hygiene, and was showered one time weekly.

R3's undated NA task sheet, indicated R3 received assistance with bathing on Monday evenings.

Documentation provided by the facility from 7/4/16 to 8/4/16, indicated R3 had received one shower a week for the month of July into August.

During interview on 8/3/16, at 9:32 a.m. NA-B stated the nursing assistants were in charge of giving baths and that each resident received one bath a week. NA-B also said R3 needed minimal assistance with showering. NA-B further stated residents could have more baths or showers if they asked for them, but she was unaware R3 had ever requested any more frequent showering.

During interview on 8/3/16, at 11:37 a.m. RN-A was interviewed and stated, "typically residents receive one bath a week." RN-A stated she didn't always think one a week was enough. She further

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stated the activities department was responsible for completing the preferences assessment at admission. RN-A stated if a resident requested more than one bath in a week it would be provided to him or her that week, then would go back to the once a week schedule, unless the resident specifically requested a set amount in a week.

During interview on 8/3/16, at 12:06 p.m. the concierge/activities coordinator stated she completed the preferences assessment upon admission to assess the resident's preferred method of bathing. She stated she did not ask about the frequency with which residents wanted to be bathed. The concierge/activities coordinator said summary notes regarding resident preferences were filed in the resident's medical record to communicate those preferences to nursing staff. She clarified that nursing staff were responsible for assessing the frequency of bathing for residents.

During interview on 8/3/16, at 1:05 p.m. RN-C stated she was unaware R3 wanted more frequent showers. RN-C verified R3 only needed supervision with showering to ensure safety. She stated nursing staff try to stick to the bathing schedules established, however, R3 frequently left the building and she thought he received showers as he wanted them. RN-C also stated if a resident wanted more than one bath a week, he or she would report that to nursing staff and the request would be accommodated, however, she said unless a resident specifically asked for more frequent bathing, it would not be added to the schedule.

A facility policy entitled Shower/Tub Bath dated

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F 242	Continued From page 7 7/1/09, directed staff on how to give residents baths and showers; however, did not address resident choice for method and/or frequency of bathing.	F 242		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care to ensure a pressure reducing boot was in place while in bed for 1 of 3 residents (R71) reviewed for pressure ulcers, failed to ensure dirty nails were cleaned for 1 of 3 residents (R71), and failed to ensure that shaving and oral care were completed for 1 of 3 residents (R134) reviewed for activities of daily living (ADL). Findings include: R71's care plan was not followed for placement of a heel protector. R71's care plan dated 6/30/16, identified R71 had a purple non- blanchable area to the the left heel and to ensure a heel protector was in place while in bed. R71's quarterly Minimum Data Set (MDS) dated 5/26/16, indicated R71 was cognitively intact, and was at risk for pressure ulcers.	F 282	F282: Services by qualified persons/Per care plan In order to remain in compliance, the facility submits the following: Corrective action for resident found to be affected by alleged deficient practice: R71□s care plan was reviewed and revised as appropriate to include nail care with each bathing experience and as needed. Intervention related to placement of pressure reduction boot each night remains as indicated on the care plan. R134 discharged 8/9/16 IDENTIFY OTHERS POTENTIALLY AFFECTED: ADL care plans for all residents reviewed and updated as necessary Measures put into place or systemic changes: Licensed Nurses and Nursing Assistant in	8/26/16

