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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: O2KN

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 09/25/2013 (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 **125** (L18)

13.Total Certified Beds **125** (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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	125			
(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):
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. The facility is certified for 125 skilled nursing facility beds effective September 30, 2013.

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 09/30/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/19/2013 (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
Posted 1/8/2014 ML O2KN

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/18/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5275 December 19, 2013

Mr. Todd Carsen, Administrator
Edina Care & Rehab Center
6200 Xerxes Avenue South
Richfield, Minnesota 55423

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 18, 2013, the above facility is certified for:

125 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 125 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,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

September 30, 2013

Mr. Todd Carsen, Administrator
Edina Care & Rehabiliation Center
6200 Xerxes Avenue South
Richfield, Minnesota 55423

RE: Project Number S5275023

Dear Mr. Carsen:

On August 23, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 9, 2013. 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 September 25, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 24, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 9, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 18, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 9, 2013, effective September 18, 2013 and therefore remedies outlined in our letter to you dated August 23, 2013, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (612) 201-4124
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245275	A. Building B. Wing	9/25/2013

Name of Facility	Street Address, City, State, Zip Code
EDINA CARE & REHAB CENTER	6200 XERXES AVENUE SOUTH 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 **F0241** Reg. # **483.15(a)** LSC	Correction Completed **09/18/2013**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **09/18/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **09/18/2013**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/18/2013**	ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **09/18/2013**	ID Prefix **F0364** Reg. # **483.35(d)(1)-(2)** LSC	Correction Completed **09/18/2013**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **09/18/2013**	ID Prefix **F0412** Reg. # **483.55(b)** LSC	Correction Completed **09/18/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/AK	09/30/2013	15507	09/25/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/9/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245275	01 - MAIN BUILDING 01	9/24/2013

Name of Facility	Street Address, City, State, Zip Code
EDINA CARE & REHAB CENTER	6200 XERXES AVENUE SOUTH 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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0062	09/18/2013	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/KJ	Date: 09/13/2013	Signature of Surveyor: 19251	Date: 09/24/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 8/7/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

September 9, 2013

Mr. Todd Carsen, Administrator
Edina Care and Rehab Center
6200 Xerxes Avenue South
Edina, MN 55423

RE: Project Number S5275023

Dear Mr. Carsen:

On August 9, 2013, a survey was completed at your facility. You have alleged that the deficiencies cited on that survey by the Minnesota Department of Health, Licensing and Certification Program staff (F tags) have been corrected. We are accepting your plan of correction and presume that your facility will achieve substantial compliance.

Sincerely,

Gayle Lantto

Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3794 Fax: (651) 201-3790

cc: Licensing and Certification File

POCA HEALTH SURVEY.ORC

September 17, 2013

Mr. Todd Carsen,
Edina Care & Rehab Center
6200 Xerxes Avenue South
Richfield, MN 55423

Dear Mr. Carsen:

On 08/07/2013 a survey was completed at your facility. You have alleged that the deficiencies cited on that survey by the Minnesota Department of Public Safety, State Fire Marshal Division staff (K tags) have been, or will be corrected. We are accepting your plan of correction and presume that your facility will achieve substantial compliance.

Unless waivers have been recommended for all deficiencies cited, we will be conducting a revisit of your facility to verify that substantial compliance has been achieved and maintained.

Patrick Sheehan, Fire Safety Supervisor
Deputy State Fire Marshal
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Pat.Sheehan@state.mn.us

cc: Licensing and Certification File
Unit Supervisor
SFM File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: O2KN

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: **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 **08/09/2013** (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 **125** (L18)

13.Total Certified Beds **125** (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
	125			
(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 :
Sue Miller, HFE NE II 09/13/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 09/30/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 24-5275

At the time of the standard survey completed August 9, 2013, the facility was not in substantial compliance and the most serious deficiencies were found 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. Also, at the time of the standard survey complaint number H5275066 was investigated and found substantiated. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 2932

Mr. Todd Carsen, Administrator
Edina Care and Rehabilitation Center
6200 Xerxes Avenue South
Richfield, Minnesota 55423

RE: Project Number S5275023 and H5275066

Dear Mr. Carsen:

On August 9, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the August 9, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5275066.

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. In addition, at the time of the August 9, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5275066 that was found to be substantiated.

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

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

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

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

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
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (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 September 18, 2013, 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 18, 2013 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 November 9, 2013 (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 9, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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:

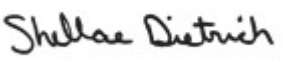
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5275s13.rtf

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 _____	08/09/2013

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 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A standard recertification survey and complaint investigation was conducted. Complaint H5275066 was substantiated and deficiencies were issued at F364.	F 000	F000 Edina Care and Rehabilitation Center objects to and disagrees with both the findings of non-compliance and the level of deficiency cited. 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 of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of deficiencies as a condition to participate in the Medicare & 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 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to offer food choices and to ensure food was served at the proper temperature, potentially affecting nine residents in the facility who were prescribed mechanically altered diets. Findings include: Observations were conducted in the three south	F 241	POC accepted by Kari TD 9/9/13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Todd M. Linn — TITLE: Executive Director — (X6) DATE: 9/5/13

