DEPARTMENT OF HEALTI	H AND HUMA	N SERVICES			CENTERS FOR MEE	DICARE & MEDIC	CAID SERVICES
					AND TRANSMITTAL		ID: PF24
	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	1	Facility ID: 00189
1. MEDICARE/MEDICAID PROVIDE (L1) 245556	ER NO.	3. NAME AND AI (L3) PRESBYTE			OMINGTON	4. TYPE OF ACTIO	DN: <u>7(</u> L8)
(L1) 245556 2.STATE VENDOR OR MEDICAID N	10	(L4) <b>9889 PENN</b>				1. Initial	2. Recertification
(L2) <b>376724800</b>		(L5) BLOOMING	GTON, MN		(L6) <b>55431</b>	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF C	OWNERSHIP	7. PROVIDER/SU	IPPLIER CATEO	GORY	<u>02</u> (L7)	7. On-Site Visit	9. Other
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After	r Complaint
6. DATE OF SURVEY <b>04/27</b>	<b>/2015</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDI	NG DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31	
11LTC PERIOD OF CERTIFICATION	J	10.THE FACILITY		45.			
From (a):	<b>N</b>	X A. In Complia		A5.	And/Or Approved Waivers Of	The Following Requirem	ents:
To (b):			equirements		2. Technical Personnel		
	<b>60</b> (110)	-	e Based On:		3. 24 Hour RN	7. Medical Di	
12.Total Facility Beds	<b>98</b> (L18)	l. A	cceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code	IF) <u>8.</u> Patient Roo 9. Beds/Room	
13.Total Certified Beds	<b>98</b> (L17)		npliance with Pro				
		Requirem	ents and/or Appl	ied Waivers:	* Code: <b>A</b> *	(L12)	
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
98							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Gayle Lantto, Supervisor		C	4/27/2015		Anne Kleppe, Enforce	ement Specialist	04/27/2015
· · · · ·				(L19)	**	*	(L20)
PAI	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	L OFFICE OR SINGLE S	TATE AGENCY	
19. DETERMINATION OF ELIGIBIL	ITY		IPLIANCE WIT	H CIVIL	21. 1. Statement of Finar 2. Ownership/Control	ncial Solvency (HCFA-257 ol Interest Disclosure Stmt	
<b>X</b> 1. Facility is Eligible to P	articipate	KIOI	IISACI.		3. Both of the Above		(IICIA-1515)
2. Facility is not Eligible	(L21)						
	. ,						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:		(L30)
OF PARTICIPATION	BEGINNINC	5 DATE	ENDING DA	TE	<u>VOLUNTARY</u> <u>00</u>		
04/01/1991					01-Merger, Closure 02-Dissatisfaction W/ Reimburse		Meet Health/Safety
(L24)	(L41)		(L25)		03-Risk of Involuntary Terminatio	n	Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS n of Admissions:			04-Other Reason for Withdrawal	07-Provid	er Status Change
	A. Suspension	i of Admissions.	(L44)			00-Active	U
(L27)	B. Rescind St	spension Date:					
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION 04/21/2015	OF APPROVAL	LDATE			
	(L32)	04/21/2013		(L33)	DETERMINATION APPE	ROVAL	

DETERMINATION APPROVAL



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5556

Electronically Delivered: April 27, 2015

Mr. Blake Boche, Administrator Presbyterian Homes of Bloomington 9889 Penn Avenue South Bloomington, Minnesota 55431

Dear Mr. Boche:

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 April 14, 2015 the above facility is certified for:

98 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 98 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 about this electronic notice.

Sincerely,

Ane Klagse

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



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: April 27, 2015

Mr. Blake Boche, Administrator Presbyterian Homes of Bloomington 9889 Penn Avenue South Bloomington, Minnesota 55431

RE: Project Number S5556027

Dear Mr. Boche:

On March 23, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 5, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 27, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 16, 2015 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 March 5, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 14, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 5, 2015, effective April 14, 2015 and therefore remedies outlined in our letter to you dated March 23, 2015, will not be imposed.

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

Sincerely,

Ame Klagse

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

#### **Post-Certification Revisit Report**

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245556	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 4/27/2015
Name of Facility		Street Address, City, State, Zip Code		
PRESBYTERIAN HOMES OF BLOOMINGTON			9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431	

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
	F0246 483.15(e)(1)	0	Correction Completed 04/14/2015		F0282 483.20(k)(3)(ii)		Correction Completed 04/14/2015			F0312 483.25(a)(3)		Correction Completed 04/14/2015
	F0314 483.25(c)	(	Correction Completed 14/14/2015	ID Prefix Reg. # LSC	F0329 483.25(I)		Correction Completed <b>04/14/2015</b>			F0356 483.30(e)		Correction Completed 04/14/2015
	F0371 483.35(i)	0	Correction Completed 14/14/2015	ID Prefix Reg. # LSC	483.60(c)		Correction Completed 04/14/2015			F0431 483.60(b), (d)		Correction Completed 04/14/2015
ID Prefix Reg. #		(	Correction Completed 4/14/2015		F0463 483.70(f)		Correction Completed 04/14/2015					Correction Completed
Reg. #			Correction Completed	ID Prefix								
State Agen	-	Reviewed I GL/AK Reviewed I		Date: 04/27/20 Date:	Signature 015 Signature		•		15507		Date: 04/2 Date:	7/2015
Followup	to Survey Cor 3/5/2	-			Check for any Uncorrected					Summary of the Facility?	YES	NO

#### **Post-Certification Revisit Report**

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

(Y1) Provider / Supplier / CLIA / Identification Number 245556	(Y2) Multiple Cons A. Building B. Wing		W BUILDING	(Y3) Date of Revisit 4/16/2015	
Name of Facility		Street Address, City, State, Zip Code			
PRESBYTERIAN HOMES OF BLOO	MINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431			

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).

	Correctio Complete 04/14/20	ed	Correctio	on		Correction	
		ID Prefix	Complet	ed ID Prefix		Completed	
Reg. # N		Reg. #		Reg. #			
LSC K	0076			LSC			
	Correctio	n	Correctio	on		Correction	
ID Prefix	Complete	ed ID Prefix	Complet	ed ID Prefix		Completed	
Reg. #							
	Correctio	n	Correctio	on		Correction	
ID Prefix	Complete	ed	Complet			Completed	
Reg. #			· · ·	ID Prefix			
		Reg. # LSC		Reg. # LSC			
	Correctio	n	Correctio	on		Correction	
ID Prefix	Complete	ed ID Prefix	Complet	ed ID Prefix		Completed	
D #							
LSC		LSC		LSC			
ID Prefix	Correctio Complete	ed	Correctio Complet			Correction Completed	
Reg. #		Reg. #		Reg. #			
LSC		LSC		LSC			
<b></b>	<b>_</b>						
Reviewed By		Date:	Signature of Surveyor:	28120	Date:	16/2015	
State Agency		04/27/2015	0:	28120		10/2013	
Reviewed By CMS RO	——— Reviewed By	Date:	Signature of Surveyor:		Date:		
Followup to S	Followup to Survey Completed on: 3/5/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?				

DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			CENTERS FOR MED	DICARE & MEDICA	ID SERVICES
					AND TRANSMITTAL	ID:	: PF24
	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	Fa	cility ID: 00189
1. MEDICARE/MEDICAID PROVIDE (L1) 245556	R NO.	3. NAME AND AD (L3) <b>PRESBYTE</b>			OMINGTON	<ol> <li>TYPE OF ACTION:</li> <li>1. Initial</li> </ol>	2 (L8) 2. Recertification
2.STATE VENDOR OR MEDICAID N (L2) 376724800	Э.	(L4) 9889 PENN A (L5) BLOOMING		JTH	(L6) <b>55431</b>	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF O (L9)	WNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEC	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	<ol> <li>7. On-Site Visit</li> <li>8. Full Survey After C</li> </ol>	9. Other omplaint
<ul> <li>6. DATE OF SURVEY 03/05/</li> <li>8. ACCREDITATION STATUS:</li> <li>0 Unaccredited 1 TJC 2 AOA 3 Other</li> </ul>	<b>2015</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING	G DATE: (L35)
<ul> <li>11LTC PERIOD OF CERTIFICATION</li> <li>From (a):</li> <li>To (b):</li> <li>12.Total Facility Beds</li> </ul>	<b>98</b> (L18)	Compliance	nce With equirements e Based On: cceptable POC		And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	6. Scope of Servi 7. Medical Direc	ices Limit tor
13.Total Certified Beds	<b>98</b> (L17)	X B. Not in Com Requirement	pliance with Progents and/or Appli		* Code: <b>B</b> *	(L12)	
14. LTC CERTIFIED BED BREAKDOW	VN				15. FACILITY MEETS		
18 SNF 18/19 SNF 98	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Douglas Stevens, HFE N	E II	0	4/03/2015	(L19)	Anne Kleppe, Enforc	ement Specialist	04/21/2015 (L20)
PAR	T II - TO BE	COMPLETED F	BY HCFA RI	EGIONAI	COFFICE OR SINGLE S	TATE AGENCY	
<ol> <li>DETERMINATION OF ELIGIBILI</li> <li>1. Facility is Eligible to Pa</li> <li>2. Facility is not Eligible</li> </ol>			IPLIANCE WITI ITS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (H : :	CFA-1513)
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L.	30)
OF PARTICIPATION <b>04/01/1991</b>	BEGINNINC	G DATE	ENDING DA	ΓE	VOLUNTARY     00       01-Merger, Closure		ARY eet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse		eet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:			03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider	Status Change
(L27)	B. Rescind St	spension Date:	(L44)			00-Active	
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE			
	(L32)			(L33)	DETERMINATION APPE	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: March 23, 2015

Mr. Blake Boche, Administrator Presbyterian Homes of Bloomington 9889 Penn Avenue South Bloomington, Minnesota 55431

RE: Project Number S5556027

Dear Mr. Boche:

On March 5, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

# <u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

# <u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

# DEPARTMENT CONTACT

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

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

Email: <u>gayle.lantto@state.mn.us</u> 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 April 14, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 14, 2015 the following remedy will be imposed:

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

# ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

# VERIFICATION OF SUBSTANTIAL COMPLIANCE

Presbyterian Homes of Bloomington March 23, 2015 Page 4

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

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

### Original deficiencies not corrected

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

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

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

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

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

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

If substantial compliance with the regulations is not verified by June 5, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

Presbyterian Homes of Bloomington March 23, 2015 Page 5

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 September 5, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

## INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Please contact me if you have any questions about this electronic notice.

Presbyterian Homes of Bloomington March 23, 2015 Page 6

Sincerely,

Ame Klagge

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3	) DATE SURVEY COMPLETED
		245556			00/05/0045
	PROVIDER OR SUPPLIER	243330		STREET ADDRESS, CITY, STATE, ZIP CODE	03/05/2015
				9889 PENN AVENUE SOUTH	
PRESBY	TERIAN HOMES OF I	BLOOMINGTON		BLOOMINGTON, MN 55431	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 000	INITIAL COMMENT	rs	F 000		
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance.			
F 246 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with ONABLE ACCOMMODATION ERENCES	F 246		4/14/15
	services in the facil accommodations o preferences, excep	right to reside and receive ity with reasonable f individual needs and t when the health or safety of her residents would be			
	by: Based on observat review the facility fa within reach for 1 o reviewed for hospic Findings include: R89 was seated in	NT is not met as evidenced tion, interview and document ailed to ensure a call light was f 1 resident (R89) who was ce care. a specialized wheelchair in her 9:22 a.m. The resident's		Resident □s care plan was reviewed by the care team for safety and call light accessibility. Call light was pinned to g and corrected as soon as identified ar current. Resident is on hospice care a her cares are collaborated with a hosp agency. The hospice agency was immediately notified about this incident and asked	jown id is and pice

Electronically Signed

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.

04/02/2015

PRINTED: 04/20/2015

STATEMEN	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
		245556	B. WING			02/	0.5/0015
NAME OF	PROVIDER OR SUPPLIER	240000		S	TREET ADDRESS, CITY, STATE, ZIP CODE	03/0	05/2015
	TERIAN HOMES OF	BLOOMINGTON		98	889 PENN AVENUE SOUTH LOOMINGTON, MN 55431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIC DATE
F 246	down while calling of ah, ah, ah." The ca and was wedged b rail, approximately stated she did not k light. A nursing assistant "We clip her call lig NA proceeded to ta the mattress and b upper jacket and th hand. NA-C further well. That is why we NA-C reported R89 used her call light. then stated R89's co onto the front of he blind. R89's Minimum Da indicated the reside vision due to retino causing vision loss vision, and was abl She required exten of daily living (ADLs R89's 8/9/13, care resident's call light area so she could I 2/24/15, hospice ca blind. Place my cal hands and show m falls with injuries. I sweater so am able	out in a distressed tone, "Ah, Il light was behind the resident, etween the mattress and bed five feet from her reach. R89 know the location of her call (NA)-C explained at 9:27 a.m. ht on her clothing here," as the ike the call light from between ed rail and clip it to R89's ten place it in the resident's stated, "She does not see e put the call light in her hand." Was capable of using and A registered nurse (RN)-H call light was always clipped r clothing, as she was legally ta Set (MDS) dated 1/21/15, ent had severely impaired pathy and glaucoma (both ), had moderately impaired e to make herself understood. sive assistance with activities s). plan directed staff to clip the to her sweater on the chest ocate it to call for help. A are also noted, "I am legally I light on my gown, guide my e where it isI am at risk for want my call light pinned to my	F 24	46	collaborative care for hospice resid Review of this resident s specific plan needs regarding the call light also completed with facility staff. All residents are assessed for safe call light use upon admission, with quarterly MDS assessments, with significant change, annually with vendors and as needed as part of process. A review of this resident s care pl Best day was completed to ensure resident neetings to be complet 4/10/15. Staff are trained in comp class upon hire and as needed. Collaboration of care with hospice agencies will continue being comp between facility staff and hospice s ensure both parties understand resident s plan of care. Staff will r for call light placement with roundia all residents. Audits of the resident s plan of care call light placement will be conduct weeks and results reported to facil committee to ensure ongoing com The Clinical Coordinators and Clin Administrator are responsible for compliance. Date certain compliant April 14th, 2015.	care was ety and outside the RAI an, My ill red by etency leted staff to nonitor ng for re and red for 4 ity QA pliance. ical	

If continuation sheet Page 2 of 38

		AND HUMAN SERVICES			F <sup>i</sup>	ITED: 04/20/2015 ORM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			B) DATE SURVEY COMPLETED
		245556	B. WING			03/05/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	
PRESBY	TERIAN HOMES OF I	BLOOMINGTON			389 PENN AVENUE SOUTH LOOMINGTON, MN 55431	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 246		-	F 2	246		
F 282 SS=D	residents' reach at 483.20(k)(3)(ii) SER PERSONS/PER C/	RVICES BY QUALIFIED	F 2	282		4/14/15
	must be provided b	led or arranged by the facility y qualified persons in Ich resident's written plan of				
	by: Based on observat review the facility fa followed for 1 of 1 r hospice, 1 of 2 resi pressure ulcers, an reviewed for activiti Findings include: R89's 8/9/13, care resident's call light area so she could I 2/24/15, hospice ca blind. Place my call hands and show m falls with injuries. I sweater so am able R89 was seated in room on 3/5/15, at knees were bent as down while calling of ah, ah, ah." The ca and was wedged bo rail, approximately	NT is not met as evidenced tion, interview and document ailed to ensure care plans were resident (R89) reviewed for dents (R205) reviewed for d 1 of 3 residents (R339) es of daily living (ADLs). plan directed staff to clip the to her sweater on the chest ocate it to call for help. A are also noted, "I am legally light on my gown, guide my e where it isI am at risk for want my call light pinned to my e to reach it easily." a specialized wheelchair in her 9:22 a.m. The resident's a she lifted her legs up and but in a distressed tone, "Ah, Il light was behind the resident, etween the mattress and bed five feet from her reach. R89 know the location of her call			Residents R89, R225 & R339 care pl were reviewed by the care team for sa and call light accessibility; repositionin and grooming. Resident R089 is on hospice care and cares are in collaboration with a hospi agency. For resident R89, the call wa immediately corrected once identified placed within reach per resident's preference. The hospice agency was immediately notified about this incider and asked to offer education to its sta ensure collaborative care for hospice residents. Review of this resident □s specific care plan needs regarding the light was also completed with facility s and the care plan was updated and m best day is current. Resident's care pl and My Best Day are updated per RA process and with change of condition change of preference. Staff are remin to follow care plan at stand up and shi change and through other on-going communication. Resident 225□s was reassessed for s risk and individual preferences for	afety g d her ce s and t ff to e call taff y ans l or ded ift

Facility ID: 00189

If continuation sheet Page 3 of 38

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE		(X3) DATE	0938-039
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245556	B. WING _			03/0	)5/2015
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF	BLOOMINGTON			889 PENN AVENUE SOUTH LOOMINGTON, MN 55431		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 282	Continued From pa	age 3	F 28	32			
	light.		0	-	repositioning. The repositioning car	re plan	
					was reviewed and updated to reflect	rt .	
		t (NA)-C explained at 9:27 a.m.			resident s preference of extended		
		ht on her clothing here," as the ake the call light from between			times and refusal of repositioning w sleeping. Resident sleeps in until la		
		ed rail and clip it to R89's			the morning. Resident has supporting		
		nen place it in the resident's			surfaces on her bed that support he		
	hand. NA-C further	stated, "She does not see			tissue tolerance and does not requi		
		e put the call light in her hand."			every two hour repositioning. Resid		
		was capable of using and			also has the ability to make slight ch		
		A registered nurse (RN)-H call light was always clipped			in her position and has grab bars or bed to enhance her bed mobility.	nce her bed mobility.	
		er clothing, as she was legally			Resident s care plan will now requ		
	blind.				repositioning only while awake durin		
					day and as needed, to meet resider	nt⊡s	
		a.m. the director of nursing			choices while supporting the wound		
	residents' reach at	ights should have been within a all times.			healing process. Resident skin inte will be monitored daily during cares		
					with RAI process. For all residents,		
		ck Guide to ADLs (activities of			assessed daily with cares, weekly the		
		le in the resident's room			body audits, and as needed with ch		
		position the resident every two			of condition and in coordination with		
		ed. The care plan noted "I for alteration in skin integrity r/t			RAI process. All residents with wou were reviewed and care plans curre		
		sed mobility, Incontinence,			Resident 339 was immediately offer		
		left buttock, right buttock and			care and she declined nail trimming		
		The care plan goal read, "My			stating I like my nails long. Resider	nt	
		ith out getting infected," and			R339 care plan was reviewed for		
	every two hours an	cluded offering repositioning			grooming and staff were re-educate the need to complete all ADLs daily		
					as needed. Care Plan and My bes		
	R205 was continue	ously observed on 3/4/15, from			was updated for preferences. Staff		
	6:58 to 10:05 a.m.	(3 hours, 7 minutes). Although			educated to report to nurse of resid		
		t on staff for repositioning and			refusal for re-approach and		
		(full thickness tissue loss with			documentation. She allowed cleani		
		don, or muscle) pressure offered or encouraged to			underneath her nails. Resident is no	WC	
		uring the observation.			deceased; she expired on $3/20/15$ . A review of these residents $\Box$ care p	olan	
				- I	-7	nun,	