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F 282	Continued From page 8 On 8/3/16, at 7:25 a.m. nursing assistant (NA)-B pulled down R71's blankets and R71 had non skid socks to both of her feet. There was not a pressure reduction boot on R71's left foot as care planned. During interview on 8/3/16, at 8:24 a.m. NA-B stated that the the pressure reduction boot was not on R71's foot when she went to get her up. During interview on 8/3/16, at 2:44 p.m. the director of nursing (DON) stated that care planned interventions were expected to be followed. R71's care plan was not followed for nail care. R71's care plan dated 5/23/16, identified R71 had a self care deficit and directed staff to clean and manicure nails as needed. On 8/1/16, at 5:35 p.m. R71 was observed to have a thick black substance under both of her thumb nails. A subsequent observation on 8/2/16, at 2:17 p.m. revealed that the black substance remained under both of her thumb nails. Following R71's shower on 8/3/16, at 8:24 a.m. R71's thumb nails remained dirty. NA-B stated that R71's thumb nails were dirty and that nail care should have been completed with her shower and it was not. During interview on 8/3/16, at 2:44 p.m. the DON stated that cleaning the nails was to be done minimally on the bath day, but should be done as needed.	F 282	servicing was conducted between August 18 □ 25th 2016. Agenda included review of facilities expectation to provide assistance to residents that are dependent on staff for activities of daily living to maintain good nutrition, grooming and personal and oral hygiene. The policy and procedure for following a residents individual care plan was reviewed and is current MONITOR: Random weekly audits will be conducted for 20% residents for 60 days and then monthly x's 1 month to ensure residents residing in the Medicare Distinctive Unit, who require assistance with ADL□s are receiving proper assistance with cares. Results will be presenedt to QAPI/QA committee with review for additional recommendations and continued auditing. DATES OF COMPLETION: August 26, 2016 RESPONSIBLE: Director of Nursing/designee	

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R134's care plan was not followed for oral care and shaving facial hair.

R134's care plan dated 7/29/16, identified him as needing extensive assistance with hygiene and grooming. The care plan directed staff to provide oral care, including cleaning his mouth and brushing his teeth, after meals and at bedtime. It did not direct that R134 did not want to be shaved or indicate a frequency in which he was to be shaved.

On 8/2/16, at 8:33 a.m., R134 was observed in bed. Long white and gray facial hair was noted on his upper lip, around his cheeks, and on his chin.

During interview that same day, at 10:23 a.m. family member (F)-A stated R134 had recently had pneumonia, was concerned he was not receiving oral cares, and at times during visits, noted an odor in his mouth. F-A further stated R134 was unshaven even though an electric shaver had been provided, had always been clean shaven, and during visits had started stroking the facial hair.

On 8/2/16, at 2:17 p.m. R134 was again observed in bed. Facial hair was again noted. In his bathroom, an electric shaver was lying on the metal shelf above the sink. In addition, a toothbrush and paste were observed on the same metal shelf. The toothbrush appeared dry with hardened paste on the bristles.

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On 8/3/16, at 7:02 a.m. R134 was in bed. Nursing assistant (NA)-B stated she had assisted R134 with dressing that morning, however, R134 had wanted to go back to bed after dressing. NA-B stated she would assist R134 to the bathroom and complete morning cares, including oral care, before taking him to breakfast. NA-B never mentioned shaving.

At 8:06 a.m., RN-A woke R134 and assisted him to breakfast. R134 was not offered or assisted to the bathroom nor were any cares provided.

On 8/3/16, from 8:26 a.m. to 9:05 a.m., R134 was continuously observed in bed until being brought to occupational therapy. No cares were provided.

At 9:55 a.m., R134 was brought back to his room and assisted into bed. In an interview immediately after, occupational therapist stated R134 had not worked on any activities of daily living during the therapy session.

During interview on 8/3/16, at 11:37 a.m., RN-A stated physical therapy was working with R134, who had previously been napping. RN-A further stated R134 would be brought to lunch directly from physical therapy. After lunch, 12:33 p.m., R134 was observed back in bed. He continued to have long facial hair. No morning cares had been provided.