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

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F 241	Continued From page 1 dining room on 8/7/13, at 11:58 a.m. Dietary aides were serving food for residents who received mechanical soft and pureed diets from a steam table in the kitchen. Staff then placed plastic covers over the plates with no plate warmers under the plates. The plates were then placed on the portable steam table and were transported to the units. The steam table contained food for residents on regular diets and included spaghetti with meat sauce, parmesan breadsticks, steamed broccoli and an alternative choice of chicken fillet, mashed potatoes and gravy and peas. The surveyor followed the staff with the steam table which was then set up in the 3 south dining room. Four plates with pureed food were on a tray near the steam table. Diet cards had been placed at the place settings in the three south dining room. The cards included the diet order, as well as the resident likes and dislikes. Multiple staff assisted in serving the residents in the dining room. Each resident who received a regular diet was asked their beverage preference and whether they preferred spaghetti or chicken. Choices were not offered, however, to residents who received mechanically altered diets. The staff picked up the diet cards and approached the dietary staff and requested "mechanical soft" or "pureed" food. The mechanical soft diet consisted of ground noodles with meat sauce, mashed potatoes, and peas. The pureed diet consisted of blended meat sauce, mashed potatoes, and peas. No bread was served with either altered diet. The menu extension for altered diets for 8/7/13 indicated soft chop diet would receive all diet	F 241	F241 The Registered Dietitian will revise menu extensions to include alternatives for mechanically altered diets. Mechanically altered diet food choices will be held on steam tables until meals are served to ensure adequate temperatures are sustained. Serving staff will be educated on 9/9/13 to offer choices to those residents who are capable of making choices. For those who are unable, serving staff will take into account food preferences noted on tray cards. Monitoring of meal service will be done and results will be reviewed at QA&A meeting. The Kitchen Operations Manager or designee will be responsible for compliance. 9/18/13 RECEIVED SEP - 6 2013 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	

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F 241	Continued From page 2 options with the exception of the breadstick, and in its place mashed potatoes would be served. The mechanical soft/ground meat diet indicated no spaghetti noodles, corn or peas unless pureed, and no breadstick. The meat sauce and mashed potatoes would be served. The pureed diet included meat sauce with tomato sauce added would be served with mashed potatoes and pureed vegetables. No noodles, chicken filet, or bread would be served. At 12:25 p.m. the DM confirmed all residents should have been offered a choice between the regular meal and the alternative meal. He stated they did not have the altered diets prepared, but it could have been requested from the kitchen. At 12:45 p.m. the registered dietitian (RD) stated that the residents knew the menu and choices that were available. She reported that they were unable to puree bread or noodles, and that the pureed diets were limited. They only offered the main choice to residents on altered diets unless their dietary card indicated they could not have the food items. In those cases the alternative would be served. The RD stated that most of the residents who received pureed diets had end stage dementia.	F 241		
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.	F 312		

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F 312	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper perineal care was provided after an incontinent bowel episode for 1 of 6 residents (R128) reviewed for activities of daily living. Findings include: R128's morning cares were observed on 8/8/13 at 10:30 a.m. provided by a nursing assistant (NA)-F as follows: The NA emptied the resident's catheter drainage bag, and began to clean the resident of incontinent stool. The NA washed her hands and donned gloves and prepared soapy water. Although the resident's perineal area and buttocks were washed, the NA did not perform thorough pericare, including pulling back the resident's foreskin. An incontinence brief was then put on the resident and he was dressed for the day. R128's care plan dated 7/12/13, directed staff to provide pericare after each incontinent bowel episode. R128 had a history of urinary tract infections, a suprapubic catheter, and incontinence of bowel. The facility's policy and procedure for perineal care dated 2006, indicated care for males should include "apply disposable gloves, form a mitten with the washcloth and apply soap, gently wash pubis and penis. If uncircumcised pull back foreskin and wash. Carefully dry and return foreskin to normal position. make sure shaft of penis is dry. Ask resident to bend and separate knees, wash scrotum carefully. Rinse and pat dry. Turn the resident and wash around anus."	F 312	**F312D** A resident who is unable to carry out the activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. During resident R128's morning cares, the NAR did not perform thorough perineal care due to not pulling back the resident's foreskin to clean the area. This NAR was immediately reeducated and resident R128 was properly cleansed. All nursing assistants reeducated on facility policy and procedure for perineal care on 8/20/13 and all residents who require assistance with ADL's will be provided thorough perineal care. Periodic audits will be conducted by Nurse Manager/Staff Development/Designee. Results of audits will be reviewed at QA to assure compliance. The Director of Nursing is responsible for compliance.	9/18/13