Facility ID: 00189

If continuation sheet Page 4 of 38

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		BENTI IOATION NOMBER.	A. BUILDIN	IG	001	
		245556	B. WING _			05/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
PRESBY	TERIAN HOMES OF	BLOOMINGTON		9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 282	usually ate brunch and was provided stated R205's daily completed at 10:30 On 3/4/15, at 9:24 be repositioned wh because she had w When NA-D was a what time R205 ha answered, "The re say for last night. U on the night shift a she did not know w repositioned, but th repositioned her be and NA-D verified noted the time R20 morning. NA-D exp worksheet was how had been and was On 3/4/15, at 10:56 supposed to be co was consistent with On 3/4/15, at 2:58 supposed to have hours according to R339's care plan d needed verbal cue	a.m. RN-J explained R205 at noon, preferring to sleep in, supplements. RN-J further wound care was typically 0 a.m. at the earliest. a.m. NA-E stated R205 was to been in bed every two hours, wounds on her buttocks. sked on 3/4/15, at 10:37 a.m. id last been repositioned, NA-D positioning worksheet didn't Jsually she is repositioned last t six a.m." RN-J then stated when R205 had last been hat the night staff usually efore leaving for the day. RN-J the night shift staff had not 05 had been repositioned that olained the repositioning w staff tracked when a resident due for repositioning. 6 a.m. NA-C stated R205 was mpeted every two hours and h the NA care sheets. p.m. RN-G stated R205 was been repositioned every two	F 28	22 completed to ensure their in All residents are reviewed a updated upon admission, w MDS assessments, with sig change, annually and as ne of the RAI process. Care c scheduled with each reside to hear feedback on their pl to provide updates. Staff will be educated throu and household meetings co April 10, 2015. New staff ar hire and as needed. Audits of the resident s pla following plan of care will be 4 weeks and results reporte committee to ensure ongoin The Clinical Coordinators a Administrator are responsib compliance. Date certain co April 14th, 2015.	nd care plan ith quarterly nificant eded as part onferences are nt and family an of care and gh in-services mpleted by e trained upon n of care and e conducted for ed to facility QA ng compliance. nd Clinical le for	

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	04/20/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		245556	B. WING		03/	05/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PRESBY	TERIAN HOMES OF E	BLOOMINGTON		9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	were unclean with k nails and were untri 1 inch long. In addit facial hair approxim stated she needed and to trim facial ha 11:10 a.m. R339 wa wearing pajamas, h her fingernails still u On 3/4/15, at 11:22 stated the residents day and facial hair v in the morning. RN resident bath days, daily report sheets to On 3/4/15, at 2:45 p expected staff to fo On Thursday 3/5/15 lying in bed wearing hair had been trimm long, unclean finger legs and feet was d were thick and long in length. R339 rep toenail trimming.	sed in pajamas, her fingernails black debris underneath the immed varying in length 3/4 to ion R339 had untrimmed hately one inch in length. R339 staff's assistance for nail care in. On Wednesday 3/4/15, at as observed in her room her facial hairs untrimmed and unclean and untrimmed. a.m. a registered nurse (RN)-I b' nails were trimmed on bath was trimmed with daily cares -I also stated the NAS knew as they were indicated on the the NAs carried. b.m. the DON stated she llow the residents' care plans. 5, at 9:39 a.m. R339 again g pajamas. Although her facial hed, she continued to have rnails. The skin on her lower ry and flaky. Her toenails , approximately 1/4 to 1/2 inch borted she needed help with	F 282			
F 312 SS=D	indicated staff were in resident care plat resident care, and t 483.25(a)(3) ADL C	Resident Care Plan policy to communicate information ns to all staff providing direct o "list preventative measures." ARE PROVIDED FOR IDENTS	F 312			4/14/15
	A resident who is u	nable to carry out activities of				

		AND HUMAN SERVICES					APPROVE 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		E SURVEY PLETED	
		245556	B. WING			03/05/2015		
NAME OF	PROVIDER OR SUPPLIER	•		STREE	T ADDRESS, CITY, STATE, ZIP CODE	-		
PRESBY	TERIAN HOMES OF	BLOOMINGTON			PENN AVENUE SOUTH MINGTON, MN 55431			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 312	daily living receives	age 6 the necessary services to ition, grooming, and personal	F 3	12				
	by: Based on observa review the facility fa assistance for 1 of for activities of daily Findings include: R339 was in her ro p.m. She was dress were unclean with I nails and were untr 1 inch long. In addi facial hair approxim stated she needed and to trim facial ha 11:10 a.m. R339 w wearing pajamas, H her fingernails still f On 3/4/15, at 11:22 stated the residents day and facial hair in the morning. RN assistants (NAs) kr they were indicated NAs carried. On Thursday 3/5/15	NT is not met as evidenced tion, interview and document ailed to provide grooming 3 residents (R339) reviewed y living (ADLs). om on Monday 3/2/15, at 3:15 sed in pajamas, her fingernails black debris underneath the immed varying in length 3/4 to tion R339 had untrimmed nately one inch in length. R339 staff's assistance for nail care air. On Wednesday 3/4/15, at as observed in her room her facial hairs untrimmed and unclean and untrimmed. ca.m. a registered nurse (RN)-I s' nails were trimmed on bath was trimmed with daily cares I-I also stated the nursing hew resident bath days, as i on the daily report sheets the 5, at 9:39 a.m. R339 again g pajamas. Although her facial ned, she continued to have		na sta R3 acc re- AE ne nu for all Re on Ar as co ne as ad as an pro Sta an by hir res co re	esident R339 was immediately of il care and she declined nail trin ating I like my nails long. Reside 39 s care plan was reviewed f tivities of daily living and staff w educated on the need to compl DL aspects with routine cares, a eded. Staff was educated to re- rse whenever resident s refuse re-approach and documentation bwed cleaning underneath her re- sident is now deceased; she ex- 3/20/15. review of this resident s care p signment sheets was immediate mpleted to ensure resident s g eds were met. All residents and sessed for need for all ADLS u mission, with quarterly MDS sessments, with significant chain nually and as needed as part of bocess. aff will be educated through in-se d household meetings to be con 4/10/15. New staff will be train e and as needed. Audits of all of sident s ADL plan of cares will inducted for 4 weeks and results borted to facility QA committee to sure ongoing compliance.	nming ent or as ete all nd as port to e care on. She nails. cpired an and ely rooming e upon nge, the RAI ervice mpleted ed upon other be		

Facility ID: 00189

If continuation sheet Page 7 of 38

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION		E SURVEY	
ND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	IPLETED	
		245556	B. WING		03/	05/2015	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PRESBY	TERIAN HOMES OF I	BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 312	were thick and long	ge 7 ry and flaky. Her toenails , approximately 1/4 to 1/2 inch ported she needed help with	F 312	Administrator are responsible for compliance. Date certain complia April 14th, 2015.	nce is		
	needed verbal cues assistance with bat Data Set (MDS) da was cognitively inta corresponding Care 3/3/15, indicated th assist with persona bathing. The daily r	ated 2/18/15, indicated R339 s with grooming, and needed hing. The admission Minimum ted 2/25/15, indicated R339 ct. The MDS as well as the e Area Assessment dated e resident required extensive I hygiene and partial help with eport sheet dated 3/5/15, ath days were Tuesday and					
F 314 SS=D	stated she expecte daily and as needed Facility's 9/3/10, Re staff as follows: "E HS [evening] cares face and hands and 483.25(c) TREATM	esident Care policy directed very resident to have A.M. and done dailyWash residents d dryShave residents in am."	F 314			4/14/15	
	resident, the facility who enters the faci does not develop p individual's clinical they were unavoida pressure sores reco	rehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and a healing, prevent infection and from developing					

Facility ID: 00189

If continuation sheet Page 8 of 38

		& MEDICAID SERVICES			OMB NO.	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · /	E SURVEY PLETED
		245556	B. WING		03/05/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
PRESBY	TERIAN HOMES OF E	BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 314	Continued From pa	ige 8	F 3	14		
	This REQUIREMEN	NT is not met as evidenced				
	Based on observat review the facility facare and treatment pressure ulcers for reviewed for pressure Findings include: R205 was continuo 6:58 to 10:05 a.m. ( she was dependent had three Stage IV exposed bone, tend ulcers she was not change positions du On 3/4/15, at 6:58 a back and slightly to placed on either sid head of bed (HOB) a.m. a registered nu room. R205 asked RN-J adjusted the p slightly. R205 was a experiencing any pa inhaler were admin lowered slightly. At repositioning. At 8:0 light and requested surveyor asked a n see if RN-J could re surveyor planned to for repositioning. At in the vicinity of R20	tion, interview and document ailed to ensure appropriate to promote healing of 1 of 2 residents (R205) ure ulcers. usly observed on 3/4/15, from (3 hours, 7 minutes). Although t on staff for repositioning and (full thickness tissue loss with don, or muscle) pressure offered or encouraged to uring the observation. a.m. R205 was lying on her the left side. A pillow was de of the resident, and the was slightly elevated. At 7:40 urse (RN)-J entered R205's RN-J to adjust her pillow. oillow and raised the HOB asked whether she was ain. Her medications and an istered, and then the HOB was no time did RN-J suggest D5 a.m. R205 used her call lip balm. At 9:30 a.m. the ursing assistant if she would eturn to R205's room, as the o question the resident's need t 9:59 a.m. RN-J was observed 05's room, when the surveyor rmed RN-J R205 had not		Resident 225 s was repositi identification and was re-asses skin risk. Repositioning care p reviewed and updated to refle- resident s preference of her sleep-in times and her choice receive nay repositioning supp sleeping. Resident has suppor surfaces on her bed that supp tissue tolerance and does not every two hour repositioning. ability to make slight body mor- using grab bars on her bed to her bed mobility. Her wounds healing. Resident has grab ba bed that enables her to adjust while in bed. Resident s care now require repositioning only awake during the day and as r meet resident s choices while the wound healing process. All residents are assessed for upon admission, with quarterly assessments, with significant annually and as needed as pa process. A review of resident s care pl Best day was completed to en resident s skin integrity is sup protected. Staff will continue to repositioning when resident is request and as needed to hor sleep preferences and monito integrity. Staff will ensure she	essed for lan was ct extended not to port while tive ort her require She has the vements enhance are also rs on her her body e plan will while needed, to e supporting skin risk v MDS change, rt of the RAI an and My sure oported and o offer awake per nor her r for skin	

Facility ID: 00189

If continuation sheet Page 9 of 38

STATEMEN	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	0938-039
AND PLAN (	JF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COM	PLETED
		245556	B. WING _		03/05/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP ( 9889 PENN AVENUE SOUTH	CODE	
PRESBY	TERIAN HOMES OF I	BLOOMINGTON				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE
F 314	entered R205's roo in the bed. She rep and "a little" pain in R205 stated, "I like sides, but not my si removed the soiled buttocks. The resid Greenish-red drain dressings, and red second dressing. T was reddened in co around the wounds left indentations in t 10:18 a.m. the resid reddened. NA-D as resident should hav proceeded to positi her back and slight either side of the re was on her right sid minutes during the returned to the sam at least three hours On 3/4/15, at 7:50 a usually ate brunch and was provided s stated R205's daily completed at 10:30 On 3/4/15, at 9:24 a be repositioned whi because she had w also stated the resi and she had never repositioning and in	m. R205 was lying nearly flat orted she had pain in her legs her wounds (on her buttocks). lying on my back and my tomach." At 10:05 a.m. RN-J dressings from R205's ent had three pressure ulcers. age was present on one of the drainage was present on a he skin on R205's buttocks olor with additional redness . Additionally, the left buttocks the skin from the dressing. At dent's buttocks remained sked RN-J in what manner the <i>re</i> been positioned. They then on the resident nearly flat on ly to the left with pillows on esident. Although the resident de for approximately 30 dressing changes, she was ne position she had been in for	F 31	4 integrity will be monitored v cares, ordered treatments a weekly audits. Nursing staff will be educa repositioning and skin risk a household meetings and in completed by 4/10/15. All residents with skin risk a weekly for skin integrity and are reviewed and updated weekly Quality Improvemen upon hire and as needed. are monitored for skin integ admission, with quarterly N assessments, with significa annually and as needed as process. Audits of residents □ plan of risk will be conducted for 4 results reported to facility C to ensure ongoing complian The Clinical Coordinators a Administrator are responsit compliance. Date certain fo is April 14th, 2015.	and scheduled ted on through -service to be are assessed d care plans as needed., nt Meetings, All residents grity upon IDS ant change, part of the RAI of care and skin weeks and DA committee nce. und Clinical ole for	

STATEMENT	OF DEFICIENCIES	KANNERSPICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	· · /		CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245556	B. WING			03/05/2015	
NAME OF	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF	BLOOMINGTON			9 PENN AVENUE SOUTH OOMINGTON, MN 55431		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 314	When NA-D was a what time R205 ha answered, "The re say for last night. U on the night shift a she did not know v repositioned, but th repositioned her bo and NA-D verified noted the time R20 morning. NA-D exp worksheet was how had been and was On 3/4/15, at 10:50 to sleep late and w repositioned, which competed every tw with the NA care show hours according to R205's significant (MDS) dated 12/3/ cognitively intact, r staff for bed mobili not exhibited. R205's 2/1/15, Qui daily living) availab directed staff to rep hours and as need have the potential [related to] Decrea pressure ulcers on right sacral area."	<ul> <li>Isked on 3/4/15, at 10:37 a.m.</li> <li>Isked on a repositioned last t six a.m." RN-J then stated when R205 had last been not the night shift staff had not 05 had been repositioned that blained the repositioning w staff tracked when a resident due for repositioning.</li> <li>Is a.m. NA-C stated R205 liked vas "always okay" with being n was supposed to be vo hours and was consistent heets.</li> <li>p.m. RN-G stated R205 was been repositioned every two</li> </ul>	F	314			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
-							
	PROVIDER OR SUPPLIER	245556	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	05/2015	
	TERIAN HOMES OF	BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE	
F 314 F 329 SS=D	every two hours an On 3/4/15, at 2:45 p stated she expecte care plans and to u needed. The facility's 8/13, 9 the policy of Presby identify, assess and clinical conditions in skin integrity, and p preventative measu appropriate treatme according industry ambulation, activity toleratedEstablish repositioning scheo immobile." 483.25(I) DRUG RE UNNECESSARY D Each resident's dru unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer should be reduced combinations of the	cluded offering repositioning d as needed. p.m. the director of nursing d staff to follow the residents' update and revise the plans as Skin Risk Policy noted, "It is yterian Homes to properly d monitor residents whose ncrease the risk for impaired pressure ulcers; to implement ures; and to provide ent modalities for ulcers standards of careEncourage y, and mobility as n an individualized turning and dule if the resident is EGIMEN IS FREE FROM DRUGS ag regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nces which indicate the dose or discontinued; or any	F 314			4/14/15	

If continuation sheet Page 12 of 38

<u>CENTE</u>	<u>RS FOR MEDICARE</u>	<u>&amp; MEDICAID SERVICES</u>				APPROVE 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED	
		245556	B. WING		03/05/2015		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PRESBY	TERIAN HOMES OF	BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 329	record; and resider drugs receive grad behavioral interver	age 12 documented in the clinical hts who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these	F 329				
	by: Based on observa review the facility fa prescribed antipsyd adequately monitoo medication side eff R155, R18) review use. Findings include: R184 was observe seated in the dining The resident was of resident. Later that observed sitting ca room when she ag Throughout the inter was calm and relats signs of anxiety or wanted to leave du resident spoke to t had been feeling w night without waking	NT is not met as evidenced tion, interview and document ailed to ensure residents chotic medications were red for efficacy and/or fects for 3 of 5 residents (R184, ed for unnecessary medication d on 3/3/15, at 8:27 a.m. while g room eating her breakfast. quietly visiting with another t day at 1:43 p.m. R184 was lmly watching television in her reed to be interviewed. erview the resident's demeanor ked. She did not display any behavior that suggested she rring the 20 minutes the he surveyor. R184 reportedly rell and was sleeping the whole ag.		Residents R184, R155 & R18 s plans were re-assessed and revie the care team for unnecessary me use. All of the three resident s sid effects monitoring tools were revie ensure they each had side-effect monitoring in their medical records of the records indicated daily side monitoring for their psychoactive medications. Records also indical except for R 184, who fairly new to building, attempts to reduce reside psychoactive medications had bee within the last four quarters for the two residents. Ortho Blood Press were conducted for residents R18 and R18 by March 31st, 2015. All residents were audited for com of orthostatic blood pressures as i on 3/6/15. All residents requiring orthostatic blood pressures were conducted and results reviewed for intervention. An immediate action ensure a Point Click Care softward demand for nurses to enter Ortho	wed by edication de ewed to s. Each effect ted that o the ent as en made o ther irres 34, R155 pletion ndicated or further to re		