During interview on 8/3/16, at 1:25 p.m. NA-B stated R134's oral care had not been done that morning before or after breakfast and had not been done after lunch. NA-B stated R134 did have facial hair, had never been shaved, but was aware that he had his own electric shaver. When asked about the facility process for shaving, NA-B

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F 282	Continued From page 11 stated residents were shaved when the nursing staff noted facial hair. During interview, R134's electric shaver was noted on his bedside table and his toothbrush was noted in his bathroom. Neither oral care nor shaving had been offered to R134. During interview at 2:35 p.m., RN-C stated oral cares were expected to be offered with morning and evening cares as a facility policy. In addition, RN-C stated shaving was expected to be completed as part of hygiene and grooming cares when facial hair was noticed and would be addressed on the care plan if a resident did not want to be shaved. The facility policy on following a residents care plan was requested and not received.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with shaving and oral care for 1 of 3 residents (R134) reviewed for activities of daily living. In addition, the facility failed to provide nail care for 1 of 3 residents (R71) who were dependent on staff for assistance with activities of daily living.	F 312	F312: ADL Care provided for dependent residents In order to remain in compliance, the facility submits the following Corrective action for resident found to be affected by alleged deficient practice: R71□s nail care provided per facility	8/26/16

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F 312	Continued From page 12 Findings include: R134's admission Minimum Data Set (MDS) identified diagnoses that included anemia, chronic kidney disease and weakness. The MDS also indicated R134 required supervision/oversight of staff for personal hygiene. On 8/2/16, at 8:33 a.m. R134 was observed in bed and long white and gray facial hair was noted on his upper lip, around his cheeks, and on his chin. During interview that same day, at 10:23 a.m. family member (F)-A stated R134 had recently had pneumonia, was concerned he was not receiving oral cares, and at times during visits, noted an odor in his mouth. FM-A further stated R134 was unshaven even though an electric shaver had been provided, had always been clean shaven, and during visits had started stroking the facial hair. At 2:17 p.m. R134 was again observed in bed. Facial hair was again noted. In his bathroom, an electric shaver was lying on the metal shelf above the sink. In addition, a toothbrush and paste were observed on the same metal shelf. The toothbrush appeared dry with hardened paste on the bristles. On 8/3/16, at 7:02 a.m. R134 was in bed. Nursing assistant (NA)-B stated she had assisted R134 with dressing that morning, however, R134 had wanted to go back to bed after getting dressed. NA-B stated she would assist R134 to the bathroom and complete morning cares, including oral care, before taking him to breakfast. NA-B	F 312	policy. Staff have been re-educated regarding daily routine expectations which includes nail care whenever needed and as part of each bathing/shower experience R134 discharged 8/9/16. Documentation on 8/2/16 indicates resident toilets self, transfers self and grooms self. Resident does not allow help with cares. IDENTIFY OTHERS POTENTIALLY AFFECTED: Personal hygiene care plans for all residents reviewed and updated as necessary and any changes communicated to staff. Measures put into place or systemic changes: Licensed Nurses and Nursing Assistant in servicing was conducted between August 18 □ 25th 2016. Agenda included review of facility expectation to provide assistance to residents that are dependent on staff for activities of daily living to maintain good nutrition, grooming and personal and oral hygiene. Discussion included observing and reporting changes in residents need for more or less assistance and revising care plan as appropriate. The policy and procedures were reviewed and is current. MONITOR: Random weekly observations of cares will be conducted by RN Manager/designee of residents who require assistance with ADL□s to insure they are receiving required assistance with their cares. Audits will be conducted on 20% of residents residing on the Medicare Distinctive Unit for 60 days then	