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F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure catheter care was provided for 1 of 1 resident (R128) who was reviewed for catheter use. Findings include: R128 was not provided suprapubic catheter (inserted directly into the bladder from the abdominal wall) care during observations of morning cares on 8/8/13 at 10:30 a.m. A nursing assistant (NA)-F washed her hands and donned gloves. She then opened the valve on the drainage spout and emptied urine from the drainage bag. She returned the drain spout in its sleeve, measured the urine, removed her gloves, and washed her hands. Although she cleaned the resident of incontinent stool, she did not clean around the catheter tubing. R128's care plan dated 7/12/13, directed staff to monitor and document output every shift, to monitor for pain discomfort due to catheter and to	F 315	**F315D** A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. R128 was not provided catheter care. NAR did not clean around catheter tubing at insertion site. The care plan did not specify how and when catheter care should be performed. R128 plan of care has been updated to cleanse area around insertion site BID with cares. All residents with catheters will have their care plans reviewed and revised to reflect that catheter care will be provided BID with cares. All nursing assistants were reeducated on facility policy and procedure for catheter care on 8/20/13. Periodic audits will be conducted by Nurse Manager/Staff Development/Designee. Results of audits will be reviewed at QA to assure compliance. The Director of Nursing is responsible for compliance.	9/18/13

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F 315	Continued From page 5 monitor for signs and symptoms of urinary tract infections. The care plan, however, did not specify how and when catheter care should be performed. The facility's policy and procedure for catheter care (undated) indicated the purpose was to prevent infection and reduce irritation. "Put on gloves; cleanse are well at catheter insertion; all debris must be removed from catheter at insertion site, rinse well with warm water and pat dry, apply antiseptic ointment at catheter insertion site as ordered by physician; and secure tubing."	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	**F329D** Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used without adequate monitoring. Orthostatic blood pressures were not completed correctly for R29 and R99. Facility policy and procedure states orthostatic blood pressure must be obtained monthly. Orthostatic blood pressures were completed for R29 and R99. All licensed staff were reeducated on Psychoactive Medication Use Policy and Procedure 8/27/13. All residents receiving psychoactive medications will have their orthostatic blood pressure checked monthly. Nurse Manager/DON/designee will conduct periodic audits of residents on antipsychotic medications for monthly orthostatic blood pressures. Results of audits will be reviewed at QA to assure compliance. The Director of Nursing is responsible for compliance.	9/18/13

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F 329	Continued From page 6	F 329		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to complete accurate orthostatic blood pressures (BPs) as ordered for 2 of 5 residents (R29, R99) with physician-ordered monthly orthostatic blood pressures.

Findings include:

Orthostatic blood pressures (to measure potential drop in BP by first measuring the BP while lying, and then sitting, and if possible then standing) were either not completed monthly as ordered, or were not completed correctly for R29 and R99.

On 3/14/13 R29's physician ordered orthostatic BPs every 30 days. BP records for R29 from 3/13 to 8/7/13 revealed orthostatic BPs were not being completed as ordered. No orthostatic blood pressures were completed during the months of March, April, May, or June, 2013. On 5/12/13 R29's BP was measured while R29 was sitting. On 5/15/13 the resident's BP was measured while lying. Postural changes could not be determined as there was not more than one BP measured in order to make a comparison. An orthostatic BP measurement taken on 7/3/13 in R29's left arm revealed R29 experienced a drop in BP greater than 20 points with postural changes. R29's BP in the left arm when lying was 164/86 and when sitting was 96/65.

On 8/7/13, at 2:08 p.m. a registered nurse-A (RN)-A reviewed R29's electronic medical record

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F 329	Continued From page 7 (e-chart) for orthostatic BPs. RN-A found documentation in the electronic medication administration record (eMAR) indicating that an orthostatic BP had been completed on 6/12/13, but was unable to locate the results. RN-A was also unable to find documentation of orthostatic BPs from March to June. R99 was admitted to the facility in 2011 with diagnoses including hypotension (low BP). Psychotropic medications are known to contribute to potential for orthostatic BPs, and R99's medications included the antipsychotic Seroquel 12.5 mg daily and 25 mg daily, as well as the antidepressant Celexa 20 mg daily. On 7/8/13 a physician requested monthly orthostatic BPs be taken for R99. A review of documentation revealed an orthostatic BP was completed after a fall on 7/20/13, but no orthostatic BPs were measured prior to the 7/8/13 physician order, despite R99 receiving an antipsychotic medication and having a diagnosis of hyptotension. A review of BP's for R99 back to 2/13 revealed staff were measuring BPs for R99 either when lying, sitting or standing, but not at the same time and in a manner that showed whether postural changes affected the resident's BP, which was verified by RN-A on 8/7/13, at 2:08 p.m.	F 329		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal	F 334		

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F 334	Continued From page 8 representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes	F 334	F334D The facility must develop policies and procedures that ensure that before offering the influenza immunization, each resident, or the legal representative receives education regarding the benefits and potential side effects of the immunization. Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized. R109 did not receive a pneumovax immunization after consent was obtained upon admission. R43 and R74 were administered influenza vaccinations, however, did not receive a risk vs benefit vaccination information statement per check box on consent form. Facility policy and procedure for Resident Immunizations and Vaccinations Pneumovax Vaccine state all new admissions will be screened and given the Prneumovax vaccine unless specifically ordered otherwise by the primary care Physician. The facility policy and procedure for Influenza Vaccination states staff will provide education to the resident or their responsible party regarding the benefits and potential side effects of the immunization. All licensed staff were reeducated on facility Influenza and Pneumovax Policy and Procedure on 8/27/13. Nurse Managers/DON/Designee will conduct audit of all new admissions for pneumovax vaccination. An Influenza Risk vs Benefit statement will be provided to all residents during Influenza season. Nurse Manager/DON/Designee will audit completion of consent forms for receipt of Risk vs Benefits statement. All audits will be reviewed at QA to assure compliance. The Director of Nursing is responsible for compliance. Federal form). per admin. 9/9/13 9/18/13	