Facility ID: 00189

If continuation sheet Page 13 of 38

	<u>RS FOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION		<u>0938-039</u> E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
		245556	B. WING _		03/	05/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9889 PENN AVENUE SOUTH		
PRESBY	TERIAN HOMES OF I	BLOOMINGTON				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 329	<ul> <li>6.25 milligrams at binsomnia.</li> <li>R184's admission N 1/28/15, indicated t cognitive impairment unspecified psycho plan dated 2/10/15, behaviors of wander rooms. The plan, h directions for staff t would have warrant potential medication</li> <li>During an interview registered nurse (R observed R184 war explained that she physician, and the p transferred to the lot this, they did not wi resident's medication RN-A confirmed that been used since 1// monitoring R184's bin justification for the of medication nor wer medication side effor</li> <li>R155 reported on 3 walked short distant her room. When shightheadedness, w down again. She s</li> </ul>	dinimum Data Set dated he resident had moderate nt with a diagnosis of sis and anxiety. R184's care directed staff to monitor for ering in the hallway or others nowever, did not include o monitor for behavior that ted antipsychotic use, nor for n side effects. Ton 3/4/15, at 2:47 p.m. the N)-A stated she had not ndering "lately." RN-A had talked to R184's primary blan was for the resident to be ong term care unit. Because of sh to make changes in the on regime until after the move. at although the medication had 22/15, they had not been behaviors to provide continued use of antipsychotic e they monitoring for potential ects.	F 32	9 trigger the nurse to complete the A new process for alerts in the B initiated. Nursing staff were educated on a check Ortho blood pressures mo all residents with psychotropic medications on 3/27/15. The po procedure was reviewed and is of Weekly audits to ensure Orthos are completed will be done week 4weeks and on going to ensure compliance and submitted to QA committee for review. The Clinical Coordinators and C Administrator are responsible fo compliance. Date certain for con is April 14th, 2015.	EMR was need to onthly for licy and current. tatic BPs cly x on-going	

If continuation sheet Page 14 of 38

						<u>). 0938-039</u>	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED	
		245556	B. WING		03	8/05/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE		
PRESBY	TERIAN HOMES OF	BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETIO DATE	
F 329	Physician orders for medications includ 12.5 milligram (mg hallucinations, mirt depression, donep dementia, as well a for high blood pres daily, hydrochlorott 20 mg daily, and hy three times daily. R155's 10/24/14, O for psychotropic dr adverse conseque antipsychotic and a care plan dated 11, depression and reo medications. In ado medications, staff or medication. No orthostatic BPs the Weights and V through 3/4/15, nor Record dated from Side Effects Inform listed "dizziness, lig potential medicatio On 3/5/15, at 10:25 (RN)-C reviewed F verified orthostatic on 12/9/14, after R On 3/5/15, at 11:03 explained that the to a new computer and the staff was fi	or R155 dated 1/8/15, revealed ing quetiapine (antipsychotic) ) at bedtime for dementia with azapine 15 mg at bedtime for ezil 10 mg daily for Lewy Body as the following medications sure (BP): Atenolol 50 mg hiazide 25 mg daily, Lisinopril ydralazine hydrochloride 25 mg Care Area Assessment (CAA) ug use indicated a potential for nces related to the use of antidepressant medication. The /5/14, noted the resident had ceived psychotropic dition to administering those was directed side effects of the had been recorded on either ital Summary dated for 5/3/14 r the Electronic Medication 1/1/15 through 3/5/15. The hation Sheets dated 9/6/14, ghtheadedness or fainting" as	F3	329			

If continuation sheet Page 15 of 38

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	(X3) DAT	E SURVEY
- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COM	IPLETED
	245556	B. WING _		03/05/2015	
ROVIDER OR SUPPLIER					
FERIAN HOMES OF I	BLOOMINGTON		BLOOMINGTON, MN 55431		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETIO DATE
talked to the compa changes. The clinic acknowledged orth completed in 1/15 of reporting light head effects of both psyce medications. R18 was observed seated in the dining (a hospice nurse). If dayroom, and RN-F until she could get a nursing assistant (N resident, but told R gait belt. Instead, th wish to sit any long the resident despite NA returned with th distance leaning to shuffling steps. RN-A reported in an p.m. that R18 had f while trying to get to "We found cups on been toileting she v R18's current care impaired cognition Staff were instructe signs "per protocol" addition, the care p medications as ord side effectsMonite	any regarding initiating cal administrator ostatic BPs had not been or 2/15, despite the resident edness and the potential side chotropic and anti-hypertensive on 3/3/15, at 1:19 p.m. while groom conversing with RN-F R18 wanted to go to the Finstructed the resident to wait someone to assist her. A NA) arrived to assist the 18 to wait until she brought a he resident stated she did not er and stood, as RN-F helped e instruction to wait. When the e gait belt, R18 walked a short the right and with short in interview on 3/2/15, at 4:36 fallen that morning apparently the bathroom. He clarified, the floor, so it may not have was after." plan noted the resident had due to Alzheimer's disease. ed to take the resident's vital ' and physician orders. In lan read, "Administer my ered. Monitor/document for or/record/report to my		29		
	OF DEFICIENCIES F CORRECTION ROVIDER OR SUPPLIER FERIAN HOMES OF I SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pat talked to the compa- changes. The clinic acknowledged orth completed in 1/15 of reporting light head effects of both psyon medications. R18 was observed seated in the dining (a hospice nurse). I dayroom, and RN-F until she could get sinursing assistant (N resident, but told R gait belt. Instead, th wish to sit any long the resident despite NA returned with th distance leaning to shuffling steps. RN-A reported in an p.m. that R18 had f while trying to get to "We found cups on been toileting she v R18's current care impaired cognition Staff were instructed signs "per protocol" addition, the care p medications as ord side effectsMonit physician as neede	IDENTIFICATION NUMBER:         245556         ROVIDER OR SUPPLIER <b>TERIAN HOMES OF BLOOMINGTON</b> SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 15         talked to the company regarding initiating changes. The clinical administrator acknowledged orthostatic BPs had not been completed in 1/15 or 2/15, despite the resident reporting light headedness and the potential side effects of both psychotropic and anti-hypertensive medications.         R18 was observed on 3/3/15, at 1:19 p.m. while seated in the dining room conversing with RN-F (a hospice nurse). R18 wanted to go to the dayroom, and RN-F instructed the resident to wait until she could get someone to assist her. A nursing assistant (NA) arrived to assist the resident, but told R18 to wait until she brought a gait belt. Instead, the resident stated she did not wish to sit any longer and stood, as RN-F helped the resident despite instruction to wait. When the NA returned with the gait belt, R18 walked a short distance leaning to the right and with short shuffling steps.         RN-A reported in an interview on 3/2/15, at 4:36 p.m. that R18 had fallen that morning apparently while trying to get to the bathroom. He clarified, "We found cups on the floor, so it may not have been toileting she was after."         R18's current care plan noted the resident had impaired cognition due to Alzheimer's disease. Staff were instructed to take the resident for side effectsMonitor/record/report to my physician as needed in regards to side effects."	OF DEFICIENCIES F CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULT A. BUILDIN         245556       B. WING	OP DEFICIENCIES       (M) PROVIDERSUPPLIER/CLA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION         A BUILDING	OF DEFICIENCIES       (X1) PROVIDERSUPPLIER/CLAID       (X2) MULTIPLE CONSTRUCTION       (X3) MUTTPLE CONSTRUCTION         A. BUILDING

If continuation sheet Page 16 of 38

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	MB NO. (X3) DATI	E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COM	PLETED
		245556	B. WING _		03/	05/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF	BLOOMINGTON		9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 329	was located in the in During an interview verified R18's ortho routinely measured see orthostatic BPs month. They haven resident has refuse staff would try again reported he was un orthostatic BPs in F should have been t	ation of other orthostatic BPs resident's record. on 3/5/15, at 9:30 a.m., RN-A ostatic BPs were not being I. He stated, "I would expect to s for antipsychotic use every I't been consistent. The ed at times, but I would expect n." At 10:53 a.m. RN-A hable to locate additional R18's record, and stated they aken monthly.	F 32	29		
F 356 SS=C	noted "Each reside from unnecessary of any drug when use monitoredSide ef conducted for all ps For antipsychotic m monitoring will inclu pressure."	otropic Medication Use policy nt's drug regimen must be free drugs. Unnecessary drugs are dWithout adequate fect monitoring will be sychotherapeutic medications. nedication the side effect ude a monthly orthostatic blood	F 35	56		4/14/15
	a daily basis: o Facility name. o The current date. o The total number by the following cat unlicensed nursing resident care per sl - Registered nu - Licensed prace	and the actual hours worked segories of licensed and staff directly responsible for hift: Irses. stical nurses or licensed as defined under State law).				

Facility ID: 00189

If continuation sheet Page 17 of 38

TATEMENT	OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	``'	IPLE CONSTRUCTION		E SURVEY PLETED	
		245556	B. WING				
	PROVIDER OR SUPPLIER		B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	05/2015	
	TERIAN HOMES OF		9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE	
F 356	Continued From p o Resident census	•	F 35	56			
	specified above or of each shift. Data o Clear and reada	lace readily accessible to					
	make nurse staffir	upon oral or written request, ng data available to the public t not to exceed the community					
	staffing data for a	naintain the posted daily nurse minimum of 18 months, or as aw, whichever is greater.					
	by: Based on observa review the facility f reflect the current hours as required.	ENT is not met as evidenced ation, interview and document ailed to post daily staffing to census and actual nursing This had the potential to affect siding in the facility and their		Policy and procedure for updat Nurse Staffing Information was by interdisciplinary team. Policy reviewed and updated to reach compliance. Staffing departme update the required posting at t beginning of the AM and PM sh	reviewed v was nt will he		
	days following 3/3/ Report of Nursing updates in census hours. Although th census and sched in a review on wor	on 3/2/15, at 12:02 p.m. and (15, 3/4/15, and 3/5/15, the Staff was posted without changes as well as in staffing ere were changes in the work ules, these were not reflected k schedules, Daily Census Reports of Nursing Staff dated		reflect accurate census and in H staffing for nursing department corresponding shift and through shift with changes. The NOC I care nurse will be responsible to posting throughout the NOC sh reflect accurate census and in H staffing for nursing department NOC shift. On the weekends, t Weekend manager on duty will	nouse for the nout the ong-term o update ift to nouse for the ne		

Facility ID: 00189

If continuation sheet Page 18 of 38

	RS FOR MEDICARE OF DEFICIENCIES	& MEDICAID SERVICES		י יחוד			0938-039	
				(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245556	B. WING			03/0	05/2015	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
PRESBYTERIAN HOMES OF BLOOMINGTON				98 Bl				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 356	Continued From pa	age 18	F 3	56				
	On 3/5/15, at 10:54 a.m. a staffing coordinator (SC)-B stated she looked at daily staffing on the schedule and counted hours for registered nurses (RNs), licensed practical nurses (LPNs) and nursing assistants (NAs) who were scheduled to work the following day, entered the information into the computer, and posted it on the board. At 10:56 a.m. SC-A repotted she put the next day's schedule with the Report of Nursing Staff on the bulletin board by the time clock, and then the night nurse took the report after midnight and replaced it with the previous one. SC-A verified the information was not revised once it was posted, although changes may have occurred in the census or staffing. "We don't make updates to the census or the hours posted. We have always done it this way. We just make changes on the work schedule."		5		they are not on site. Also, facility has updated the staff posting document to include acknowledgement that the pos has been updated/reviewed each shift indicating time of update and initials of individual who has updated the docum Records will be preserved according to regulation. Posting will be audited daily for a period of 4 weeks and ongoing weekly after that by Clinical Administra or designee. Results reviewed by QA for on-going compliance. Clinical Administrator or designee is responsible for compliance. Date certa for compliance is April 14th, 2015.			
	about the census w midnight. The cens day, but we do not Staff for census cha Report of Nursing S such as filling a RN did happen on 3/1/ with [LPN-C] due to On 3/5/15, at 11:17 residents' families I	tt 11:03 a.m. "When we talk we talk about the census at sus does change during the update the Report of Nursing anges. We do not update the Staff for scheduling changes I shift with a LPN such as what 15, when [RN-H] was replaced to a call in." Y a.m. SC-A stated, "The look at the staffing report and their family member. Families						
	can't tell if the facili is not updated." On 3/5/15, at 1:04 j	p.m. the administrator stated, sing Staff should accurately						

If continuation sheet Page 19 of 38

	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3	NO. 0938-039 DATE SURVEY COMPLETED	
				à		
		245556	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	03/05/2015	
NAME OF PROVIDER OR SUPPLIER PRESBYTERIAN HOMES OF BLOOMINGTON						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETIO DATE	
F 356 F 371 SS=F	reflect our census as of midnight and actual hours of nursing staff scheduled to be worked that day. I have not expected the staffing coordinators to update the posting, partly because of the constant admissions and discharges in the TCU [transitional care unit] census, and because the staffing coordinators have been primarily focused on scheduling and replacements. I have not required the Report of Nursing Staff to be updated." 483.35(i) FOOD PROCURE,		F 356		4/14/15	
	by: Based on observat failed to serve food of 18 residents (R1 R200, R127, R29, I room. In addition, s maintained in unit k food was stored. Th	NT is not met as evidenced tion and interview the facility at proper temperatures for 9 4, R165, R209, R3, R143, R183) in the first floor dining anitary food storage was not titchenettes where resident his had the potential to affect hts residing in the facility.		The staff involved was immediately provided with retraining on practices a policies related to serving food at prop temperatures on the date of the incide The policy and procedure was reviewe and is current. In-services were completed on March 16, 2015 with al culinary services staff re-educated on proper food temperatures, proper procedure on taking accurate food temperatures, proper procedure on wit to do if food does not reach adequate	ver int. ed	

Event ID: PF2411

Facility ID: 00189

If continuation sheet Page 20 of 38

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED	
			A. BUILDIN	NG _				
245556		B. WING			03/05/2015			
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
PRESBYTERIAN HOMES OF BLOOMINGTON			9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE	
F 371	Continued From pa	age 20	F 37	71				
	observed uncoveri of the Cambrose c and placing them in When DA-A check the thermometer to The surveyor instru- temperature in the could have artificia reading. The temp- degrees. DA-A rep on individual pans the veal is warming is less than 140 de on the steam table heat up the food. I get hotter. I have he DA-A then proceed requested turkey v scooped up the las was then checked 122 degrees. Whe next, DA-A answer Surveyor then inter his supervisor befor residents. At 5:33 p DA-A, "We have ta instructed DA-A to with plastic and he for three minutes a again. After rehea 160 degrees. DA-A food. The dietary s mention to our staf	p.m. dietary aide (DA)-A was ng individual pans of food out arts (food transport containers) in the electric steam table. ed the temperature of the veal, buched the bottom of the pan ucted DA-A to measure the middle of the food as this Ily raised the temperature erature registered 130 borted they did not use covers of food. She explained, "While g up I will make saladsIf food grees I usually let it sit longer because the steam table will will serve the veal lastlet it ad to deal with this before." ded to serve residents who ersus veal. At 5:25 p.m. DA-A st turkey to be served. The veal and the temperature registered n asked what he planned to do ed, "I am going to serve it." rvened and suggested notifying ore serving the last nine born. the dietary supervisor told liked about this before," and put the veal on a plate, cover at up the veal in the microwave and then take the temperature ting temperature registered A finished dishing the residents' upervisor then stated, "We do f about how to reheat foods, up the cook for new food."			temperature, and proper procedure transporting the food to each house ensure keeping food at temperature Dietary supervisors will conduct dail audits of all serving kitchens during service to ensure proper procedures followed by observing, checking temperature log books, and taking temperatures of food x 4 weeks and ongoing to ensure compliance. Any variances will be addressed by culin supervisor as needed. Results will I reviewed by QA committee. IDT team reviewed and updated pol related to cleaning procedures for kitchenette refrigerators and microw Daily cleaning tasks were added to culinary servers to clean and sanitiz refrigerators on their household wee Housekeeping staff task lists were updated to include cleaning and sar of microwaves on each household v All staff including culinary, housekee clinical, and therapy provided in-sern not keep staff food or non food prod stored in household refrigerators to completed by 4/10/15. Dietary super will conduct daily audits of househol kitchenette cleanliness x 4 weeks at ongoing. Results reported to QA committee. The Director of Nutrition and Culinar Services or their designee is respon for compliance. Date certain for compliance is April 14th, 2015.	hold to e. ly meal s are d hary be licy vaves. re all ekly. hitizing veekly. eping, vice to lucts be rvisors ld nd		

Facility ID: 00189

If continuation sheet Page 21 of 38

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245556	B. WING _		03/	05/2015
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF	BLOOMINGTON		9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 371	"Sometimes the sta and the food gets of "The food gets colorsteam table." On 3/4/15, at 3:53 explained the staff food covered on th foods did not cool, or asking the cook cooled. Kitchenettes On 3/3/15, from 12 kitchenettes were of dietary director (AE noted: Pathway kitchenette food was noted on as standing water. be cleaned. We clean Arbor kitchenette finsides where ice created stored. The ADD we Bridgeway freezer stored had sticky s crumbs. The ADD we than the other one. the food. The ADD pack away, and sa the residents. She see staff lunch bag	hecked. The cook also stated, aff uncover the food too soon cold."At 6:05 p.m. DA-B added, d when not using covers on the p.m. the dietary director (DD) should have been leaving the e steam tables to ensue hot to heat food in the microwave for a replacement if food had ::59 to 1:31 the unit observed with the assistant DD) and the following was the refrigerator freezer spilled the shelving and doors, as well The ADD stated, It needs to	F 37	71		

If continuation sheet Page 22 of 38

STATEMEN	OF DEFICIENCIES	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
			NG			
		245556	B. WING _		03/	/05/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF I	BLOOMINGTON		9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 371	It contained a blue freezer and was tak cooler. The microw ADD explained, "W schedules. The ser cleaning the unit kit Crossway kitchene crumbs and red spl substance on the d The microwave had substance on the ir On 3/4/15 at 4:21 p constantly training a turnover. The facility's 10/11, Food Temperatures internal cooking ter temperatures of po recorded and moni Staff to ensure safe and holdingFood service. Holding ter degrees F (Fahren Troubleshooting: If degrees F for two call the cook that p back to the kitchen The facility's 2/2/15 policy noted, "Refrig maintained to ensure	are Unit freezer was unclean. gel ice pack was stored in the oled for use in the laboratory vave was also unclean. The 'e have weekly cleaning vers are responsible for tchenettes." tte refrigerator/freezer had latters, and a yellow sticky loor shelf and bottom shelf. d a spilled white food nterior of the door. o.m. the DD stated she was and retraining staff because of Recording and Monitoring s policy indicated, "Minimum nperatures and holding tentially hazardous food will be tored by Nutrition and Culinary e food products during cooking will be: Covered until ready for mperatures: Hot food 145 heit) or higher. the hot food is not at 145 r, You must reheat the food to 15 seconds by the following owaving up on the community, orepared the food to bring food	F 37			