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F 312	Continued From page 13 never mentioned shaving. On 8/3/16, at 8:06 a.m., registered nurse (RN)-A woke R134 and assisted him to breakfast. R134 was not offered or assisted to the bathroom nor were any cares provided. On that same day, from 8:26 a.m. to 9:05 a.m. R134 was continuously observed in bed until being brought to occupational therapy. No cares were provided. At 9:55 a.m. R134 was brought back to his room and assisted into bed. In an interview immediately after, occupational therapist stated R134 had not worked on any activities of daily living during the therapy session. She further stated only selected residents performed morning cares with therapy, therapy would notify nursing staff of the selected residents, and nursing was responsible for completed morning cares with the unselected residents. At 11:37 a.m. RN-A stated physical therapy was working with R134, who had previously been napping. RN-A further stated R134 would be brought to lunch directly from physical therapy. After lunch, 12:33 p.m. R134 was observed back in bed. He continued to have long facial hair. No morning cares had been provided. During interview on 8/3/16, at 1:25 p.m. NA-B stated R134's oral care had not been done that morning before or after breakfast and had not been done after lunch. NA-B stated R134 did have facial hair, had never been shaved, but was aware that he had his own electric shaver. When asked about the facility process for shaving, NA-B stated residents were shaved when the nursing	F 312	monthly x's 1 month and then as directed by QAPI/QA. All results will be presented to QAPI/QA committee with review for additional recommendations. DATES OF COMPLETION: August 26, 2016 RESPONSIBLE: Director of Nursing/designee	

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staff noted facial hair. During interview, R134's electric shaver was noted on his bedside table and his toothbrush was noted in his bathroom. Neither oral care nor shaving had been offered to R134.

During interview on 8/3/16, at 2:35 p.m. RN-C stated oral cares were expected to be offered with morning and evening cares as a facility policy. In addition, RN-C stated shaving was expected to be completed as part of hygiene and grooming cares when facial hair was noticed and would be addressed on the care plan if a resident did not want to be shaved.

R134's current care plan, dated 7/29/16, identified him as needing extensive assistance with hygiene and grooming. The care plan directed staff to provide oral care, including cleaning his mouth and brushing his teeth, after meals and at bedtime. It did not direct that R134 did not want to be shaved.

A facility policy entitled: Brushing Teeth, dated 7/1/09, directed that residents were assisted with oral cares based on individual needs, were documented in the medical record in the morning and evening, and refusals of oral care reported to a supervisor.

A facility policy entitled: Shaving the Resident, dated 7/1/09, directed staff on how to perform shaving and where to document the procedure. It did not address the frequency of or when shaving should be performed.

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R71's quarterly MDS dated 5/26/16, indicated R71 needed extensive assistance with personal hygiene. The MDS also identified R71 had diagnoses of diabetes and dementia. R71's activities of daily living (ADL) Care Area Assessment (CAA) dated 3/3/16, indicated R71 needed extensive assistance with all her ADL's. Weakness, poor motivation and possibly pain were identified contributing factors.

R71's care plan dated 5/23/16, identified R71 had a self care deficit and directed staff to clean and manicure nails as needed.

On 8/1/16, at 5:35 p.m. R71 was observed to have a thick black substance under both of her thumb nails. A subsequent observation on 8/2/16, at 2:17 p.m. revealed that the black substance remained under both of her thumb nails.

During interview on 8/2/16, at 2:27 p.m. NA-A stated that cleaning under residents' fingernails was to be done weekly with their baths.

On 8/3/16, at 8:24 a.m. R71 had just finished showering and the black substance remained under her thumb nails. NA- B verified that there was a black substance under R71's thumb nails. NA-B stated that nail care including cleaning and trimming nails was supposed to done on bath days and she had not cleaned her nails in the shower.

During interview on 8/3/16, at 1:09 p.m. RN- B stated that nail care, including cleaning under the nails should be done with bathing weekly.