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F 334	Continued From page 9 documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide immunization to 1 of 5 residents (R109) as requested by the resident and/or representative, and to ensure the required Centers for Disease (CDC) fact sheet for the influenza 2012-13 season was provided for 2 of 3 residents (R43 and R74) and/or their representative whose influenza vaccinations were administered at the facility. Findings include: R109 was admitted to the facility on 3/9/13, and requested a pneumovax immunization. The consent for the pneumovax vaccination was signed by the resident at the time of admission,	F 334		

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F 334	Continued From page 10 however, no documentation was located in the resident's record to show the resident had the pneumovax immunization. When interviewed on 8/7/13, at 11:24 a.m. a licensed practical nurse (LPN)-C stated the facility did not receive an order from the physician to give R109 the pneumovax immunization at the time of admission, although the resident had requested and consented to vaccination. LPN-C further stated she called the physician on 8/6/13, and obtained an order to give the pneumovax immunization. Influenza (flu) immunization records for two residents who received the immunization at the facility were reviewed. R43 and R74 were administered the influenza vaccination on 11/12/12. Although the residents had been immunized for the 2012-13 flu season, the information provided to the resident and/or their representative regarding the risk and benefit of vaccination from the Centers for Disease Control (CDC) Vaccination Information Statement as required by federal law was not documented as provided to the resident and/or representative. LPN-C confirmed on 8/7/13, at 11:24 a.m. confirmed that the records for R43 and R64 did not include documentation showing they had been provided the required CDC risk and benefit information for influenza (flu) immunization. LPN-C stated the consent form for influenza vaccination was limited to a check mark that education was provided to the resident and/or responsible party. The facility policy Resident Immunizations and Vaccinations Pneumovax Vaccine (2008) read,	F 334		

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F 334	Continued From page 11 "Primary care physicians will be notified by the facility Medical Director annually, via letter, that all new admission will be screened and given the Pneumovax vaccine unless specifically ordered otherwise by the primary care Primary Physician on admission orders. This letter is sen to primary physicians with current privileges to admit to this facility. Nursing staff does not need to contact the primary physician for orders pertaining to administration of the vaccine for each resident. Nursing staff will contact the primary physician if they have questions or concerns that can not be answered by the resident or their medical decision maker about the criteria listed in the Standing Orders for Pneumovax Vaccine (e.g. diseases or allergy history, history of receipt of the vaccine). Every admission is screened for contradictions, following the criteria contained within the standing orders and administered the vaccine, if indicated. Licensed nursing staff performs the screening and vaccine administration. A record of vaccination will be placed in the residents's medical record and in their vaccination record." The facility policy and procedure Influenza Vaccination (revised 10/06) directed staff to "Provide education to the resident or their responsible party regarding the benefits and potential side effects of the immunization. Document education in the medical record."	F 334		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper	F 364		

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 _____	08/09/2013

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 364	Continued From page 12 temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure pureed food temperatures were maintained at acceptable temperatures for four residents who received pureed diets on the three south unit. Findings include: Temperatures of the noon meal were measured by the cook on 8/7/13, at 11:13 a.m. prior to placing the food in the steam tables, at which time all foods were within acceptable range. Observations were conducted in the three south dining room on 8/7/13, at 11:58 a.m. Dietary aides were serving food for residents who received mechanical soft and pureed diets from a steam table in the kitchen. Staff then placed plastic covers over the plates with no plate warmers under the plates. The plates were then placed on the portable steam table and were transported to the units. The steam table contained food for residents on regular diets and included spaghetti with meat sauce, parmesan breadsticks, steamed broccoli and an alternative choice of chicken fillet, mashed potatoes and gravy and peas. The surveyor followed the staff with the steam table which was then set up in the 3 south dining room. Four plates with pureed food were on a tray near the steam table. At 11:58 a.m. dietary staff dished food for residents on pureed diets onto plates that were then covered with plastic covers and were placed	F 364	F364 Pureed diet food choices will be held on steam tables while meals are served. Periodic audits of food temperatures will be monitored and recorded on food temperature logs. The results of the monitoring will be reviewed at the QA&A Committee meeting. The Kitchen Operations Manager is responsible for compliance.	9/18/13