Facility ID: 00189

If continuation sheet Page 23 of 38

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· · /	IPLE CONSTRUCTION		E SURVEY	
NU PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		245556	B. WING _		03/	05/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9889 PENN AVENUE SOUTH			
PRESBY	TERIAN HOMES OF I	BLOOMINGTON		BLOOMINGTON, MN 55431			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETIO DATE	
F 371	Continued From pa	ge 23	F 37	1			
		d by Nutrition and Culinary I side job server cleaning list."					
	staff to ensure "N be maintained to er disinfected and are conditionMicroway	ves will be routinely cleaned by ulinary and/or housekeeper					
F 428 SS=D	IRREGULAR, ACT	of each resident must be	F 42	28		4/14/15	
	pharmacist.	nce a month by a licensed					
	the attending physic	st report any irregularities to cian, and the director of reports must be acted upon.					
		NT is not met as evidenced					
	review the facility fa pharmacist identifie	tion, interview and document alled to ensure the consultant of irregularities for 3 of 5 155, R18) reviewed for ation use.		Residents R184, R155 & R18 s v re-assessed/reviewed by pharmac consultant and the care team for unnecessary medication use. All o three resident s side effect monito tools was reviewed to ensure they	ist f the oring		
	Findings include:			had side-effect monitoring in their Each of the records indicated daily	records. <sup>,</sup> side		
	1/21/15, indicted Se	charge physician orders dated eroquel (antipsychotic illigrams (mg) was initiated for		effect monitoring for their psychoa medications. Records also indicat except for R 184 who fairly new to	ed that		

Facility ID: 00189

If continuation sheet Page 24 of 38

	OF DEFICIENCIES	& MEDICAID SERVICES		ייסו			0938-039 SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:					PLETED	
		245556	B. WING			03/05/2015		
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
PRESBY	TERIAN HOMES OF	BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE	
F 428		-	F 4	28				
	Record (MAR) for t indicated R184 was (antipsychotic med mouth at bed time a diagnosis of "inso R184's admission I dated 1/28/15, india moderate cognitive of unspecified psyc care plan dated 2/1 medication was pre- monitor for behavio or others rooms," b monitoring that wo antipsychotic media side effects. R184's behavior m 2/15 and 3/15, note behaviors of episod others rooms for R for 2/15 revealed F in 3/15, no wanderi Nursing notes from documentation a tr reduction (GDR) of considered. R184' documentation of r review or recomme During an interview registered nurse (F antipsychotic media	Minimum Data Set (MDS) cated the resident had e impairment with a diagnosis chosis and anxiety. R184's 10/15, indicated psychotropic escribed and staff was to ors of "wandering in the hallway out lacked specific behavior uld have warranted the use of cations, as well as for potential onitoring for the months for ed staff was to monitor target des of wandering in hallway or 184. R184's behavior monitor 8184 wandered three times and			building, attempts to reduce resident psychoactive medications had been n within the last four quarters for the oth two residents. The policy and procedure was review and is current. The Pharmacist consu- reviewed all resident records and may recommendations as appropriate. Results of the survey findings were shared with the consultant Pharmaciss who was asked to ensure review of ex- resident s chart monthly per requirements. The pharmacists will re- records monthly for side effect monito and will continue with monthly visits a share his/her recommendations and findings with the care team to ensure unnecessary medications are reviewed all residents. Weekly audits to ensure Orthostatic are completed will be done weekly x 4weeks and on going to ensure on-g compliance. The pharmacist will prov report of all resident to the Clinical administration with a summary of recommendations made. The Clinical Coordinators and Clinica Administrator are responsible for compliance. Date certain for complian- is April 14th, 2015.	made her ved ultant ide st each eview oring and e all ed for BPs going <i>i</i> de a		

If continuation sheet Page 25 of 38

ATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	IPLE CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED	
			A. BUILDIN	NG			
		245556	B. WING			8/05/2015	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
PRESBY	TERIAN HOMES OF	BLOOMINGTON		9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 428	Continued From p	age 25	F 42	28			
	explained that she physician and the	had talked to R185's primary plan was for R184 to be					
ti ru F n h p	this, they did not w resident's medicat	ong term care unit. Because of rish to make changes to the ion regime until after the move. at although the antipsychotic					
	medication had be had not been mon provide justification	en used since 1/22/15, they itoring R184's behaviors to n for the continued use of ications nor for potential					
	medication side ef to R184 care plan effects of antipsyc	fects. RN-A stated she added for staff to monitor for side hotic starting on 3/3/15, after entation was brought to her					
	the consulting pha have expected sta	erview on 3/5/15, at 4:13 p.m. rmacist stated that she would ff to monitor R184's behaviors sident and/or others in danger rs.					
	walked short dista her room. When s lightheadedness, v down again. She	3/4/15, at 10:16 a.m. she nces with her walker outside he stood she felt which resolved when she sat said she had reported it to the n instructed to use her call light					
	medications includ 12.5 milligram (mg hallucinations, mir depression, donep dementia, as well	or R155 dated 1/8/15, revealed ling quetiapine (antipsychotic) g) at bedtime for dementia with tazapine 15 mg at bedtime for bezil 10 mg daily for Lewy Body as the following medications ssure (BP): Atenolol 50 mg					

If continuation sheet Page 26 of 38

		AND HUMAN SERVICES			FORM	04/20/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245556	B. WING		03/	05/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PRESBY	TERIAN HOMES OF I	BLOOMINGTON	-	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 428	Continued From pa three times daily.	.ge 26	F 428			
	for psychotropic dru adverse consequer antipsychotic and a care plan dated 11/ depression and rec medications. In add	are Area Assessment (CAA) ug use indicated a potential for necs related to the use of untidepressant medication. The 5/14, noted the resident had reived psychotropic dition to administering those was directed side effects of the				
	the Weights and Vir through 3/4/15, nor Record dated from Side Effects Inform	had been recorded on either tal Summary dated for 5/3/14 the Electronic Medication 1/1/15 through 3/5/15. The ation Sheets dated 9/6/14, htheadedness or fainting" as n side effects.				
	(RN)-C reviewed R verified orthostatic	a.m. a registered nurse 155's medical record and BPs had only been measured 155 had experienced a fall.				
	explained that the f to a new computer and the staff was fin interventions, such talked to the compa changes. The clinic acknowledged orthic completed in 1/15 of reporting light head effects of both psyce medications.	a.m. the clinical administrator acility had just switched over system the previous month, nding it difficult to read the as orthostatic BPs. They had any regarding initiating cal administrator ostatic BPs had not been or 2/15, despite the resident ledness and the potential side chotropic and anti-hypertensive				

If continuation sheet Page 27 of 38

		& MEDICAID SERVICES	1			0.0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
		245556	B. WING		03/05/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF I	BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 428	consultant pharmad consultant pharmad orthostatic blood pr 5/1/14, last year ex consultant pharmad and R155 should he pressures complete asked if she was av feeling lightheaded pharmacist stated " regarding the blood R18 was observed seated in the dining (a hospice nurse). If dayroom, and RN-F until she could get a nursing assistant (N resident, but told R gait belt. Instead, th wish to sit any long the resident despite NA returned with th distance leaning to shuffling steps. RN-A reported in an p.m. that R18 had f while trying to get to "We found cups on been toileting she v R18's current care impaired cognition Staff were instructe signs "per protocol"	cist (CP)-A. When the cist was informed R155 had no ressure measured since cept after a fall 12/9/14, the cist stated it was an oversight ave had orthostatic blood ed at least quarterly. When ware R155 was reporting ness, the consultant 'I don't have any notations I pressure." on 3/3/15, at 1:19 p.m. while g room conversing with RN-F R18 wanted to go to the F instructed the resident to wait someone to assist her. A NA) arrived to assist the 18 to wait until she brought a ne resident stated she did not er and stood, as RN-F helped e instruction to wait. When the e gait belt, R18 walked a short the right and with short of the bathroom. He clarified, the floor, so it may not have was after." plan noted the resident had due to Alzheimer's disease. ed to take the resident's vital ' and physician orders. In lan read, "Administer my ered. Monitor/document for	F 42	28		

If continuation sheet Page 28 of 38

		AND HUMAN SERVICES			FORM	04/20/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245556	B. WING		03/	05/2015
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF I	BLOOMINGTON		889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	A review of R18's review of R18's review of R18's review of R18's review as located in the resident and the resident has refuse staff would try again reported he was un orthostatic BPs in F should have been to The facility's Psych noted "Each reside from unnecessary of any drug when use monitoredSide eff conducted for all ps For antipsychotic monitoring will inclupressure." The facility's consulting the facility's consulting the facility's consulting the face of the facility's consulting the face of th	d in regards to side effects." ecord revealed orthostatic BPs only for 3/4/15 and 8/2/14. No ation of other orthostatic BPs resident's record. To n 3/5/15, at 9:30 a.m., RN-A static BPs were not being . He stated, "I would expect to a for antipsychotic use every 't been consistent. The d at times, but I would expect n." At 10:53 a.m. RN-A able to locate additional R18's record, and stated they aken monthly. otropic Medication Use policy nt's drug regimen must be free drugs. Unnecessary drugs are dWithout adequate fect monitoring will be sychotherapeutic medications. hedication the side effect ide a monthly orthostatic blood ltant pharmacist (CP)-A was ohone on 3/5/15, at 4:10 p.m. tatic blood pressures were not nonthly, but should have been y, as this was linked to the data gathering. 2/5/15 of R18's monthly reviews by the facility's cist from 7/14 to 3/15 no	F 428			
	consulting pharmad					

If continuation sheet Page 29 of 38

	OF DEFICIENCIES	& MEDICAID SERVICES		LE CONSTRUCTION		. 0938-039 E SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	( )			IPLETED	
		245556	B. WING		03/	/05/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PRESBY	TERIAN HOMES OF	BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 428	regarding the lack	age 29 of orthostatic BPs in R18's	F 428				
F 431 SS=D	record. 483.60(b), (d), (e)   LABEL/STORE DF	DRUG RECORDS, RUGS & BIOLOGICALS	F 431			4/14/15	
	a licensed pharma of records of receip controlled drugs in accurate reconcilia records are in orde	mploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug or and that an account of all maintained and periodically					
	labeled in accordat professional princip appropriate access	als used in the facility must be nee with currently accepted bles, and include the sory and cautionary e expiration date when					
	facility must store a locked compartme	State and Federal laws, the all drugs and biologicals in nts under proper temperature it only authorized personnel to keys.					
	permanently affixed controlled drugs lis Comprehensive Dr Control Act of 1976 abuse, except whe package drug distr	rovide separately locked, d compartments for storage of ted in Schedule II of the rug Abuse Prevention and and other drugs subject to n the facility uses single unit ibution systems in which the ninimal and a missing dose can l.					

Facility ID: 00189

If continuation sheet Page 30 of 38

					NO. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		245556	B. WING		03/05/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9889 PENN AVENUE SOUTH	
PRESBY	TERIAN HOMES OF	BLOOMINGTON			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 431	Continued From pa	age 30	F 43	1	
	This REQUIREME	NT is not met as evidenced			
	review the facility fa medication of insul diabetes) were rem for 1 of 2 residents storage. Findings include: An observation of t system was conduc vial of Lantus labele at room temperatur vial had a handwritt and a handwritten of However, according Lantus vial would h instead of 2/29/15. (LPN)-A and a regis confirmed the Lant have been removed R14's physician ord staff to administer l	tion, interview and document ailed to ensure expired in vials (used to manage noved from the medication cart (R14) reviewed for medication (R14) reviewed for medication he facility's medication storage cted on 3/2/15, at 1:18 p.m. A ed for R14 was stored for use re in the medication cart. The ten opened date of 1/29/15, expiration date of 2/29/15. g to expiration guidelines the lave expired on 2/26/15 A licensed practical nurse stered nurse (RN)-C both us had expired and should d for destruction. ders dated 11/21/15, directed Lantus 100/milliliters 5 units ubquentanious injection. The stration record for the months		Resident R14 □s expired Lantus insulir was immediately removed from the car as soon as the surveyor noticed it. The facility medication error process was followed and completed and the resident □s Nurse Practitioner was updated. Resident was observed for sid effects of using the expired Lantus and none were observed. Family was also updated. Policy and procedure was reviewed and current. Nurses were immediately educated on the medication storage an medication expiration process. Storage Insulins was specifically reviewed and nurses verbalized understanding. Weekly audits to ensure no expired medications are stored in carts and/or reach residents will be done weekly x 4weeks and on going to ensure on-goi compliance. The Clinical Coordinators and Clinical Administrator are responsible for compliance. Date certain for compliance is April 14th, 2015.	t d is d of
F 441 SS=D	A 4/14 Medication S Guidelines policy n room temperature days after the first of	N CONTROL, PREVENT	F 44	1	4/14/15

If continuation sheet Page 31 of 38

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245556	B. WING		03	03/05/2015	
	PROVIDER OR SUPPLIER	BLOOMINGTON		STREET ADDRESS, CITY, STATE, ZIP ( 9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE	
F 441	Continued From pa	age 31	F 4	41			
	Infection Control P safe, sanitary and to help prevent the of disease and infe						
	Program under wh (1) Investigates, co in the facility; (2) Decides what p should be applied t	stablish an Infection Control ich it - ontrols, and prevents infections rocedures, such as isolation, to an individual resident; and ord of incidents and corrective					
	determines that a r prevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will t (3) The facility mus hands after each d	tion Control Program resident needs isolation to of infection, the facility must t. st prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. st require staff to wash their irect resident contact for which dicated by accepted					
		ndle, store, process and as to prevent the spread of					

Facility ID: 00189

If continuation sheet Page 32 of 38

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245556	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	03/0	05/2015
	PROVIDER OR SUPPLIER					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	BLOOMINGTON, MN 55431 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
F 441	by: Based on observa review, the facility infection control m cares for 2 of 2 res for activities of dai pressure ulcer car reviewed for press Findings include: R218 was observe lying in bed. The r she had planned to bathroom, but had assistant (NA)-A re with R218, but was donned gloves and bathroom. R218's and placed in the g notable soaked wi her gloves and wit left the room. NA-/ gloves, and hande her face. She then NA-A then obtaine emptied stool from R218 assisted and R218 continued her gloves and rinsed the colo liquid was remover NA-A's gloves, wh The NA, however,	ENT is not met as evidenced ation, interview and document failed to ensure appropriate easures were used during sidents (R218, R205) reviewed ly living (ADLs), and during e for 1 of 2 residents (R65)	F 44	1 Residents R218, R205 & R65 splans was reviewed by the care to infection control prevention during Initial staff involved were re-educed immediately. Infection control policies and prowere reviewed and are current, all expected to adhere to the infector process during resident of includes washing of hands in bet cares. All staff have been re-educed the need to wash their hands in the cares especially when gloves are changed. Staff have individually audited for this practice during careminded about standard precaustaff are educated on infection coupon hire, with annual compliant weekly Quality Improvement teameetings and as needed. Audits of infection control practice conducted with routine cares and for 10% of residents for 4 weeks results reported to facility QA core to ensure ongoing compliance. Scontinue being educated during Quality Improvement meetings, a with annual training, upon hire are needed for compliance. The Clinical Coordinators, House Coordinators and Clinical Adminia are responsible for compliance.	eam for g cares. sated cedures Staff are oction are that ween ucated on between ares and tions. All botrol se review, m es will be d services and nmittee Staff will weekly annually of as ehold strator Date	

If continuation sheet Page 33 of 38

						). 0938-039	
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED	
		245556	B. WING		03/05/2015		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PRESBY	PRESBYTERIAN HOMES OF BLOOMINGTON			9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 441	pull up her pants. T were again toucher cylinder was clean donned a clean pa seat of spills, and g product and gown tossed on the floor wheelchair handles cup of water, and r brought the soiled upon leaving the ro foam near the door Following the obser reported she was a her hands after ren from soiled to clean she would just was NA-A stated, "I kep much." On 3/4/15, at 8:06 (LPN)-B stated the washed their hands doing. "Like for exa the colostomy bag hands with glove c On 3/5/15, at 10:55 (RN)-C explained t have washed hand donning gloves, an with any bodily fluid received training af when infection con expected the staff hands. RN-C furthe	The handles of the wheelchair d by NA-A. The graduate ed in the bathroom. NA-A then ir of gloves, wiped the toilet gathered the soiled incontinent into plastic bags that were then . NA-A again touched the s, proceeded to bring R218 a nade the bed. NA-A then linens to the utility room, and bom, used the hand sanitizing r. ervations at 8:00 a.m. NA-A aware she should have washed noving her gloves (when going n tasks), but thought instead sh her hands when finished. It changing my glovesit's too a.m. a licensed practical nurse staff were supposed to have s depending on what they were ampleif they were cleaning they are supposed to wash hanges." D a.m. a registered nurse he staff were supposed to ls in between all cares, before id when coming into contact ds. RN-C reported all staff had t orientation, annually, and trol issues arose. She to appropriately wash their er stated the facility had also reminder for staffs' name tags	F 4	41			