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F 312	Continued From page 16 During interview on 8/3/16, at 2:44 p.m. the DON stated that cleaning the nails was to be done minimally on the bath day, but should be done as needed. The facility policy Care of Fingernails/ Toenails dated 7/1/09, directed staff that nails can be partially cleaned during bath care and nail care includes daily cleaning and regular trimming.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess pressure ulcer risk factors after the development of pressure ulcers, and failed to implement interventions to prevent the deterioration of an existing pressure ulcer, and the development and deterioration of a new pressure ulcer for 1 of 3 residents (R71) reviewed for pressure ulcers. R71 experienced actual harm due to the development and deterioration of a new pressure ulcer. Findings include:	F 314	F314: Treatment to prevent/heal pressure sores In order to remain in compliance, the facility submits the following: Corrective action for resident found to be affected by alleged deficient practice: R71 enrolled in Hospice 8/15/16 and remains a resident at this facility. Comprehensive assessment completed related to diabetic ulcer development and Hospice enrollment.	8/26/16

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F 314	Continued From page 17 R71's pressure ulcer to the left heel was identified on 8/1/16, at 5:21 p.m. during an interview with registered nurse (RN)-D. RN-D stated R71 had one pressure ulcer, an unstageable ulcer to her left heel (a pressure ulcer where the wound bed is covered with eschar or slough and unable to determine thickness of the tissue loss). RN-D stated the pressure ulcer to the resident's left heel had first been identified after a hospitalization. She also stated the unstageable pressure ulcer was first documented on 6/29/16, as a suspected deep tissue injury (purple or maroon localized area of discolored intact skin due to damage of underlying soft tissue). R71 was observed on 8/2/16, at 2:17 p.m. sitting in her wheelchair. R71 was wearing non-skid socks on both feet, but her feet were in direct contact with the hard foot pedals without any cushion. At the time of the observation, R71 stated she required staff assistance to move out of her chair. On 8/3/16, at 7:25 a.m. nursing assistant (NA)-B was heard to ask R71, who was lying on her right side in bed, if she wanted to get up for a shower. When R71 responded affirmatively, NA-B was observed to pull down the blankets. R71 was observed to be wearing non-skid socks on both feet. The resident was not observed to be utilizing any kind of pressure reduction boot. In addition, R71's feet were positioned such that the outer side of her right foot was laying directly on the mattress with the left foot on top of the right foot. When NA-B prepared R71's wheelchair for transfer, it was noted the wheelchair did not have a pressure reduction cushion on the seat. Instead, the wheelchair seat was noted to have a	F 314	Braden and Tissue Tolerance re-assessments completed and evaluated. " 8/8/16 OT evaluated and new pressure reducing cushion applied to wheelchair " Pressure reducing heel boot added to right foot 8/3/16 in addition to one already in place for left foot. " Dietary updated on additional skin issues. 8/4/15 reviewed intake no changes recommended - supplement already in place Boost Breeze. Resident consumption of supplement is monitored and recorded daily by nursing. " Restorative standing program initiated although resident frequently declines to participate " Consulting pharmacist review completed 8/23/16 related to skin injury risk factors □ no changes recommended " Comprehensive nursing progress note 8/16/16 " Seen by Wound specialist Dr. Friedman 8/24/16. MD classified both ulcers as Diabetic Foot ulcers. Recommendation to wear pressure reduction boots when out of bed and to float heals when in bed put into place. Dressing changes per MD orders/recommendation. Primary MD/NP notified of recommendations. " Care plan revised per order changes IDENTIFY OTHERS POTENTIALLY AFFECTED: Completed comprehensive assessment of all current residents with pressure ulcers on Medicare Distinctive unit. Reviewed assessment of all other residents for completeness of Braden	