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 _____	08/09/2013

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F 364	Continued From page 13 onto a tray. No method of keeping the food (such as heated plate warmers) were used. The portable steam table was then transported to the second and third floors. At 12:05 p.m. the dietary staff began dishing food for residents who received regular and mechanical soft diets. The food that was kept in the steam table was observed to be steaming. The four residents whose trays were dished in the kitchen on the third floor remained on the tray adjacent to the steam table until all residents had been served their meals. At 12:25 p.m. the four residents were served their pureed food. Three of the four residents were assisted to eat, and a fourth resident had his head down and eyes closed. No staff approached the resident to assist him to eat, and temperatures of the meal were then measured by the dietary manager. The meat sauce was 100 degrees Fahrenheit (F) and the mashed potatoes and peas were 120 degrees F. The DM then requested a new plate of food for the resident from the kitchen. When the food arrived and the cover was removed, visible steam was observed coming from the food. On 8/8/13, at approximately 11:30 a.m. the dietary manager stated that the food should have been held at 140 degrees F. The facility procedure regarding food temperatures dated 7/11, directed staff to measure temperature by inserting the thermometer stem into the thickest part of the product and wait for the thermometer reading to steady before recording the temperature. "All hot food should reach internal temperature of one hundred-forty-one degrees Fahrenheit to one	F 364		

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F 364	Continued From page 14 hundred-eighty degrees Fahrenheit."	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure dry food itmes were stored in a sanitary manner, potentially affecting all 103 residents residing in the facility. Findings include: On 8/7/13 at 11:55 a.m. flour, sugar, and Thick-it (for thickening liquids) were observed stored in large plastic containers with plastic covers that were cracked and broken, potentially exposing the food to contaminants, humidity, pest infestation, and/or deterioration of the food. In addition, a one cup measure that was covered in flour was stored inside the flour container, and scoops were also stored inside the sugar and Thick-it containers. At 11:48 a.m. the dietary manager verified the poor condition of the containers and the presence of scoops inside the food containers. He stated	F 371	F371 The Kitchen Operations Manager order replacement lids or replace the entire containers. Dietary Staff will be educated on 9/9/13 on recognizing when lids are no longer fitting properly and to ensure that scoops are not left in food containers. The Kitchen Operations Manager will review and revise as necessary the Kitchen Cleanliness audit form. Periodic audits will be performed and the results will be reviewed at the QA&A Committee meeting. The Kitchen Operation Manager is responsible for compliance.	9/18/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 15 that all food should have been stored in sealable containers, and the scoops should have been stored outside the containers rather than touching the food.	F 371		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dental follow up services were provided for 1 of 3 residents (R145) reviewed for dental services. Findings include: R145 had loose fitting dentures, however, had not received dental follow up as recommended on 4/3/13. On 8/5/13, at 4:26 p.m. a conversation took place with R145. The resident's upper denture was lose and moved when the resident spoke. A dental consultation dated 4/3/13, revealed a check for "Broken or loosely fitting full or partial	F 412	F412D The facility must provide or obtain from an outside resource routine and emergency dental services to meet the needs of the resident. The facility failed to ensure dental follow-up services were provided for R145. R145 had loose fitting dentures with a follow up to make new upper dentures. Review of record indicated no documentation of dental follow up. R145 is scheduled for fitting of dentures at next facility Dental visit. Nurse Mangers/DON/Designee will review all Dental Referrals and recommendations to ensure follow up. Results will be reviewed at QA to assure compliance. The Director of Nursing is responsible for compliance.	9/18/13

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F 412	Continued From page 16 denture (chipped, cracked, uncleanable, or loose)." A written note stated "anchor tooth has been lost since upper partial has been made," and the section for notes to nursing staff for follow up/care conference directed, "Make new upper full denture?" Further review of the record revealed no documentation of follow up to dental recommendation. R145's annual Minimum Data Set (MDS) dated 4/23/13, identified the resident as having severe cognitive impairment and no natural teeth or tooth fragment (s). The Oral/Dental quarterly assessment dated 7/20/13, revealed "no natural teeth, dentures are loose, will not let nurse teach how to use Fixadent due to language barrier but family already understands and will remind him and denies pain or discomfort but will continue to monitor for signs of pain." The care plan dated 5/10/12, indicated "I have no natural teeth and wear dentures." Interventions directed staff to monitor/document/report any issues of oral problems needing attention including pain (gums, toothache, palate), abscess, debris in mouth, lips cracked or bleeding. The staff was to provide cues and supervision, as well as sometimes minimal assistance with oral hygiene. When interviewed on 8/8/13, at 2:30 p.m. the licensed practical nurse (LPN)-C stated the facility should have followed up by calling R145's family for consent for a follow up dental appointment and scheduled an appointment for the resident. A facility policy/procedures for scheduling of follow up appointments was requested from the director of nursing on 8/8/13, at 3:00 p.m. but was not provided.	F 412		

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	245275	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/07/2013**

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on August 08, 2013. At the time of this survey, Edina Care Center & Rehabilitation Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections	K 000	RECEIVED SEP 9 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok TB 9-13-13	

DC: 09.18.2013

EXIT: 08/09/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Todd M. Cain — TITLE: Executive Director — (X6) DATE: 9/5/13

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 **01 - MAIN BUILDING 01** B. WING _____	**08/07/2013**

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

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K 000	Continued From page 1 State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or By E-Mail to: Barbara.Lundberg@state.mn.us, and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 3-story building was determined to be of Type II (222) construction. It has a full basement and is fully 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 130 beds and had a census of 105 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating	K 062		