Facility ID: 00189

If continuation sheet Page 34 of 38

	OF DEFICIENCIES	KEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:				E SURVEY
				NG		
		245556	B. WING		03/05/2015	
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
PRESBY	TERIAN HOMES OF	BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 441	Continued From pa	age 34	F 4	41		
	Precautions directed be the primary me- transmission of inf hygiene15. Before with personal care resident's mucous excretions; 17. After linens, dressings, I After removing glo R65's dressing cha	ange was observed on 3/14/15,				
	the observation, su placed on a clean table. Packaged su pre-opened for eas change. RN-G as side. She then dor soiled dressing fro wound. Without ch her hands, RN-G to dressing change. on the wound, the protective skin bar skin around the wo	brmed by RN-G. At the start of applies had already been incontinence pad on a bedside applies had not been sy access during the dressing sisted R65 to turn onto the right and gloves to remove the m the resident's buttock banging her gloves and washing began the "clean" part of the Wound cleanser was sprayed skin was dried, and a rier wipe was used to wipe the bund edges. RN-G then				
	soiled gloves, pick used a cotton swal wound bed. This p more times where and again. The sp packed with a rope touching the packi RN-G then chang hand washing prio	poply table, and with the same ed up a tube of ointment, and b to dab the ointment into the rocedure was repeated two RN-G touched the tube again bace of the wound was then e-type packing, which involved ing with the original gloves. ed gloves, but did not perform r to donning a new pair of to the dressing package was				

Facility ID: 00189

If continuation sheet Page 35 of 38

TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY IPLETED	
				NG			
		245556	B. WING _		03/	05/2015	
	PROVIDER OR SUPPLIER	BLOOMINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 441 F 463 SS=D	the dressing, and the the packing and wor a stool smear at the she changed gloves washing before app the resident's anal a with a moist bath w gloves, but did not applied barrier creat During an interview RN-G verified she of any glove changes. surveyors said chan hands were not need dressing change." 483.70(f) RESIDEN ROOMS/TOILET/B The nurses' station resident calls throug from resident room facilities. This REQUIREMEN by: Based on observat failed to ensure call of 6 residents (R33 Findings include: R335's call light wa when tested on 3/2 resident pushed the	used to date the outside of the dressing was applied over bund. RN-G then cleaned away e resident's anus and although s, she did not perform hand olying a skin cream cleanser to area and wiped R65's skin ipe. RN-G then changed perform hand washing, and im to the skin of the buttocks. Ton 3/14/15, at 10:27 a.m. did not wash hands between She stated, "Last year the nging gloves and washing eded during the process of the IT CALL SYSTEM -	F 44		to nurse ired by the for notified by cording to cate that in through	4/14/15	

Facility ID: 00189

If continuation sheet Page 36 of 38

TATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	0938-039 SURVEY PLETED
		245556	B. WING			02/0	)E/001E
NAME OF	PROVIDER OR SUPPLIER	240000			REET ADDRESS, CITY, STATE, ZIP CODE	03/0	)5/2015
	TERIAN HOMES OF E	BLOOMINGTON		98	189 PENN AVENUE SOUTH LOOMINGTON, MN 55431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 463	to activate the light call light did not wor R335's call light wo button was depress seconds. However able to perform the light button for a few her cognition. A reg notified, and also tr the light. RN-D left hand held bell for R for the non-working would put in a work R335's care plan direct light was within read it for assistance. On 3/5/15, at 10:31 was completed. Du (E)-A and (E)-B rep R335's call light wa that when a resider was considered an staff to let the engin either a work order that an engineer wa p.m. and an on-call 24-hours a day. Alt resident's call light for documentation was During the environr also stated he woul	four additional times and the four additional times and the rk. It was discovered that uld work only if the call light sed and held down for a few , R335's tried and was not tasks of holding down the call w seconds to activate it due to gistered nurse (RN)-D was ied unsuccessfully to activate the room and returned with a tasts to use as a replacement call light, and stated she order. evised date of 2/25/15, ent was at risk for falls due to nt and had a history of falls. ted staff to make sure call ch and encourage R335 to use a.m. an environmental tour ring the tour the engineers orted they were unaware s not functioning. E-A stated nt's call light was not working it emergency. E-A expected neers know "right away" by or phone call. E-A explained as in the building until 10:00 engineer until morning though they checked every monthly, no written s kept related to the audits. nental tour the administrator d have expected staff to fill out all down to the engineer if a	F 46	53	transferred within the facility to long care. All call lights checked for pro- functioning. Policy and procedure reviewed rela- ensuring call light functionality. The current call system does initiate a w to nursing desk on every unit if a ba- running low in the call system by identifying Low Battery and the corresponding unit. Each househol equipped with policy related to loss light function which is included in emergency procedure manual. Ca- will be tested monthly by household coordinators or their designee durin household rounds, as well as upon admission and as needed. Call light response will be reviewed Resident Council meetings. Staff w review weekly call light response re and respond to concerns as identif On-going education provided to st timely response at weekly QI. Audits of call light for each unit will conducted to ensure functionality o room. Each room will be tested on week for a period of 4 weeks and co per current procedure of upon adm monthly, and as needed. Care Center Administrator or desig be responsible for compliance. Da certain for compliance is April 14th.	per tted to evarning attery is ld is of call ll lights d ng l at vill eport ied. taff on be f each ce per ongoing ission, nee will te	

If continuation sheet Page 37 of 38

		AND HUMAN SERVICES			FORM	): 04/20/2015 / APPROVED ). 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245556	B. WING _	·····	03	/05/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
PRESBY	TERIAN HOMES OF	BLOOMINGTON		9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 463	On 3/5/15, at 10:55 (RN)-B stated that light not working or hand-held bell to no for assistance. The VisionLink Cal revealed R335 had multiple times each showed the call ligh 7:57 a.m. and not a 31 minutes later wh surveyor observed functioning properly A policy was reques	a.m. a registered nurse she was unaware R335's call that the resident was using a otify nursing staff of the need I Data from 2/23/15 to 3/2/15, been using her call light a day. The data specifically nt was activated on 3/1/15, at activated again until 34 hours, hen on 3/2/15, at 6:28 p.m. the R335's call light was not y.	F 46			

Facility ID: 00189

If continuation sheet Page 38 of 38

CENTERS FOR MEDICARE & MEDICAID SEF	RVICES			1B NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIES IDENTIFICATION		LTIPLE CONSTRUCTION DING 1N - NEW BUILDING	(	(X3) DATE SURVEY COMPLETED
245556	B. WING	B		03/05/2015
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE	, ZIP CODE	
PRESBYTERIAN HOMES OF BLOOMINGTON		9889 PENN AVENUE SOUTH BLOOMINGTON, MN 5543	1	
		PROVIDER'S PLAN		(X5)
(X4) ID SUMMARY STATEMENT OF DEFICIENC PREFIX (EACH DEFICIENCY MUST BE PRECEDED TAG REGULATORY OR LSC IDENTIFYING INFOR	BY FULL PREF	IX (EACH CORRECTIVE A	CTION SHOULD E	BE COMPLETION
K 000 INITIAL COMMENTS	к	000		
FIRE SAFETY		1		
<ul> <li>THE FACILITY'S POC WILL SERVE A ALLEGATION OF COMPLIANCE UP DEPARTMENT'S ACCEPTANCE. YO SIGNATURE AT THE BOTTOM OF T PAGE OF THE CMS-2567 WILL BE UVERIFICATION OF COMPLIANCE.</li> <li>UPON RECEIPT OF AN ACCEPTABLE ON-SITE REVISIT OF YOUR FACILIT CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH REGULATIONS HAS BEEN ATTAINE ACCORDANCE WITH YOUR VERIFIER A Life Safety Code Survey was condured Minnesota Department of Public Safetime of this survey, Presbyterian Hom Bloomington Care Center was found of substantial compliance with the require participation in Medicare/Medicaid at A Subpart 483.70(a), Life Safety from Fi 2000 edition of National Fire Protection Association (NFPA) Standard 101, Lift Code (LSC), Chapter 18 New Health of PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFE DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR</li> </ul>	ON THE DUR HE FIRST JSED AS LE POC, AN TY MAY BE THE D IN CATION. cted by the ty. At the es of not in rements for 42 CFR, ire, and the in e Safety Care.	EP	00	
By email to:				
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRES Electronically Signed	ENTATIVE'S SIGNATURE	TITLE		(X6) DATE 04/02/2015

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

PRINTED: 04/03/2015

D PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 1N - NEW BUILDING	(X3) DATE SURVEY COMPLETED	
		245556	B. WING		03/05/201	
	PROVIDER OR SUPPLIER	BLOOMINGTON	98	TREET ADDRESS, CITY, STATE, ZIP CODE 389 PENN AVENUE SOUTH LOOMINGTON, MN 55431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLE	
K 000	Marian.Whitney@s	-	K 000			
	DEFICIENCY MUS FOLLOWING INFO	T INCLUDE ALL OF THE DRMATION: what has been, or will be, done				
		oposed, completion date.				
	responsible for cor	r title of the person rection and monitoring to ence of the deficiency.				
	Type II(222) constr and is fully fire spri alarm system with rooms, corridors and that is monitored for notification. The fact	g was determined to be of uction. It has a full basement nklered. The facility has a fire smoke detection in resident nd spaces open to the corridor or automatic fire department cility has a capacity of 98 beds of 92 beds at the time of the				
K 076 SS=F	NOT MET as evide	t 42 CFR, Subpart 483.70(a) is enced by: \FETY CODE STANDARD	K 076		4/14/1	
00-r		e and administration areas are lance with NFPA 99, Standards cilities.				
		e locations of greater than				

Facility ID: 00189

PRINTED: 04/03/2015

	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · /	PLE CONSTRUCTION		E SURVEY PLETED
		245556	B. WING		03/0	)5/2015
AME OF F	PROVIDER OR SUPPLIER	110000		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/0	012010
RESBY	TERIAN HOMES OF I	BLOOMINGTON		9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
K 076		ge 2 ted to the outside. NFPA 99	K 076	5		
	Based on observat failed to maintain the in accordance with practice could affect Findings include: During facility tour I PM on 03/05/2015, there was oxygen in shop hair dryer. Fut that the resident whe while on oxygen was resident but an ass This deficient pract	s not met as evidenced by: tion and interview, the facility he medical gas administration NFPA 99. This deficient at all residents.		Upon identification of infraction, administrator immediately informe Beauty Shop staff and resident inv discontinue hair drying while on ox Resident identified was not a facili resident. Administrator met with Salon staff manager on 3/5/15 to re-educate of related to oxygen use in the beaut Salon employees are expected to to policy which states that if reside requires the use of oxygen that the cannot be placed in the proximity drying machine, also to include ha hair dryers. Residents who requir continuous oxygen will be shamp and set only and returned to the household to allow hair to dry. Sa employees will be expected to communicate with household clinit to understand oxygen needs to be the individual. Care Center Salon schedule which is used as commu- of appointments between househol and salon employees has been up to include notification of residents on oxygen. Salon schedule will be retained for a period of one month salon staff to assure compliance Care Center administrator or desig- audit daily salon schedule weekly period of 4 weeks to ensure comp	volved to cygen. ty and on policy y shop. adhere ent ey of a hair ind held e booed lon cal staff odated who are e by gnee will for a	

Facility ID: 00189

If continuation sheet Page 3 of 4

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/03/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 1N - NEW BUILDING	(X3) DATE SURVEY COMPLETED	
		245556	B. WING	-		03/0	05/2015
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF E	×			389 PENN AVENUE SOUTH LOOMINGTON, MN 55431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 076	Continued From pa	ge 3	K	076	for compliance. Date certain for compliance is April 14th, 2015.		
							-
					2		

Event ID: PF2421

Facility ID: 00189

If continuation sheet Page 4 of 4

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Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: March 23, 2015

Mr. Blake Boche, Administrator Presbyterian Homes of Bloomington 9889 Penn Avenue South Bloomington, Minnesota 55431

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5556027

Dear Mr. Boche:

The above facility was surveyed on March 2, 2015 through March 5, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction

Presbyterian Homes of Bloomington March 23, 2015 Page 2

and the Time Period For Correction.

### PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

# THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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

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

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

Please contact me if you have any questions about this electronic notice.

Sincerely,

Ane Klasse

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

Minnesc	ta Department of He	alth			-	_
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00189	B. WING		03/0	5/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF I	31 OOMING LON	IN AVENUE S IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correpursuant to a surver found that the defice herein are not corrected shall with a schedule of f the Minnesota Dep Determination of will corrected requires requirements of the number and MN Ru	hether a violation has been compliance with all a rule provided at the tag ule number indicated below.				
	comply with any of lack of compliance. re-inspection with a result in the assess	ns several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The State delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 04/02/15

STATE FORM

If continuation sheet 1 of 44

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00189			03/	05/2015
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			00/2010
PRESBY	TERIAN HOMES OF		NN AVENUE S NGTON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th	Alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rrected" in the box available for in indicate in the electronic cess, under the heading he date your orders will be electronically submitting to the nent of Health.				
	Department's staff, the following correct Please indicate in y correction that you	3/5/15, surveyors of this , visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, te when they will be completed				
	the State Licensing federal software. Ta	nent of Health is documenting correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "IE statute/rule out of of "Summary Stateme and replaces the "T correction order. The findings which are after the statement evidence by." Follo	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute t, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. AR ON EACH PAGE.				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		00189	B. WING		03/05/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE	
RESBY	TERIAN HOMES OF I	31 OOMINGTON	NN AVENUE NGTON, MN		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE
2 000	Continued From pa	ge 2	2 000		
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.			
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565		4/14/15
		omprehensive plan of care personnel involved in the			
	by: Based on observative review the facility fat followed for 1 of 1 reviews, 1 of 2 resive pressure ulcers, and the second seco	ent is not met as evidenced on, interview and document alled to ensure care plans were esident (R89) reviewed for dents (R205) reviewed for d 1 of 3 residents (R339) es of daily living (ADLs).		Corrected	
	Findings include:				
	resident's call light area so she could l 2/24/15, hospice ca blind. Place my call hands and show m	plan directed staff to clip the to her sweater on the chest ocate it to call for help. A ure also noted, "I am legally light on my gown, guide my e where it isI am at risk for want my call light pinned to my e to reach it easily."	,		
	room on 3/5/15, at knees were bent as	a specialized wheelchair in he 9:22 a.m. The resident's s she lifted her legs up and put in a distressed tone, "Ah,	r		

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00189	B. WING		03/	05/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PRESBY	TERIAN HOMES OF	RLOOMINGTON	NN AVENUE S NGTON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 3	2 565			
	and was wedged b rail, approximately	Il light was behind the resident etween the mattress and bed five feet from her reach. R89 know the location of her call	.,			
	"We clip her call lig NA proceeded to ta the mattress and b upper jacket and th hand. NA-C further well. That is why w NA-C reported R89 used her call light. then stated R89's c	t (NA)-C explained at 9:27 a.m pht on her clothing here," as the ake the call light from between ed rail and clip it to R89's hen place it in the resident's r stated, "She does not see e put the call light in her hand." Was capable of using and A registered nurse (RN)-H call light was always clipped er clothing, as she was legally	•			
		a.m. the director of nursing ights should have been within a all times.	a			
	daily living) availab directed staff to rep hours and as need have the potential f [related to] Decreas pressure ulcers on right sacral area." wounds will heal wi	ck Guide to ADLs (activities of le in the resident's room position the resident every two ed. The care plan noted "I for alteration in skin integrity r/t sed mobility, Incontinence, left buttock, right buttock and The care plan goal read, "My ith out getting infected," and icluded offering repositioning id as needed.				
	6:58 to 10:05 a.m. she was dependen had three Stage IV	busly observed on 3/4/15, from (3 hours, 7 minutes). Although it on staff for repositioning and (full thickness tissue loss with don, or muscle) pressure				

	NT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00189	B. WING		03/	05/2015
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
RESBY	TERIAN HOMES OF	RLOOMINGION	NN AVENUE S NGTON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	age 4	2 565			
		offered or encouraged to uring the observation.				
	usually ate brunch and was provided s stated R205's daily	a.m. RN-J explained R205 at noon, preferring to sleep in, supplements. RN-J further wound care was typically a.m. at the earliest.				
	be repositioned wh	a.m. NA-E stated R205 was to en in bed every two hours, vounds on her buttocks.				
	what time R205 ha answered, "The rep say for last night. U on the night shift at she did not know w repositioned, but th repositioned her be and NA-D verified t noted the time R20 morning. NA-D exp worksheet was how	sked on 3/4/15, at 10:37 a.m. d last been repositioned, NA-E positioning worksheet didn't Isually she is repositioned last a six a.m." RN-J then stated when R205 had last been hat the night staff usually efore leaving for the day. RN-J the night shift staff had not b had been repositioned that plained the repositioning v staff tracked when a resident due for repositioning.				
	supposed to be cor	a.m. NA-C stated R205 was mpeted every two hours and the NA care sheets.				
		p.m. RN-G stated R205 was been repositioned every two her care plan.				
	needed verbal cues The daily report she	ated 2/18/15, indicated R339 s with grooming and bathing. eet dated 3/5/15, indicated vere Tuesday and Saturday				