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F 314	Continued From page 18 chair pad type cushion, resembling a cushion from a rocker. After R71 had been transferred to the wheelchair, it was observed there were two pressure reducing blue boots lying on the floor. On 8/3/16, at 7:48 a.m. registered nurse (RN)-A conducted R71's weekly skin observation while the resident was in the tub room. RN-A was observed to check each of R71's feet along with the rest of her body. R71's right foot was observed to be covered with a bandage on the outer part of the foot. RN-A stated the dressing was covering an abrasion, however, when RN-A removed the dressing, a round open area was observed. RN-A stated the open area was no longer an abrasion, but had deteriorated since she had viewed it the week before. The open area to the right foot was left uncovered while NA-B proceeded to shower R71. After R71's shower NA-B applied non-skid socks to both feet and placed her feet directly on the foot pedals of the wheelchair. During interview on 8/3/16, at 8:24 a.m. NA-B stated she thought R71 should be repositioned every couple of hours but was not sure. NA-B added that R71 would be repositioned when staff assisted her with toileting. NA-B also said she thought R71 was to wear the pressure reduction boot to her left foot while in bed, but was not sure whether R71 was supposed to have a boot on one foot, or both feet. NA-B confirmed two pressure reducing boots had been on the floor in R71's room that morning, and that R71 had not been wearing any boot when NA-B had assisted R71 with getting up. On 8/3/16, at 9:47 a.m. RN-A entered R71's room to measure R71's wounds. R71's unstageable	F 314	assessments and weekly skin check to identify any potential skin injury/risk. Care plans updated and additional interventions implemented as appropriate. Measures put into place or systemic changes: Licensed Nurses in servicing conducted on August 22, 24 & 25th, 2016 with on-going training scheduled as needed. Agenda included review of facilities policy and procedure for admission and on going assessments. Facility Skin and Wound Care Process/Guideline and Pressure Ulcer Management Form updated and reviewed with licensed nurses. RN Manager will complete Comprehensive Skin Risk Assessment and Intervention form within 7 days of admission. Wound rounds will be completed weekly by RN Manager/wound nurse. Referrals to Dietary, Restorative, and therapy will be made per protocol guidelines to ensure needs are being addressed. Daily skin checks implemented for residents identified as high risk for skin injury. Continue with weekly review of skin checks for all residents. MONITOR: Random weekly audits will be conducted for all residents with pressure ulcers or high risk for skin injury residing on the Medicare Distinctive Unit, to ensure assessments are complete and ongoing documentation is in place per facility protocol to notify, prevent, treat and monitor skin. Random audits will continue x□'s 60 days then monthly x's 2 months with additional recommendations from QAPI/QA committee for continued auditing. RN Manager/designee will	

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F 314	Continued From page 19 pressure ulcer to the left heel had eschar (thick leathery dead tissue) covering the wound bed, the edges were intact, there was no redness to the surrounding skin, and there was no odor or drainage. The pressure ulcer measured 1.5 centimeters (cm) x 1.0 cm. RN-A measured the area on R71's right outer foot as 1.0 cm x 1.0 cm. The wound bed was described as covered with slough, the ulcer was round, the edges were intact, with pinkness on the surrounding skin, and there was no odor or drainage. RN-A stated the area on the outer right foot was likely caused by pressure, as it is a bony area of her foot. RN-A also stated the facility had stopped putting shoes on R71 about a week ago because they felt R71's shoes were causing pressure. RN-A stated any open skin areas are to be measured and documented every week as part of the weekly skin assessment. RN-A stated the nurse manager initiates a skin investigative flow sheet to assess and document a pressure ulcer weekly. She further said the weekly skin assessment includes a head to toe assessment of the skin, including feet and heels, and the nurses are expected to chart the assessment in the progress notes. RN-A further stated when a new pressure area was identified, a Risk Watch (facility process for reporting occurrences) was to be filled out and the physician, family and nurse manager were to be notified. RN-A was unsure if a Risk Watch had been initiated for R71 when the stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough and may present as an intact or ruptured blister)pressure ulcer on the right foot had been identified. However, RN-A stated she had notified the physician and nurse manager after having completed a Risk Watch after observation of the open area the week prior. RN-A stated the nurse	F 314	visually observe that appropriate interventions are in place and protocols are being followed for all residents with pressure ulcer or identified as high risk for skin injury. DATES OF COMPLETION: August 26, 2016 RESPONSIBLE: Director of Nursing/designee	

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manager was responsible for assessing wounds and updating any interventions, although any RN could update or revise a resident's care plan. RN-A also stated she was not sure where R71's wheelchair cushion had come from, but thought R71's family had brought it in for her because it was not a facility wheelchair cushion.