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	245275	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/07/2013**

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

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K 062	Continued From page 2 condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 LSC (00) section 19.7.6, 4.6.12. This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 52 residents, staff and visitors. Findings include: On facility tour between 9:30 AM and 1:00 PM on 8/07/2013, 1. It was observed that the laundry room in the facility had several sprinkler heads that had an excessive amount of dust accumulation that did not meet the requirements of NFPA 13(99) and NFPA 25(98) and, 2. It was observed that the sprinkler head located on 3rd floor next to the southside smoke barrier door and the kitchen dish washing area had fire rated caulk around the escutcheon plate and not the proper plastic plate as required. These deficient practices were verified by the Maintenance Supervisor.	K 062	K 062 The sprinkler heads in the laundry have been cleaned. Periodic audits of sprinkler heads will be done to ensure all are clean. The sprinkler heads in the kitchen dish washing area and the head on the 3rd floor will have the fire rated caulking removed and appropriate plates installed. An audit of sprinkler heads in the building found 4 additional heads with the same fire caulking. These, too, will have the caulking removed and plates installed. Periodic audits of the sprinkler heads will be done to ensure they are clean and functioning. The Director of Environmental Services or designee is responsible for compliance.	9/18/13

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 2932

August 23, 2013

Mr. Todd Carsen, Administrator
Edina Care and Rehabilitation Center
6200 Xerxes Avenue South
Richfield, Minnesota 55423

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5275023 and H5275066

Dear Mr. Carsen:

The above facility was surveyed on August 5, 2013 through August 9, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5275066 that was found to be substantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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.

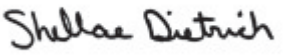
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55164-0900. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5275s13lic.rtf

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 _____	08/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On August 5 through August 9, 2013, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring,	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state	

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2 000	Continued From page 1 Licensing and Certification Programs; P.O. Box 64900, St. Paul, Minnesota 55164-0900.	2 000	statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." 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 evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	

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	00740	A. BUILDING: _____ B. WING _____	08/09/2013

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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) COMPLETE DATE
2 840	Continued From page 2	2 840		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be	2 840		

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2 840	Continued From page 3 completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper perineal care and catheter care was provided 1 of 6 residents (R128) reviewed for activities of daily living. Findings include: R128's morning cares were observed on 8/8/13 at 10:30 a.m. provided by a nursing assistant (NA)-F. Suprapubic catheter (inserted directly into the bladder from the abdominal wall) care was not provided during the observation. NA-F washed her hands and donned gloves. She then opened the valve on the drainage spout and emptied urine from the drainage bag. She returned the drain spout in its sleeve, measured the urine, removed her gloves, and washed her hands. Although she cleaned the resident of incontinent stool, she did not clean around the catheter tubing. The resident's perineal area and buttocks were washed, the NA did not perform thorough pericare, including pulling back the resident's foreskin. An incontinence brief was then put on the resident and he was dressed for the day. R128's care plan dated 7/12/13, directed staff to monitor and document output every shift, to monitor for pain discomfort due to catheter and to monitor for signs and symptoms of urinary tract	2 840		

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2 840	Continued From page 4 infections. The care plan, however, did not specify how and when catheter care should be performed. Staff was to provide pericare after each incontinent bowel episode. R128 had a history of urinary tract infections, a suprapubic catheter, and incontinence of bowel. The facility's policy and procedure for perineal care dated 2006, indicated care for males should include "apply disposable gloves, form a mitten with the washcloth and apply soap, gently wash pubis and penis. If uncircumcised pull back foreskin and wash. Carefully dry and return foreskin to normal position. make sure shaft of penis is dry. Ask resident to bend and separate knees, wash scrotum carefully. Rinse and pat dry. Turn the resident and wash around anus." The facility's policy and procedure for catheter care (undated) indicated the purpose was to prevent infection and reduce irritation. "Put on gloves; cleanse are well at catheter insertion; all debris must be removed from catheter at insertion site, rinse well with warm water and pat dry, apply antiseptic ointment at catheter insertion site as ordered by physician; and secure tubing." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review policies and procedures regarding proper perineal care after an incontinent episode. Staff should then be observed to ensure proper perineal care is provided and retrained as necessary. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840		

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21015	Continued From page 5	21015		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure dry food itmes were stored in a sanitary manner, potentially affecting all 103 residents residing in the facility. Findings include: On 8/7/13 at 11:55 a.m. flour, sugar, and Thick-it (for thickening liquids) were observed stored in large plastic containers with plastic covers that were cracked and broken, potentially exposing the food to contaminants, humidity, pest infestation, and/or deterioration of the food. In addition, a one cup measure that was covered in flour was stored inside the flour container, and scoops were also stored inside the sugar and Thick-it containers. At 11:48 a.m. the dietary manager verified the poor condition of the containers and the presence of scoops inside the food containers. He stated that all food should have been stored in sealable containers, and the scoops should have been stored outside the containers rather than touching the food. SUGGESTED METHOD OF CORRECTION: The dietary manager or designee could develop a	21015		