00189     B. WING     03/05/2015       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     03/05/2015       PRESBYTERIAN HOMES OF BLOOMINGTON     9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431     9889 PENN AVENUE SOUTH (State)       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION (X5)		ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
WHE OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         9889 PENN AVENUE SOUTH       9889 PENN AVENUE SOUTH         PREESBYTERIAN HOMES OF BLOOMINGTON       9889 PENN AVENUE SOUTH         1000000000000000000000000000000000000			00190	-		02/	00/05/0045	
PRESENTERIAN HOMES OF BLOOMINGTON         9889 PENN AVENUE SOUTH BLOOMINGTON, MM 55431           (M) D PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY VILL REGULTORY OR LSC IDENTIFYING INFORMATION)         D PREFIX TAG         PROVIDER'S PLAN OF CORRECTION (EACH OPREFICIENCY TAG         PROVIDER'S PLAN OF CORRECTION (EACH OPREFICIENCY TAG         OWNED CACH OPREFICIENCY TAG         OWNED CACH OPREFICIENCY TAG         OWNED CACH OPREFICIENCY           2 565         Continued From page 5         2 565         2 565           R339 was in her room on Monday 3/2/15, at 3:15 p.m. She was dressed in pajamas, her fingernails were unclean with black debris unclean with black debris were unclean with a daris untimmed and her fingernails still unclean and untrimmed.         A find to tim facial hair: On Wednesday 3/4/15, at 11:10 a.m. R339 was observed in her room wearing pajamas, her facial hairs untrimmed and her fingernails still unclean and untrimmed.         A find the resident's nails were timmed on bath day and facial hair was trimmed with daily cares in the morning. RN-1 also stated the NAS knew resident bath days, as they were indicated on the daily report sheets the NAS carried.         An 3/4/15, at 2:45 p.m. the DON stated she expected staff to follow the resident's care plans.           On Thursday 3/5/15, at 9:39 a.m. Fi339 again lying in bed wearing pajamas. Although her facial hair had been trimmed, she continued to have long, unclean fingernais. The skin on her lower legs and feet was dry and flaky. Her toenalis were thick and long, approximately 1/4 to 1/2 inchni						03/	05/2015	
BLCOMING TON, MR 5431           Organ D PREFIX TAG         SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REDULATORY OR LSCIDENTIFYING INFORMATION)         DB PREFIX TAG         PROVIDER'S PLAN OF CORRECTION (EACH ODRECTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE DEFICIENCY)         OWNER CROSS-REFERENCED TO THE ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE DEFICIENCY)         OWNER CROSS-REFERENCED TO THE ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE DEFICIENCY)         OWNER CROSS-REFERENCED TO THE ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE DEFICIENCY)         OWNER CROSS-REFERENCED TO THE ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE DEFICIENCY)         OWNER CROSS-REFERENCED TO THE ACTION SHOULD THE ACTION SHOULD BE DEFICIENCY)         OWNER CROSS-REFERENCED TO THE ACTION SHOULD THE ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD ATTION TO ACTION SHOULD BE DEFICIENCY)         OWNER CROSS-REFERENCED TO THE ACTION SHOULD ATTION THE ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE DEFICIENCY)         OWNER CROSS-REFERENCED TO THE ACTION SHOULD ATTION THE ACTION SHOULD BE THE ACTION THE ACTION SHOULD ATTION SHOULD ATTION TO THE ACTION THE ACTION AND THE ACTION SHOULD ATTION THE ACTION THE ACTION AND ACTION AND ACTION ATTION THE ACTION AND ACTION AND ACTION AND ACTION AND ACTION THE ACTION AND ACTION AND ACTION AND ACTION AND ACTION AND ACTION THE ACTION AND ACTION AND ACTION AND ACTION AND ACTION AND ACTION THE ACTION AND ACTION AND ACTION AND ACTION AND ACTION AND ACTION THE ACTION AND ACTION AND ACTION AND ACTION AND ACTION AND ACTION THE ACTION AND ACTION AND ACTION AND ACTION AND ACTION AND ACTION THE ACTION AND ACTION AND ACTION AND ACTION AND ACTION AND ACTION AND ACTION THE ACTION AND ACTION AND ACTION AND ACTION			9889 PFI					
PREFIX TAG       IEACH CORPERIDENCY MUST BE PRECEDED BY FULL PRECIVE ACTIONS HOULD BE CROSS-REFERENCE TO THE APPROPRIATE       COMMAE DEFICIENCY         2 565       Continued From page 5       2 565         R339 was in her room on Monday 3/2/15, at 3:15 p.m. She was dressed in pajamas, her fingernalis were unclean with black debris underneath the nails and were untrimmed varying in length 3/4 to 1 inch long. In addition R339 had untrimmed facial hair approximately one inch in length. R339 stated she needed staff's assistance for nail care and to trim facial hair. On Wednesday 3/4/15, at 11:10 a.m. R339 was observed in her room wearing pajamas, her facial hairs untrimmed and her fingernalis still unclean and untrimmed.         On 3/4/15, at 11:22 a.m. a registered nurse (RN)-I stated the residents' nails were timmed on bath day and facial hair was trimmed with daily cares in the morning. RN-I also stated the NAS knew resident bath days, as they were indicated on the daily report sheets the NAs carried.         On 13/4/15, at 2:45 p.m. the DON stated she expected staff to follow the residents' care plans.         On Thrursday 3/5/15, at 9:39 a.m. R339 again lying in bed wearing pajamas. Although her facial hair had been trimmed, she continued to have long, unclean fingernalis. The skin on her lower legs and feet was dry and flaky. Her toenalis were thick and long, approximately 1/4 to 1/2 inch in length. R339 reported she needed help with toenall trimming.         The facility's 6/14, Resident Care Plan policy indicated staff were to communicate information in resident care, and to "list preventative measures."         SUGGESTED METHOD OF CORRECTION:	RESBY	TERIAN HOMES OF I	BLOOMINGTON BLOOMI	NGTON, MN 5	5431			
<ul> <li>R339 was in her room on Monday 3/2/15, at 3:15 p.m. She was dressed in pajamas, her fingernails were unclean with black debris underneath the nails and were untrimmed varying in length 3/4 to 1 inch long. In addition R339 had untrimmed facial hair approximately one inch in length. R339 stated she needed staff's assistance for nail care and to trim facial hair. On Wednesday 3/4/15, at 11:10 a.m. R339 was observed in her room wearing pajamas, her facial hairs untrimmed and her fingernails still unclean and untrimmed.</li> <li>On 3/4/15, at 11:22 a.m. a registered nurse (RN)-I stated the residents' nails were trimmed on bath day and facial hair was trimmed with daily cares in the morning. RN-I also stated the NAS knew resident bath days, as they were indicated on the daily report sheets the NAs carried.</li> <li>On 3/4/15, at 2:45 p.m. the DON stated she expected staff to follow the residents' care plans.</li> <li>On Thursday 3/5/15, at 9:39 a.m. R339 again lying in bed wearing pajamas. Although her facial hair had been trimmed, she continued to have long, unclean fingernais. The skin on her lower legs and feet was dry and flaky. Her toenails were thick and long, approximately 1/4 to 1/2 inch in length. R339 reported she needed help with toenail trimming.</li> <li>The facility's 6/14, Resident Care Plan policy indicated staff were to communicate information in resident care, and to "list preventative measures."</li> <li>SUGGESTED METHOD OF CORRECTION:</li> </ul>	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	COMPLET	
<ul> <li>p.m. She was dressed in pajamas, her fingernails were unclean with black debris underneath the nails and were untrimmed varying in length 3/4 to 1 inch long. In addition R339 had untrimmed facial hair approximately one inch in length. R339 stated she needed staff's assistance for nail care and to trim facial hair. On Wednesday 3/4/15, at 11:10 a.m. R339 was observed in her room wearing pajamas, her facial hairs untrimmed and her fingernails still unclean and untrimmed.</li> <li>On 3/4/15, at 11:22 a.m. a registered nurse (RN)-I stated the residents' nails were trimmed on bath day and facial hair was trimmed with daily cares in the morning. RN-I also stated the NAS knew resident bath days, as they were indicated on the daily report sheets the NAS carried.</li> <li>On 3/4/15, at 2:45 p.m. the DON stated she expected staff to follow the residents' care plans.</li> <li>On Thursday 3/5/15, at 9:39 a.m. R339 again lying in bed wearing pajamas. Although her facial hair was dry and flaky. Her toenails were thick and long, approximately 1/4 to 1/2 inch in length. R339 reported she needed help with toenail trimming.</li> <li>The facility's 6/14. Resident Care Plan policy indicated staff were to communicate information in resident care, and to "list preventative measures."</li> <li>SUGGESTED METHOD OF CORRECTION:</li> </ul>	2 565	Continued From pa	ge 5	2 565				
ensure policies and procedures address		p.m. She was dress were unclean with a nails and were untr 1 inch long. In addit facial hair approxim stated she needed and to trim facial hai 11:10 a.m. R339 wa wearing pajamas, r her fingernails still u On 3/4/15, at 11:22 stated the residents day and facial hair in the morning. RN resident bath days, daily report sheets On 3/4/15, at 2:45 p expected staff to fo On Thursday 3/5/18 lying in bed wearing hair had been trimm long, unclean fingel legs and feet was d were thick and long in length. R339 rep toenail trimming. The facility's 6/14, F indicated staff were in resident care pla resident care, and t SUGGESTED MET The director of nurs	sed in pajamas, her fingernails black debris underneath the immed varying in length 3/4 to tion R339 had untrimmed hately one inch in length. R339 staff's assistance for nail care air. On Wednesday 3/4/15, at as observed in her room her facial hairs untrimmed and unclean and untrimmed. a.m. a registered nurse (RN)- 5' nails were trimmed on bath was trimmed with daily cares I-I also stated the NAS knew as they were indicated on the the NAs carried. b.m. the DON stated she llow the residents' care plans. 5, at 9:39 a.m. R339 again g pajamas. Although her facia ned, she continued to have rnails. The skin on her lower lry and flaky. Her toenails g, approximately 1/4 to 1/2 inch borted she needed help with Resident Care Plan policy e to communicate information ns to all staff providing direct to "list preventative measures."					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X:	3) DATE SURVEY COMPLETED
		00189	B. WING		03/05/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
PRESBY	TERIAN HOMES OF I	RLOOMINGTON	NN AVENUE NGTON, MN		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
2 565	Continued From pa	ige 6	2 565		
	Appropriate staff co tool could be develo audits could be bro for review.	e care plans are followed. buld be trained. An auditing oped and the results of those ught to the quality committee			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one			
2 850	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 2 D Adequate and re; Shaving	2 850		4/14/15
	proper care. The c adequate and prop D. Assistance	or determining adequate and criteria for determining er care include: with or supervision of shaving necessary to keep them clean			
	by: Based on observati review the facility fa	ent is not met as evidenced ion, interview and document ailed to provide grooming 3 residents (R339) reviewed 7 living (ADLs).		Completed	
	Findings include:				
	p.m. She had untrir one inch in length. staff's assistance to Wednesday 3/4/15	om on Monday 3/2/15, at 3:15 nmed facial hair approximately R339 stated she needed o trim facial hair. On , at 11:10 a.m. R339 was I hair continued untrimmed.	,		
		a.m. a registered nurse (RN)-l as trimmed with daily cares in			

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		00189	B. WING		03/	05/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PRESBY	TERIAN HOMES OF	RLOOMINGTON	NN AVENUE SO NGTON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 850	Continued From pa	age 7	2 850			
	needed verbal cues admission Minimur 2/25/15, indicated I The MDS as well a Assessment dated	ated 2/18/15, indicated R339 s with grooming. The n Data Set (MDS) dated R339 was cognitively intact. s the corresponding Care Area 3/3/15, indicated the resident assist with personal hygiene.	a			
		a.m. the director of nursing d residents to be groomed d.				
	staff as follows: "E	esident Care policy directed Every resident to have A.M. and a done dailyShave residents	I			
	The director of nurse ensure policies and measures to ensure appropriately each be trained. An audi	THOD OF CORRECTION: sing (DON) or designee could d procedures address e residents are groomed day. Appropriate staff could ting tool could be developed hose audits could be brought nittee for review.				
	TIME PERIOD FO (14) days.	R CORRECTION: Fourteen				
2 860	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 2 F. Adequate and re; Hands-Feet	2 860			4/14/15
	proper care. The c adequate and prop E. per care and at	or determining adequate and criteria for determining per care include: tention to hands and feet. enails must be kept clean and				

STATE FORM

PF2411

If continuation sheet 8 of 44

Minnesc	ta Department of He	alth	-			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMPI	
		00189	B. WING		03/0	5/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF I	RLOOMINGTON	NN AVENUE S NGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 860	Continued From pa	ge 8	2 860			
	by: Based on observati review the facility fa	ent is not met as evidenced ion, interview and document ailed to provide grooming 3 residents (R339) reviewed 7 living (ADLs).		Corrected		
	Findings include:					
	p.m. Her fingernails debris underneath t varying in length 3/4 she needed staff's Wednesday 3/4/15,	om on Monday 3/2/15, at 3:15 s were unclean with black the nails and were untrimmed 4 to 1 inch long. R339 stated assistance for nail care. On , at 11:10 a.m. R339 was om and her fingernails still med.				
	stated the residents day and facial hair in the morning. RN assistants (NAs) kr they were indicated NAs carried.	a.m. a registered nurse (RN)-I s' nails were trimmed on bath was trimmed with daily cares I-I also stated the nursing new resident bath days, as I on the daily report sheets the				
	again observed with toenails were thick	5, at 9:39 a.m. R339 was h long, unclean fingernails. Her and long, approximately 1/4 to R339 reported she needed mming.				
Minnocoto D	needed verbal cues assistance with bat Data Set (MDS) da was cognitively inta	ated 2/18/15, indicated R339 s with grooming, and needed hing. The admission Minimum ted 2/25/15, indicated R339 ct. The MDS as well as the e Area Assessment dated				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00189	B. WING		03/	05/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PRESBY	TERIAN HOMES OF	RLOOMINGION	NN AVENUE S NGTON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 860	Continued From pa	ige 9	2 860			
	assist with persona bathing. The daily r	e resident required extensive I hygiene and partial help with eport sheet dated 3/5/15, ath days were Tuesday and				
		a.m. the director of nursing d residents to be groomed d.				
		esident Care policy directed very resident to have A.M. and done daily."				
	The director of nurse ensure policies and measures to ensure residents on bath d nails are trimmed a could be trained. And developed and the	THOD OF CORRECTION: sing (DON) or designee could d procedures address e nail care is provided to lays and as needed to ensure and cleaned. Appropriate staff n auditing tool could be results of those audits could uality committee for review.	F			
	TIME PERIOD FOI (14) days.	R CORRECTION: Fourteen				
2 905	MN Rule 4658.052	5 Subp. 4 Rehab - Positioning	2 905			4/14/15
	positioned in good of residents unable must be changed a including periods of been put to bed for has documented th hours during this tir	ng. Residents must be body alignment. The position to change their own position at least every two hours, f time after the resident has the night, unless the physiciar nat repositioning every two me period is unnecessary or ordered a different interval.	n			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED	
		00189	B. WING		03/	03/05/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	03/03/201		
RESBY	TERIAN HOMES OF	RI OOMINGTON					
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLE	
PREFIX TAG		-SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE	
2 905	Continued From pa	age 10	2 905				
	•	ent is not met as evidenced					
	by: Bacad on obconvat	tion, interview and document		Corrected			
		ailed to ensure appropriate		Corrected			
	care and treatment to promote healing of						
	pressure ulcers for reviewed for press	<sup>·</sup> 1 of 2 residents (R205) ure ulcers.					
	Findings include:						
	R205 was continuo	ously observed on 3/4/15, from					
	6:58 to 10:05 a.m.	(3 hours, 7 minutes). Although	1				
		it on staff for repositioning and (full thickness tissue loss with					
		don, or muscle) pressure					
	ulcers she was not	offered or encouraged to					
	change positions d	luring the observation.					
	On 3/4/15, at 6:58	a.m. R205 was lying on her					
	back and slightly to	the left side. A pillow was					
		de of the resident, and the					
		) was slightly elevated. At 7:40 Jurse (RN)-J entered R205's					
		RN-J to adjust her pillow.					
		pillow and raised the HOB					
	<b>e</b> ,	asked whether she was					
		ain. Her medications and an histered, and then the HOB wa	۹				
		no time did RN-J suggest					
		05 a.m. R205 used her call					
	<b>e</b> .	d lip balm. At 9:30 a.m. the					
		ursing assistant if she would eturn to R205's room, as the					
		o question the resident's need					
	for repositioning. A	t 9:59 a.m. RN-J was observe					
		205's room, when the surveyor					
		ormed RN-J R205 had not At 10:01 a.m. NA-D and RN-J					
		om. R205 was lying nearly flat					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		00189	B. WING		03/	05/2015			
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	00/00/2010				
RESBY	TERIAN HOMES OF	RLOOMINGTON	NN AVENUE S NGTON, MN 5						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE			
2 905	Continued From pa	age 11	2 905						
	R205 stated, "I like sides, but not my s removed the soiled buttocks. The resid Greenish-red drain dressings, and red second dressing. T was reddened in co around the wounds left indentations in 10:18 a.m. the resi reddened. NA-D as resident should hav proceeded to positi her back and slight either side of the re was on her right sid minutes during the returned to the san at least three hours								
	usually ate brunch and was provided s stated R205's daily	a.m. RN-J explained R205 at noon, preferring to sleep in, supplements. RN-J further wound care was typically a.m. at the earliest.							
	be repositioned wh because she had w also stated the resi and she had never repositioning and in	a.m. NA-E stated R205 was to en in bed every two hours, vounds on her buttocks. NA-E ident allowed repositioning, known R205 to refuse n fact liked to be repositioned. e likes to stay on the same							
		sked on 3/4/15, at 10:37 a.m. d last been repositioned, NA-D	)						

		Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00189	B. WING		03/	05/2015
IAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
RESBY	TERIAN HOMES OF I	RLOOMINGTON	NN AVENUE SC NGTON, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 905	answered, "The rep say for last night. U on the night shift at she did not know w repositioned, but th repositioned her be and NA-D verified t noted the time R20 morning. NA-D exp worksheet was how had been and was On 3/4/15, at 10:56 to sleep late and wa repositioned, which competed every two with the NA care sh On 3/4/15, at 2:58 p supposed to have b hours according to R205's significant of (MDS) dated 12/3/1 cognitively intact, re staff for bed mobilit not exhibited. R205's 2/1/15, Quid daily living) availabl directed staff to rep hours and as neede have the potential f [related to] Decreas pressure ulcers on	positioning worksheet didn't sually she is repositioned last six a.m." RN-J then stated hen R205 had last been at the night staff usually fore leaving for the day. RN-J he night shift staff had not 5 had been repositioned that lained the repositioning v staff tracked when a resident due for repositioning. a.m. NA-C stated R205 liked as "always okay" with being was supposed to be o hours and was consistent neets.				