A pressure ulcer Care Area Assessment (CAA) dated 3/3/16, indicated R71 required staff assistance to move sufficiently to relieve pressure over any one site, was confined to a bed or chair all or most of the time, needed a special mattress or seat cushion to reduce or relieve pressure, and required a regular schedule for turning. The CAA further indicated R71 was at risk for pressure ulcers due to frequent incontinence, impaired mobility, weakness and impaired cognition. The CAA identified that R71 was able to make frequent position changes on her own, which may not be real significant. The CAA also identified staff observed her skin daily with cares and weekly by licensed personnel on bath days.

R71's quarterly Minimum Data Set (MDS) dated 5/26/16, identified diagnoses of diabetes mellitus and dementia, and indicated R71 was cognitively intact. The MDS also identified R17 needed extensive assistance for bed mobility and transfer assistance. The MDS further indicated that R17 experienced occasional urinary and bowel incontinence. The MDS also indicated that a formal assessment tool and clinical assessment had been used to determine R71's pressure ulcer risk, and R71 was at risk to develop pressure ulcers. This quarterly MDS indicated at that time, R71 had no current pressure ulcers, but utilized a pressure relieving device for the chair and bed.

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R71's physician orders dated 6/30/16, directed staff to ensure a heel protector was on the left foot at all times when in bed.

R71's care plan dated 5/23/16, indicated R71 was at risk for skin breakdown related to incontinence, impaired mobility, impaired cognition, occasional pain and diabetes mellitus. Interventions included: cushion to wheelchair and pressure relieving mattress to bed, dietary consult, check skin for areas of redness/report any changes to the nurse, not to massage skin over pressure areas, keep fluids next to R71 at all times/provide cues and assist R71 to drink fluids with medications and in between meals, perform complete assessment of the skin and note areas of redness and nutritional supplements as recommended. On 6/30/16, the care plan identified a purple non-blanchable area to the left heel, and included interventions of a heel protector while in bed, weekly skin monitoring, and remove shoes as they are causing pressure areas. However, the care plan lacked interventions on how to protect R71's feet from pressure when up in her wheelchair. On 7/20/16, the care plan identified a small "abrasion" to lateral left foot, and an intervention to cover area with Aquacel (a dressing used for the treatment of burns, ulcers, surgical and trauma wounds and lacerations) for healing and protection until resolved.

An undated NA task sheet directed staff R71 would request to be toileted and repositioned, but needed staff assistance. The task sheet also indicated the NAs were to check R71's heels daily.

R71's progress notes from 7/6/16, through

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7/20/16, indicated the following related to a stage 2 pressure ulcer on the right foot:

- 7/6/16, at 6:43 p.m. included documentation R71 had another blister to the right foot, skin is intact and R71 denies pain.

- 7/15/16, at 11:22 p.m. included documentation of a blister to the right foot that was healing and the skin was intact.

- 7/20/16, at 10:36 a.m. included documentation that there was an "abrasion" observed to the right lateral foot. The wound measured 0.5 cm x 0.5 cm without drainage, odor, wound base was red and surrounding skin was intact and blanchable. Shoes were inspected and were removed and gripper socks were applied. Aquacel (foam dressing) applied for protection. The physician, family and nurse manager were notified.

The physician was notified of the stage 2 pressure ulcer 7/20/16, 14 days after it was first observed on 7/6/16. The clinical record lacked a reassessment of R71's skin after the development of the unstageable pressure ulcer to the left heel, and following the development and worsening of the stage 2 pressure ulcer to the right foot. The clinical record also lacked weekly documentation of stage, size, drainage and odor of the pressure ulcer on the right foot.