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21015	Continued From page 6 system to ensure lids are secure on food bins, that the lids are in good repair and scoops are not left in the bins. Staff could be trained in recognizing when lids are not longer fitting properly and to ensure scoops are not left in food containers.The manager could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Ten (10) days.	21015		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure pureed food temperatures were maintained at acceptable temperatures for four residents who received pureed diets on the three south unit. Findings include: Temperatures of the noon meal were measured by the cook on 8/7/13, at 11:13 a.m. prior to placing the food in the steam tables, at which time all foods were within acceptable range. Observations were conducted in the three south dining room on 8/7/13, at 11:58 a.m. Dietary aides	21025		

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21025	Continued From page 7	21025		

were serving food for residents who received mechanical soft and pureed diets from a steam table in the kitchen. Staff then placed plastic covers over the plates with no plate warmers under the plates. The plates were then placed on the portable steam table and were transported to the units. The steam table contained food for residents on regular diets and included spaghetti with meat sauce, parmesan breadsticks, steamed broccoli and an alternative choice of chicken fillet, mashed potatoes and gravy and peas. The surveyor followed the staff with the steam table which was then set up in the 3 south dining room. Four plates with pureed food were on a tray near the steam table.

At 11:58 a.m. dietary staff dished food for residents on pureed diets onto plates that were then covered with plastic covers and were placed onto a tray. No method of keeping the food (such as heated plate warmers) were used. The portable steam table was then transported to the second and third floors.

At 12:05 p.m. the dietary staff began dishing food for residents who received regular and mechanical soft diets. The food that was kept in the steam table was observed to be steaming. The four residents whose trays were dished in the kitchen on the third floor remained on the tray adjacent to the steam table until all residents had been served their meals. At 12:25 p.m. the four residents were served their pureed food. Three of the four residents were assisted to eat, and a fourth resident had his head down and eyes closed. No staff approached the resident to assist him to eat, and temperatures of the meal were then measured by the dietary manager. The meat sauce was 100 degrees Fahrenheit (F) and the mashed potatoes and peas were 120

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21025	Continued From page 8 degrees F. The DM then requested a new plate of food for the resident from the kitchen. When the food arrived and the cover was removed, visible steam was observed coming from the food. On 8/8/13, at approximately 11:30 a.m. the dietary manager stated that the food should have been held at 140 degrees F. The facility procedure regarding food temperatures dated 7/11, directed staff to measure temperature by inserting the thermometer stem into the thickest part of the product and wait for the thermometer reading to steady before recording the temperature. "All hot food should reach internal temperature of one hundred-forty-one degrees Fahrenheit to one hundred-eighty degrees Fahrenheit." SUGGESTED METHOD FOR CORRECTION: The administrator with the director of food service could review the procedures for maintaining proper food temperatures for food served to residents, revise if necessary and the director of food service or designee could monitor food temperatures on an ongoing basis to ensure appropriate food temperatures are maintained. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21025		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services	21325		

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21325	Continued From page 9 include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dental follow up services were provided for 1 of 3 residents (R145) reviewed for dental services. Findings include: R145 had loose fitting dentures, however, had not received dental follow up as recommended on 4/3/13. On 8/5/13, at 4:26 p.m. a conversation took place with R145. The resident's upper denture was lose and moved when the resident spoke. A dental consultation dated 4/3/13, revealed a check for "Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose)." A written note stated "anchor tooth has been lost since upper partial has been made," and the section for notes to nursing staff for follow up/care conference directed, "Make new upper full denture?" Further review of the record revealed no documentation of follow up to dental recommendation. R145's annual Minimum Data Set (MDS) dated 4/23/13, identified the resident as having severe cognitive impairment and no natural teeth or tooth fragment (s). The Oral/Dental quarterly	21325		

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21325	Continued From page 10 assessment dated 7/20/13, revealed "no natural teeth, dentures are loose, will not let nurse teach how to use Fixadent due to language barrier but family already understands and will remind him and denies pain or discomfort but will continue to monitor for signs of pain." The care plan dated 5/10/12, indicated "I have no natural teeth and wear dentures." Interventions directed staff to monitor/document/report any issues of oral problems needing attention including pain (gums, toothache, palate), abscess, debris in mouth, lips cracked or bleeding. The staff was to provide cues and supervision, as well as sometimes minimal assistance with oral hygiene. When interviewed on 8/8/13, at 2:30 p.m. the licensed practical nurse (LPN)-C stated the facility should have followed up by calling R145's family for consent for a follow up dental appointment and scheduled an appointment for the resident. A facility policy/procedures for scheduling of follow up appointments was requested from the director of nursing on 8/8/13, at 3:00 p.m. but was not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review the policies and procedures regarding the acquisition of dental services for residents. Audits of could be completed to ensure that dental services if indicated or needed have been ordered or done. Training for all personnel to ensure compliance could be completed. TIME PERIOD FOR CORRECTION: Tewnty-one (21) days.	21325		

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21540	Continued From page 11	21540		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete accurate orthostatic blood pressures (BPs) as ordered for 2 of 5 residents (R29, R99) with physician-ordered monthly orthostatic blood pressures. Findings include: Orthostatic blood pressures (to measure potential drop in BP by first measuring the BP while lying, and then sitting, and if possible then standing)	21540		

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were either not completed monthly as ordered, or were not completed correctly for R29 and R99.