CALL       CALL		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00189	B. WING		03/	05/2015
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
PRESBY	TERIAN HOMES OF	BLOOMINGION	NN AVENUE SO NGTON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 905	Continued From pa	age 13	2 905			
	stated she expecte	p.m. the director of nursing d staff to follow the residents' pdate and revise the plans as				
	the policy of Presby identify, assess and clinical conditions in skin integrity, and p preventative measu appropriate treatme according industry ambulation, activity toleratedEstablish	Skin Risk Policy noted, "It is yterian Homes to properly d monitor residents whose ncrease the risk for impaired pressure ulcers; to implement ures; and to provide ent modalities for ulcers standards of careEncourage y, and mobility as h an individualized turning and dule if the resident is				
	The director of nurse ensure policies and measures to ensure needed. Those ide of developing press and those plans are repositioning needs trained. An auditing	THOD OF CORRECTION: sing (DON) or designee could d procedures address e residents are repositioned as entified as having or are at risk sure ulcers have plans in place e followed for individualized s. Appropriate staff could be g tool could be developed and e audits could be brought to the or review.	•			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21015	MN Rule 4658.061 Requirements- Sa	0 Subp. 7 Dietary Staff nitary conditi	21015			4/14/15
	procedures and co	conditions. Sanitary nditions must be maintained in e dietary department at all				

STATE FORM

PF2411

If continuation sheet 14 of 44

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	
		00189	B. WING		03/0	5/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF I	RECOMINGTON	IN AVENUE S IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21015	Continued From pa	ge 14	21015			
	times.					
	This MN Requiremous	ent is not met as evidenced				
	Based on observati	on and interview the facility		Corrected		
		itary food storage was itchenettes where resident				
		his had the potential to affect				
	91 of the 92 resider	nts residing in the facility.				
	Findings include:					
		59 to 1:31 the unit bserved with the assistant D) and the following was				
	food was noted on	e refrigerator freezer spilled the shelving and doors, as well The ADD stated, It needs to an weekly."				
	sides where ice cre	eezer had splatters on the am and french toast was erified it needed cleaning.				
	stored had sticky sp crumbs. The ADD than the other one. the food. The ADD pack away, and sai the residents. She see staff lunch bag	where resident food was bills on the shelving and stated, "This is much cleaner ' An ice pack was stored with said she would throw the ice d it was likely used for one of also added, "Sometimes will s in the refrigerator." In wave was not clean.				
		re Unit freezer was unclean. gel ice pack was stored in the				
	freezer and was tak	bled for use in the laboratory				
Minnesota D	epartment of Health					

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
001		00189	B. WING			05/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PRESBY	TERIAN HOMES OF	RI OOMING I ON	NN AVENUE S NGTON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21015	Continued From pa	age 15	21015			
	ADD explained, "W	vave was also unclean. The /e have weekly cleaning rvers are responsible for tchenettes."				
	crumbs and red sp substance on the c	ette refrigerator/freezer had latters, and a yellow sticky loor shelf and bottom shelf. d a spilled white food nterior of the door.				
		o.m. the DD stated she was and retraining staff because of				
	policy noted, "Refri maintained to ensu cleaned/sanitized a conditionCommu be routinely cleane	5 Community Refrigerators igerators in the Care Center be ure they are routinely and are in safe working unity Kitchen Refrigerators will d by Nutrition and Culinary M side job server cleaning list.				
	staff to ensure "N be maintained to e disinfected and are conditionMicrowa	ves will be routinely cleaned by ulinary and/or housekeeper				
	The registered diet could ensure polici and appropriate sta and freezers in kitc on a more frequent followed. Random	THOD OF CORRECTION: titian and food service director es and procedures are in place aff are trained. Refrigerators chenettes could be monitored t basis to ensure policies are audits could be conducted he audits reported to the	9			

STATE FORM

6899

PF2411

If continuation sheet 16 of 44

	Ita Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (	X3) DATE SURVEY COMPLETED
		00189	B. WING		03/05/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
PRESBY	TERIAN HOMES OF E		N AVENUE : NGTON, MN		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET
21015	Continued From pa	ge 16	21015		
	TIME PERIOD FOF (14) days.	R CORRECTION: Fourteen			
21025	MN Rule 4658.0615	5 Food Temperatures	21025		4/14/15
	40 degrees Fahren or below, or 150 de centigrade) or abov food" means any fo and temperature co	us food must be maintained at heit (four degrees centigrade) grees Fahrenheit (66 degrees re. "Potentially hazardous od subject to continuous time ontrols in order to prevent the ve growth of infectious or unisms.			
	by: Based on observati failed to serve food of 18 residents (R1	ent is not met as evidenced on and interview the facility at proper temperatures for 9 4, R165, R209, R3, R143, R183) in the first floor dining		Corrected	
	Findings include:				
	observed uncovering of the Cambrose car and placing them in When DA-A checked the thermometer to The surveyor instruct temperature in the in could have artificial reading. The temper degrees. DA-A rep- on individual pans c	b.m. dietary aide (DA)-A was ag individual pans of food out arts (food transport containers) the electric steam table. ed the temperature of the veal, uched the bottom of the pan cted DA-A to measure the middle of the food as this ly raised the temperature erature registered 130 orted they did not use covers of food. She explained, "While up I will make saladsIf food			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			- (X3) DATE SURVEY COMPLETED - 03/05/2015	
		00189	B. WING			
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
RESBY	TERIAN HOMES OF	RLOOMINGTON	NN AVENUE SO NGTON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21025	Continued From pa	age 17	21025			
	heat up the food. I get hotter. I have h DA-A then proceed requested turkey version scooped up the las was then checked 122 degrees. When next, DA-A answer Surveyor then inter his supervisor befor residents. At 5:33 p DA-A, "We have ta instructed DA-A to with plastic and heat for three minutes a again. After reheat 160 degrees. DA-A food. The dietary st mention to our staf and if need be call At 6:01 p.m. in the first floor food was	because the steam table will will serve the veal lastlet it ad to deal with this before." led to serve residents who ersus veal. At 5:25 p.m. DA-A it turkey to be served. The veal and the temperature registered in asked what he planned to do ed, "I am going to serve it." vened and suggested notifying re serving the last nine b.m. the dietary supervisor told lked about this before," and put the veal on a plate, cover at up the veal in the microwave ind then take the temperature ting temperature registered in finished dishing the residents' upervisor then stated, "We do f about how to reheat foods, up the cook for new food." kitchen the cook stated the hot earlier when the hecked. The cook also stated.				
	"Sometimes the sta and the food gets of	hecked. The cook also stated, aff uncover the food too soon cold."At 6:05 p.m. DA-B added, d when not using covers on the				
	explained the staff food covered on the foods did not cool,	p.m. the dietary director (DD) should have been leaving the e steam tables to ensue hot to heat food in the microwave for a replacement if food had				
		o.m. the DD stated she was and retraining staff because of				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		(X3) DATE SU COMPLE		
		00189	B. WING		03/	/05/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
RESBY	TERIAN HOMES OF	RLOOMINGTON	NN AVENUE S NGTON, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21025	Continued From pa	age 18	21025				
	Food Temperatures internal cooking ter temperatures of por recorded and moni Staff to ensure safe and holdingFood service. Holding ter degrees F (Fahren Troubleshooting: If degrees F or highe 165 degrees F for two methods: Micro	the hot food is not at 145 er, You must reheat the food to 15 seconds by the following owaving up on the community, prepared the food to bring food	, 1 r				
	The registered diet could ensure polici and appropriate sta records could be m reviewed. Random staff at meal servic reported to the qua	THOD OF CORRECTION: itian and food service director es and procedures are in place aff are trained. Temperature nonitored and the results n audits could be conducted of the and the results of the audits ality committee. R CORRECTION: Fourteen					
	(14) days.						
21390	Subp. 4. Policies control program m procedures which p A. surveillance collection to identify residents;	0 Subp. 4 A-I Infection Control and procedures. The infectior ust include policies and provide for the following: based on systematic data y nosocomial infections in r detection, investigation, and				4/14/15	

STATE FORM

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00189	B. WING		03/05/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF I	RLOOMINGTON	NN AVENUE NGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE
21390	Continued From pa	ge 19 d precautions systems to	21390			
	reduce risk of trans D. in-service en prevention and com E. a resident h immunization progr defined in part 465 procedures of resid the prevention and F. the develop employee health po practices, including defined in part 4658 G. a system for H. a system for products which affe disinfectants, antise incontinence produ I. methods for	emission of infectious agents; ducation in infection trol; ealth program including an ram, a tuberculosis program as i8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of plicies and infection control a tuberculosis program as 8.0815; r reviewing antibiotic use; r review and evaluation of ect infection control, such as eptics, gloves, and				
	by: Based on observati review, the facility f infection control me cares for 2 of 2 res for activities of daily	ent is not met as evidenced ion, interview and document ailed to ensure appropriate easures were used during idents (R218, R205) reviewed v living (ADLs), and during of for 1 of 2 residents (R65) ure ulcers.		Corrected		
	Findings include:					
	lying in bed. The re she had planned to bathroom, but had assistant (NA)-A re	d on 3/4/15, at 7:18 a.m. while sident informed the surveyor get out of bed and use the not made it in time. A nursing ported she had never worked "filling in" until 8:00. NA-A				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00189	B. WING		03/	05/2015
AME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
PRESRY	TERIAN HOMES OF I	BLOOMINGTON	IN AVENUE SC			
ILOD I		BLOOMIN	NGTON, MN 5	5431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21390	Continued From pa	ige 20	21390			
	bathroom. R218's in and placed in the g notable soaked with her gloves and with left the room. NA-A gloves, and handed her face. She then NA-A then obtained emptied stool from R218 assisted and R218 continued hol removed her gloves and rinsed the colo liquid was removed NA-A's gloves, which The NA, however, of finished assisting th cares. She instead proceeded to look i assisted the residen her to pull up her pay wheelchair were ag graduate cylinder w NA-A then donned the toilet seat of spi incontinent product that were then toss touched the wheelch bring R218 a cup o NA-A then brought room, and upon lead sanitizing foam nead Following the obser reported she was a her hands after rem from soiled to clear she would just was	assisted R218 to the ncontinent brief was removed arbage can. The brief was h urine. NA-A then removed nout performing hand washing returned with a brief, applied d R218 a wash cloth to wash assisted the resident to dress. d a graduate cylinder and R218's colostomy bag as provided instruction. While lding the graduate, NA-A s, obtained water in a syringe stomy bag. Greenish colored I from the bag and spilled onto ch she changed periodically. did not wash her hands when he resident with colostomy donned clean gloves and n R218's closet. NA-A then nt with pericare, and assisted ants. The handles of the yain touched by NA-A. The <i>v</i> as cleaned in the bathroom. a clean pair of gloves, wiped ills, and gathered the soiled and gown into plastic bags ed on the floor. NA-A again chair handles, proceeded to f water, and made the bed. the soiled linens to the utility aving the room, used the hand ar the door.				

STATEMEN	Ita Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00189	B. WING		03/	05/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
PRESBY	TERIAN HOMES OF	RLOOMINGTON	N AVENUE SONGTON, MN 5			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI		(X5) COMPLET
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	DATE
21390	Continued From pa	age 21	21390			
	much."					
	(LPN)-B stated the washed their hands doing. "Like for exa the colostomy bag hands with glove ch On 3/5/15, at 10:59 (RN)-C explained th have washed hand donning gloves, an with any bodily fluic received training at when infection cont expected the staff th hands. RN-C further	a.m. a registered nurse he staff were supposed to s in between all cares, before d when coming into contact ds. RN-C reported all staff had corientation, annually, and trol issues arose. She to appropriately wash their er stated the facility had also reminder for staffs' name tags				
	Precautions directed be the primary mea transmission of infe hygiene15. Befor with personal care. resident's mucous excretions; 17. After linens, dressings, b After removing glow					
	The director of nurse control nurse could procedures are cor practice for infectio could be trained on when to change glo	THOD OF CORRECTION: sing (DON) and infection ensure policies and nsistent with standards of n control. Appropriate staff when to utilize gloves and oves and perform hand ng tool could be developed and				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00189	B. WING		03/05/2015	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF	RECOMINGERON	N AVENUE : IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
21390	Continued From pa	ige 22	21390			
	the results of those quality committee f	audits could be brought to the or review.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			4/14/15
	maintain a compreh infection control pro- current tuberculosis issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implement	e provider must establish and hensive tuberculosis ogram according to the most is infection control guidelines d States Centers for Disease ation (CDC), Division of hation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of the technical assistance intation of the guidelines.				
	by: Based of observation review, the facility for baseline tuberculos residents (R341, R	ent is not met as evidenced on, interview and document ailed to ensure required sis (TB) screening for 2 of 5 344) within 72 hours of months prior to admission to		Corrected		

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00189	B. WING		03/	05/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PRESBY	TERIAN HOMES OF	RLOOMINGTON	NN AVENUE S NGTON, MN 5			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21426	Continued From pa	age 23	21426			
	the facility.					
	Findings include:					
	medical record revelopment been completed on Review of the hosp Summary dated 2/2 had a chest X-ray of stay on 2/17/15, du	to the facility on 2/24/15. The ealed the TB Screening had the date of admission. bital discharge After Visit 24/15, it was revealed R341 completed during the hospital te to acute congestive heart guestionable aspiration				
	stated R341 had re been communicate RN-B showed the s signature. RN-B fur resident had a ches not show any conce X-ray as evidence however, acknowle	a.m. a registered nurse (RN)-E efused testing, and this had ed to the resident's physician. surveyor the physician's rther stated sometimes if a st X-ray completed which did erns in his lungs, they used the of TB screening. RN-B, edged the X-ray had not been sician to rule out active				
	the facility. The me screening had been admission. Review "Consent Refused" hospital discharge Notes History and I revealed R344 had during the hospital review it was revea both the nurse prace 2/19/15, 2/2/26/15,	to the facility on 2/17/15 to dical record revealed the TB n completed on the date of Immunization record indicated for TB 2-Step skin test. The Interagency Transfer Form Physical dated 2/16/15, I a chest X-ray completed stay. During further document iled R344 had been seen by ctitioner and the physician on 2/27/15, and 3/2/15. However it had not been documented				

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
	00189	B. WING		03/	03/05/2015	
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
TERIAN HOMES OF	RI OOMING I ON					
(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE	(X5) COMPLET DATE	
Continued From pa	age 24	21426				
from active infectio	us disease.					
not received tuberc instead the chest X resident's admissic out TB as chest X- Skin Test (TST) as should have been in declined TST and t to her attention. On 3/5/15, at 11:44 (CA) explained res upon admission an were educated and X-rays. They obtai had the physician r active TB. The CA expected the staff t	culin testing as required, citing (-ray from prior to the on. RN-B cited means of ruling ray, blood test or Tuberculin options. R344's physician was notified that the resident had the issue had not been brough a a.m. clinical administrator idents were offered the TST id if they refused the residents to the facility asked for past ined a copy of the X-ray and review the results to rule out further stated she would have to have ensured a resident's	5				
"Each resident beir facility will receive a an assessment of t and any current TE intradermal tubercu administered to all 72 hours of admiss documentation of a months or if contra physician/nurse pra be substituted for t does not serve to e TST" The plan di responsible to ensu	ng admitted to a skilled nursing a baseline screening including the resident risk factors for TB 3 symptoms. A standard ulin skin test (TST) will be skilled facility residents within sion, unless there is written a negative within the last 3 indicated in writing by a actitioner. A chest x-ray cannot he TST. Chest x-ray screening establish a resident's baseline d not indicate who was ure resident's records were					
	PROVIDER OR SUPPLIER TERIAN HOMES OF SUMMARY ST/ (EACH DEFICIENC REGULATORY OR I Continued From pa from active infection On 3/5/15, at 9:10 not received tuberor instead the chest X- resident's admission out TB as chest X- Skin Test (TST) as should have been to declined TST and to to her attention. On 3/5/15, at 11:44 (CA) explained res upon admission and were educated and X-rays. They obtain had the physician reviewed Undated Tuberculor "Each resident beint facility will receives an assessment of a and any current TE intradermal tuberor administered to all 72 hours of admiss documentation of a months or if contral physician/nurse pra- be substituted for to does not serve to e TST" The plan diresponsible to ensite	OF CORRECTION         IDENTIFICATION NUMBER:           00189         00189           PROVIDER OR SUPPLIER         STREET A           TERIAN HOMES OF BLOOMINGTON         9889 PE           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         SUMMARY STATEMENT OF DEFICIENCIES           Continued From page 24         from active infectious disease.         On 3/5/15, at 9:10 a.m. RN-B verified R344 had not received tuberculin testing as required, citing instead the chest X-ray from prior to the resident's admission. RN-B cited means of ruling out TB as chest X-ray, blood test or Tuberculin Skin Test (TST) as options. R344's physician was should have been notified that the resident had declined TST and the issue had not been brough to her attention.           On 3/5/15, at 11:44 a.m. clinical administrator (CA) explained residents were offered the TST upon admission and if they refused the residents were educated and the facility asked for past X-rays. They obtained a copy of the X-ray and had the physician review the results to rule out active TB. The CA further stated she would have expected the staff to have ensured a resident's physician reviewed the X-ray.           Undated Tuberculosis Control Plan directed "Each resident being admitted to a skilled nursing facility will receive a baseline screening including an assessment of the resident risk factors for TB and any current TB symptoms. A standard intradermal tuberculin skin test (TST) will be administered to all skilled facility residents within 72 hours of admission, unless there is written documentation of a negative within the last 3 months or if contraindicated in writing by a physician/nurse practitioner. A chest x-ray	TOF DEFICIENCIES OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE A. BUILDING:         00189       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, ST 9889 PENN AVENUE SU BLOOMINGTON         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 24       21426         from active infectious disease.       00 3/5/15, at 9:10 a.m. RN-B verified R344 had not received tuberculin testing as required, citing instead the chest X-ray, blood test or Tuberculin Skin Test (TST) as options. 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RN-B cited means of ruling out TB as chest X-ray from prior to the resident's admission. RN-B cited means of ruling out TB as chest X-ray blood test or Tuberculin shead the chest X-ray from prior to the resident's admission. RN-B cited means of ruling out TB as chest X-ray, blood test or Tuberculin Skin Test (TST) as options. R344's physician was should have been notified that the resident had declined TST and the issue had not been brought to her attention.       Image: Drom prior to the resident's admission and if they refused the residents were educated and the facility asked for past X-rays. They obtained a copy of the X-ray and had the physician reviewe the results to rule out active TB. The CA further stated she would have expected the staff to have ensured a resident's physician reviewed the X-ray.         Undated Tuberculins is Control Plan directed "Each resident being admitted to a skilled nursing facility will receive a baseline screening including an assessment of the resident risk factors for TB and any current TB symptoms. A standard intradermal tuberculins sk thresi swritten documentation of a negative within	TO F DEFICIENCIES OF CORRECTION       (Y) PROVIDERSUPPLIERCLA IDENTIFICATION NUMBER:       A2 MULTIPLIE CONSTRUCTION A BUILDING:       (X) DATA A BUILDING:         OD189       B. WING       03/         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         SERVINE TERIAN HOMES OF BLOOMINGTON       9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431       PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SUMMATCH)         SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SUMPORTATION)       ID PREFIX TAG       PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SUMMATCH)         Continued From page 24 from active infectious disease.       ID ON 16/5/15, at 9:10 a.m. RN-B verified R344 had not received tuberculin testing as required, citing instead the chest X-ray from prior to the resident's admission. RN-B cited means of ruling out TB as chest X-ray, blood test or Tuberculin Skin Test (TST) as options. R344's physician was should have been notified that the resident had declined TST and the issue had not been brought to her attention.         ON 3/5/15, at 11:44 a.m. clinical administrator (CA) explained residents were offered the TST upon admission and if they refused the residents were educated and the facility asked for past X-rays. They obtained a copy of the X-ray and had the physician reviewed the X-ray.         Undated Tuberculosis Control Plan directed "Each resident being admitted to a skilled nursing facility will receive a baseline screening including an assessment of the resident risk factors for TB and any current TB symptoms. Astandard intradermal luberculin skin test (TST) will be administered to all skilled facility residents writhin f22 hours of admission, nueses th	