During interview on 8/3/16, at 12:48 p.m. RN-B stated that she had not been notified of the stage 2 pressure ulcer on the right side of the R71's foot until it had opened up last week. RN-B confirmed she was responsible for wound rounding in the facility, but had yet to observe R71's pressure ulcer to the right foot, and had not

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F 314	Continued From page 23	F 314		

yet initiated a skin investigative flow sheet. RN-B stated the report she had received from RN-A regarding the observation of the wound following R71's shower earlier that day, was that now R71 had an unstageable pressure ulcer to the outside of her foot, due to the presence of slough in the wound bed. RN-B stated usually when she receives a report regarding an open area or an area of concern, she reviews the risk watch and reviews the progress notes and then follows up with the nurse practitioner or physician. She stated open areas are discussed in an interdisciplinary team (IDT) meeting where they discuss possible root causes and implement interventions. RN-B stated the conversations in the IDT meetings are not documented in the clinical record. RN-B verified that a comprehensive assessment of R71's skin risk was not completed after identifying the left heel suspected deep tissue injury, to reduce the chances of developing other pressure ulcers, or when the stage 2 pressure ulcer had been identified. RN-B stated the facility does not complete a comprehensive re-assessment when a pressure ulcer is identified.

R71's pressure ulcer on her right foot started as a stage 2 pressure ulcer identified on 7/6/16 according to the progress notes, however, it was not measured until 7/20/16, when it measured 0.5 cm x 0.5 cm. The next measurement was obtained on 8/3/16, by RN-A during care observed by the surveyor. At that time, the wound size was identified as having increased to 1.0 cm x 1.0 cm. and had worsened to an unstageable pressure ulcer.

RN-B was unaware that R71 was not utilizing a facility pressure reduction wheelchair cushion and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING _____ B. WING _____	08/03/2016

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

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F 314	Continued From page 24 it was not assessed by therapy to be appropriate in reducing pressure ulcers. During interview on 8/3/16, at 2:44 p.m. the director of nursing (DON) stated she would expect the RNs to complete a comprehensive skin assessment for newly identified pressure ulcers, along with putting appropriate interventions into place. The DON stated care planned interventions were expected to be followed, and she would have expected the nurses to recognize a blistered area needed to be reported as a possible stage 2 pressure ulcer. She said this was important in order to determine follow up, and to identify any treatments/interventions to be implemented. The facility's policy Presence of a Pressure Ulcer dated 9/1/10, identified staff are to assess pressure ulcer location, stage, size, shape, depth and surrounding tissue, along with drainage type, color, odor and amount. It further directed to identify the wound bed, wound edges and any related pain. The policy also directed staff to review the care plan and update as needed. Within one week the skin care team or representative would review all new pressure ulcers and care plans. The skin care team would then ensure all risk factors were documented in the medical record and identified on the care plan. In addition the policy directs monitoring of the pressure ulcer daily on the treatment sheet.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/04/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 4, 2016. At the time of this survey Colonial Acres Health Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The Colonial Acres Health Care Center is made up of two buildings that are attached. The original building is 1 story without a basement and was constructed in 1961. It was determined to be of Type II(000) construction and is fully fire sprinkler protected. In 1982 an addition was built to the north of the original building, is a 1 story building without a basement. It was determined to be of Type V (111) construction, is fully fire sprinkler protected and is separated with at least a 2 hour fire barrier from the original building. This building house State Licensed only beds. This building had additions to it in 2000 of the same construction type and fully fire sprinkler protected. The buildings are divided into 5 smoke zones. The facility has a fire alarm system with smoke detection in the corridor system and in all common areas. The fire alarm system is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 88 beds and had a census of 71 at the	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/04/2016**

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

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K 000	Continued From page 1 time of the survey. Of these beds only 39 are Medicare certified, 27 of these were occupied at the time of the survey. For this survey, only the 39 bed section (see sketch) and the associated exiting system are covered under this report as a single building. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		