On 3/14/13 R29's physician ordered orthostatic BPs every 30 days. BP records for R29 from 3/13 to 8/7/13 revealed orthostatic BPs were not being completed as ordered. No orthostatic blood pressures were completed during the months of March, April, May, or June, 2013. On 5/12/13 R29's BP was measured while R29 was sitting. On 5/15/13 the resident's BP was measured while lying. Postural changes could not be determined as there was not more than one BP measured in order to make a comparison. An orthostatic BP measurement taken on 7/3/13 in R29's left arm revealed R29 experienced a drop in BP greater than 20 points with postural changes. R29's BP in the left arm when lying was 164/86 and when sitting was 96/65.

On 8/7/13, at 2:08 p.m. a registered nurse-A (RN)-A reviewed R29's electronic medical record (e-chart) for orthostatic BPs. RN-A found documentation in the electronic medication administration record (eMAR) indicating that an orthostatic BP had been completed on 6/12/13, but was unable to locate the results. RN-A was also unable to find documentation of orthostatic BPs from March to June.

R99 was admitted to the facility in 2011 with diagnoses including hypotension (low BP). Psychotropic medications are known to contribute to potential for orthostatic BPs, and R99's medications included the antipsychotic Seroquel 12.5 mg daily and 25 mg daily, as well as the antidepressant Celexa 20 mg daily.

On 7/8/13 a physician requested monthly orthostatic BPs be taken for R99. A review of

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21540	Continued From page 13 documentation revealed an orthostatic BP was completed after a fall on 7/20/13, but no orthostatic BPs were measured prior to the 7/8/13 physician order, despite R99 receiving an antipsychotic medication and having a diagnosis of hyptotension. A review of BP's for R99 back to 2/13 revealed staff were measuring BPs for R99 either when lying, sitting or standing, but not at the same time and in a manner that showed whether postural changes affected the resident's BP, which was verified by RN-A on 8/7/13, at 2:08 p.m. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop policies and procedures, educate staff, and conduct random audits of resident medication regimens to ensure compliance with state and federal regulatory requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to offer food choices and to ensure food was served at the proper	21805		

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21805	Continued From page 14 temperature, potentially affecting nine residents in the facility who were prescribed mechanically altered diets. Findings include: Observations were conducted in the three south dining room on 8/7/13, at 11:58 a.m. Dietary aides were serving food for residents who received mechanical soft and pureed diets from a steam table in the kitchen. Staff then placed plastic covers over the plates with no plate warmers under the plates. The plates were then placed on the portable steam table and were transported to the units. The steam table contained food for residents on regular diets and included spaghetti with meat sauce, parmesan breadsticks, steamed broccoli and an alternative choice of chicken fillet, mashed potatoes and gravy and peas. The surveyor followed the staff with the steam table which was then set up in the 3 south dining room. Four plates with pureed food were on a tray near the steam table. Diet cards had been placed at the place settings in the three south dining room. The cards included the diet order, as well as the resident likes and dislikes. Multiple staff assisted in serving the residents in the dining room. Each resident who received a regular diet was asked their beverage preference and whether they preferred spaghetti or chicken. Choices were not offered, however, to residents who received mechanically altered diets. The staff picked up the diet cards and approached the dietary staff and requested "mechanical soft" or "pureed" food. The mechanical soft diet consisted of ground noodles with meat sauce, mashed potatoes, and	21805		

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peas. The pureed diet consisted of blended meat sauce, mashed potatoes, and peas. No bread was served with either altered diet.

The menu extension for altered diets for 8/7/13 indicated soft chop diet would receive all diet options with the exception of the breadstick, and in its place mashed potatoes would be served. The mechanical soft/ground meat diet indicated no spaghetti noodles, corn or peas unless pureed, and no breadstick. The meat sauce and mashed potatoes would be served. The pureed diet included meat sauce with tomato sauce added would be served with mashed potatoes and pureed vegetables. No noodles, chicken filet, or bread would be served.

At 12:25 p.m. the DM confirmed all residents should have been offered a choice between the regular meal and the alternative meal. He stated they did not have the altered diets prepared, but it could have been requested from the kitchen.

At 12:45 p.m. the registered dietitian (RD) stated that the residents knew the menu and choices that were available. She reported that they were unable to puree bread or noodles, and that the pureed diets were limited. They only offered the main choice to residents on altered diets unless their dietary card indicated they could not have the food items. In those cases the alternative would be served. The RD stated that most of the residents who received pureed diets had end stage dementia.

SUGGESTED METHOD OF CORRECTION: The director of the dietary department should ensure those residents on pureed and mechanical soft diets received the same food items, but in puree form at all meals, unless contraindicated by

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 _____	08/09/2013

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) COMPLETE DATE
21805	Continued From page 16 allergy or personal food preference. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		