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21426	Continued From pa	ge 25	21426				
	ensure policies and measures to ensure Appropriate staff co tool could be develo audits could be bro for review. TIME PERIOD FOR	sing (DON) or designee could I procedures address e care plans are followed. build be trained. An auditing oped and the results of those ught to the quality committee R CORRECTION: Twenty-one					
21530	(21) days. MN Rule 4658.131	0 A.B.C Drug Regimen Review	/ 21530			4/14/15	
	reviewed at least m currently licensed b This review must be Appendix N of the S Surveyor Procedure Requirements in Lo the Department of I Health Care Finand This standard is in available through th system. It is not su B. The pharma irregularities to the and the attending p must be acted upor physician visit, or su pharmacist. For pu upon" means the a report and the sign of nursing services C. If the attend with the pharmacist not provide adequa pharmacist believes	en of each resident must be nonthly by a pharmacist by the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, sing Administration, April 1992. corporated by reference. It is the Minitex interlibrary loan bject to frequent change. to frequent					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
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21530	if the medical direct physician. If the m the attending physi justification for the physician does not must be referred for assessment and as by part 4658.0070. the medical director must refer the matt assessment and as This MN Requirem by: Based on observat review the facility fa pharmacist identifier residents (R184, R unnecessary medic Findings include: R184's hospital dis 1/21/15, indicted So medication) 6.25 m "agitation." R184's Record (MAR) for t indicated R184 was (antipsychotic med mouth at bed time a diagnosis of "inso	the medical director for review tor is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter or review to the quality ssurance committee required If the attending physician is or, the consulting pharmacist ter directly to the quality ssurance committee. ent is not met as evidenced ion, interview and document ailed to ensure the consultant ed irregularities for 3 of 5 155, R18) reviewed for cation use. charge physician orders dated eroquel (antipsychotic iilligrams (mg) was initiated for Medication Administration the months of 2/15 and 3/15, s receiving Seroquel ication) 6.25 milligrams by with a start date of 1/22/15 for		Corrected		
	dated 1/28/15, india moderate cognitive of unspecified psyc care plan dated 2/1	cated the resident had impairment with a diagnosis chosis and anxiety. R184's 0/15, indicated psychotropic escribed and staff was to				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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21530	Continued From pa	age 27	21530				
	monitor for behavio	ors of "wandering in the hallway	,				
		but lacked specific behavior	, I.I.I.I.I.I.I.I.I.I.I.I.I.I.I.I.I.I.I.				
		uld have warranted the use of					
		cations, as well as for potential					
	side effects.						
		onitoring for the months for					
		ed staff was to monitor target					
		des of wandering in hallway or					
		184. R184's behavior monitor					
		184 wandered three times and	1				
	in 3/15, no wanderi	ng was noted.					
	Nursing notes from	2/1/15 to 3/4/15, lacked					
		ial or attempt at a gradual dose	9				
		R184's Seroquel had been					
		s medical chart lacked					
	documentation of n	nonthly consulting pharmacist					
	review or recomme	endations for possible GDR.					
	During an interview	/ on 3/4/15, at 2:47 p.m. the					
		RN)-A reported R184's					
		cation had been increased					
	from as needed to	scheduled nightly due to her					
	wandering into othe	ers rooms. RN-A stated she					
		R184 wandering "lately." RN-A					
		had talked to R185's primary					
		plan was for R184 to be					
		ong term care unit. Because of	ſ				
		sh to make changes to the					
		on regime until after the move. at although the antipsychotic					
		en used since 1/22/15, they					
		toring R184's behaviors to					
		for the continued use of					
	, ,	cations nor for potential					
		ects. RN-A stated she added					
		or staff to monitor for side					
	effects of antipsych	notic starting on 3/3/15, after					
	the lack of docume	ntation was brought to her	1			1	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
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21530	Continued From pa	age 28	21530			
	attention.					
	During a phone interview on 3/5/15, at 4:13 p.m. the consulting pharmacist stated that she would have expected staff to monitor R184's behaviors that placed the resident and/or others in danger and of self-transfers.					
	walked short distar her room. When sh lightheadedness, w down again. She s	3/4/15, at 10:16 a.m. she nees with her walker outside ne stood she felt which resolved when she sat said she had reported it to the n instructed to use her call light				
	medications includ 12.5 milligram (mg hallucinations, mirt depression, donep dementia, as well a for high blood pres daily, hydrochloroth	or R155 dated 1/8/15, revealed ing quetiapine (antipsychotic) ) at bedtime for dementia with azapine 15 mg at bedtime for ezil 10 mg daily for Lewy Body as the following medications sure (BP): Atenolol 50 mg niazide 25 mg daily, Lisinopril ydralazine hydrochloride 25 mg				
	for psychotropic dr adverse conseque antipsychotic and a care plan dated 11, depression and rec medications. In add	Care Area Assessment (CAA) ug use indicated a potential for nces related to the use of antidepressant medication. The /5/14, noted the resident had ceived psychotropic dition to administering those was directed side effects of the	•			
	the Weights and V	had been recorded on either ital Summary dated for 5/3/14 r the Electronic Medication				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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PRESBY	TERIAN HOMES OF	BLOOMING LON	NN AVENUE S NGTON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 29	21530			
	Side Effects Inform listed "dizziness, lig potential medicatio On 3/5/15, at 10:23 (RN)-C reviewed R verified orthostatic	<ul> <li>1/1/15 through 3/5/15. The nation Sheets dated 9/6/14, ghtheadedness or fainting" as n side effects.</li> <li>a.m. a registered nurse R155's medical record and BPs had only been measured 155 had experienced a fall.</li> </ul>				
	explained that the f to a new computer and the staff was fi interventions, such talked to the comp changes. The clinic acknowledged orth completed in 1/15 or reporting light head	B a.m. the clinical administrator facility had just switched over system the previous month, inding it difficult to read the as orthostatic BPs. They had any regarding initiating cal administrator iostatic BPs had not been or 2/15, despite the resident dedness and the potential side chotropic and anti-hypertensive				
	consultant pharma consultant pharma orthostatic blood pr 5/1/14, last year ex consultant pharma and R155 should h pressures complete asked if she was a feeling lightheaded	p.m. via a telephone call the cist (CP)-A. When the cist was informed R155 had no ressure measured since accept after a fall 12/9/14, the cist stated it was an oversight have had orthostatic blood ed at least quarterly. When ware R155 was reporting lness, the consultant "I don't have any notations d pressure."				
	seated in the dining (a hospice nurse).	on 3/3/15, at 1:19 p.m. while g room conversing with RN-F R18 wanted to go to the F instructed the resident to wai	t			

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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TERIAN HOMES OF	BLOOMINGTON BLOOMI	NGTON, MN 5	5431		
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Continued From pa	age 30	21530			
nursing assistant (I resident, but told R gait belt. Instead, th wish to sit any long the resident despite NA returned with th distance leaning to shuffling steps. RN-A reported in an p.m. that R18 had the	NA) arrived to assist the 18 to wait until she brought a he resident stated she did not er and stood, as RN-F helped e instruction to wait. When the ne gait belt, R18 walked a short the right and with short n interview on 3/2/15, at 4:36 fallen that morning apparently				
"We found cups on been toileting she v R18's current care	the floor, so it may not have was after." plan noted the resident had				
signs "per protocol" addition, the care p medications as ord side effectsMonit	" and physician orders. In plan read, "Administer my lered. Monitor/document for or/record/report to my				
were documented of monthly documentation	only for 3/4/15 and 8/2/14. No ation of other orthostatic BPs				
verified R18's orthor routinely measured see orthostatic BPs month. They haven resident has refuse staff would try agai	estatic BPs were not being I. He stated, "I would expect to s for antipsychotic use every n't been consistent. The ed at times, but I would expect n." At 10:53 a.m. RN-A				
	PROVIDER OR SUPPLIER TERIAN HOMES OF SUMMARY ST/ (EACH DEFICIENCI REGULATORY OR L Continued From pa until she could get nursing assistant (I resident, but told R gait belt. Instead, tI wish to sit any long the resident despite NA returned with th distance leaning to shuffling steps. RN-A reported in a p.m. that R18 had while trying to get t "We found cups or been toileting she w R18's current care impaired cognition Staff were instructed signs "per protocol addition, the care p medications as ord side effectsMonit physician as needed A review of R18's r were documented monthly documenta was located in the During an interview verified R18's orthor resident has refuse staff would try agai	AT OF DEFICIENCIES OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         O0189       00189         PROVIDER OR SUPPLIER       STREET AI 9889 PEI BLOOMINGTON         TERIAN HOMES OF BLOOMINGTON       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 30       until she could get someone to assist her. A nursing assistant (NA) arrived to assist the resident, but told R18 to wait until she brought a gait belt. Instead, the resident stated she did not wish to sit any longer and stood, as RN-F helped the resident despite instruction to wait. When the NA returned with the gait belt, R18 walked a short distance leaning to the right and with short shuffling steps.         RN-A reported in an interview on 3/2/15, at 4:36 p.m. that R18 had fallen that morning apparently while trying to get to the bathroom. He clarified, "We found cups on the floor, so it may not have been toileting she was after."         R18's current care plan noted the resident had impaired cognition due to Alzheimer's disease. Staff were instructed to take the resident's vital signs "per protocol" and physician orders. In addition, the care plan read, "Administer my medications as ordered. Monitor/document for side effectsMonitor/record/report to my physician as needed in regards to side effects"         A review of R18's record revealed orthostatic BPs were documented only for 3/4/15 and 8/2/14. No monthly documentation of other orthostatic BPs was located in the resident's record.         During an interview on 3/5/15, at 9:30 a.m., RN-A verified R18's orthostatic BPs were not being	AT OF DEFICIENCIES OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:       (X2) MULTIPLE A. BUILDING:	AT OF DEFICIENCIES OF CORRECTION       (R1) PROVIDER/SUPPLIER/LIANCIA IDENTIFICATION NUMBER:       (R2) MULTIPLE CONSTRUCTION A. BUILDING:         O189       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PLUL REGULATORY OR LSC IDENTIFYING INFORMATION)       B. WING         Continued From page 30       21530         Residuation of the right and with short shuffling steps.       SIM ARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PLUL REGULATORY OR LSC IDENTIFYING INFORMATION)       PROVIDER'S PLAN OF (EACH CORRECTIVE ACT TAG         Continued From page 30       21530         Continued From page 30       21530         Row and the sistant (NA) arrived to assist the resident, but told R18 to wait until she brought a gait betit. Instead, the resident stated she did not wish to sit any longer and stood, as RN-F helped the resident despite instruction to wait. When the NA returned with the gait betit, R18 walked a short distance leaning to the to the bathroom. He clarified, "We found cups on the floor, so it may not have been toileting she was after."         R18's current care plan noted the resident had impaired conginion due to Alzheimer's disease. Staff were instructed to take the resident size side effectsMonitor/record/report to my physician as needed in regards to side effects." <t< td=""><td>TO P DEFICIENCIES OF CORRECTION       (N) PROVIDERSUPPLIENCLIA IDENTIFICATION NUMBER:       A2 MULTIPLIE CONSTRUCTION A BUILDING:       (N3 DATE A BUILDING:         00189       B. WING       03//         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         SERVING:       BESS PENN AVENUE SOUTH BLOOMINGTON, MN S5431         SUMMARY STATEMENT OF DEFICIENCIES REQUENTION ON LSC IDENTIFYING INFORMATION       ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SUMPORMATION)         Continued From page 30       21530         Continued From page 30       21530         Until she could get someone to assist her. A runsing assistant (NA) arrived to assist the resident, but told R18 to wait until she brought a gait belt. Instead, the resident stade she did not wish to sit any longer and stoad, as RN-F helped the resident despite instruction to wait. When the NA returned with the gait belt, R18 walked a short distance leaning to the right and with short shuffling steps.         RN-A reported in an interview on 3/2/15, at 4.36 p.m. that R18 had failen that morning apparently while trying to get to the bathroom. He clarified, "We found cups on the floor, so it may not have been toileting she was after."         R18's current care plan noted the resident had impaired cognition due to Alzheimer's disease. Staff were instructed to take the resident for side effects. Monitor/record/report to my physician as needed in regards to side effects."         A review of R18's record revealed orthostatic BPs was located in the resident's record.         During an interview on 3/5/15, at 9:30 a.m., RN-A werified R18'</td></t<>	TO P DEFICIENCIES OF CORRECTION       (N) PROVIDERSUPPLIENCLIA IDENTIFICATION NUMBER:       A2 MULTIPLIE CONSTRUCTION A BUILDING:       (N3 DATE A BUILDING:         00189       B. WING       03//         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         SERVING:       BESS PENN AVENUE SOUTH BLOOMINGTON, MN S5431         SUMMARY STATEMENT OF DEFICIENCIES REQUENTION ON LSC IDENTIFYING INFORMATION       ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SUMPORMATION)         Continued From page 30       21530         Continued From page 30       21530         Until she could get someone to assist her. A runsing assistant (NA) arrived to assist the resident, but told R18 to wait until she brought a gait belt. Instead, the resident stade she did not wish to sit any longer and stoad, as RN-F helped the resident despite instruction to wait. When the NA returned with the gait belt, R18 walked a short distance leaning to the right and with short shuffling steps.         RN-A reported in an interview on 3/2/15, at 4.36 p.m. that R18 had failen that morning apparently while trying to get to the bathroom. He clarified, "We found cups on the floor, so it may not have been toileting she was after."         R18's current care plan noted the resident had impaired cognition due to Alzheimer's disease. Staff were instructed to take the resident for side effects. Monitor/record/report to my physician as needed in regards to side effects."         A review of R18's record revealed orthostatic BPs was located in the resident's record.         During an interview on 3/5/15, at 9:30 a.m., RN-A werified R18'

SUMMARY STA EACH DEFICIENC' EGULATORY OR L inued From pa facility's Psych d "Each reside unnecessary of rug when use toredSide ef ucted for all psychotic n toring will inclu- sure."	<b>BLOOMINGTON</b> <b>BLOOM</b> ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) Age 31 otropic Medication Use policy nt's drug regimen must be freed drugs. Unnecessary drugs and dWithout adequate fect monitoring will be sychotherapeutic medications hedication the side effect ide a monthly orthostatic bloc Itant pharmacist (CP)-A was bhone on 3/5/15, at 4:10 p.m.	B. WING ADDRESS, CITY, S ENN AVENUE S MINGTON, MN 4 PREFIX TAG 21530 / 2e e s. od	OUTH	CORRECTION TION SHOULD BE THE APPROPRIATE	05/2015 (X5) COMPLET DATE
N HOMES OF SUMMARY STA EACH DEFICIENC' EGULATORY OR L inued From pa facility's Psych d "Each reside unnecessary of rug when use toredSide ef ucted for all ps intipsychotic n toring will inclu- sure."	<b>BLOOMINGTON</b> <b>BLOOM</b> ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) Age 31 otropic Medication Use policy nt's drug regimen must be freed drugs. Unnecessary drugs and dWithout adequate fect monitoring will be sychotherapeutic medications hedication the side effect ide a monthly orthostatic bloc Itant pharmacist (CP)-A was bhone on 3/5/15, at 4:10 p.m.	ENN AVENUE S MINGTON, MN S PREFIX TAG 21530 / ee e s. od	OUTH 55431 PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO	CORRECTION TION SHOULD BE THE APPROPRIATE	(X5) COMPLET
SUMMARY STA EACH DEFICIENC' EGULATORY OR L inued From pa facility's Psych d "Each reside unnecessary of rug when use toredSide ef ucted for all psychotic n toring will inclu- sure."	BLOOMINGTON BLOOM TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 31 otropic Medication Use policy nt's drug regimen must be free drugs. Unnecessary drugs and dWithout adequate fect monitoring will be sychotherapeutic medications hedication the side effect ide a monthly orthostatic bloc ltant pharmacist (CP)-A was bhone on 3/5/15, at 4:10 p.m.	AINGTON, MN 9 ID PREFIX TAG 21530 / See e s. od	55431 PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLET
EACH DEFICIENC EGULATORY OR L inued From pa acility's Psych d "Each reside unnecessary of rug when use toredSide ef ucted for all ps untipsychotic n toring will inclu- sure."	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 31 otropic Medication Use policy nt's drug regimen must be free drugs. Unnecessary drugs are dWithout adequate fect monitoring will be sychotherapeutic medications nedication the side effect ide a monthly orthostatic bloc ltant pharmacist (CP)-A was ohone on 3/5/15, at 4:10 p.m.	21530 / 2e e s. od	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLE
acility's Psych d "Each reside unnecessary frug when use toredSide ef ucted for all ps untipsychotic n toring will inclu sure." acility's consu	otropic Medication Use policy nt's drug regimen must be fre drugs. Unnecessary drugs and dWithout adequate fect monitoring will be sychotherapeutic medications nedication the side effect ide a monthly orthostatic bloc ltant pharmacist (CP)-A was ohone on 3/5/15, at 4:10 p.m.	/ ee e s. od			
d "Each reside unnecessary lrug when use toredSide ef ucted for all pe ntipsychotic n toring will inclu sure." facility's consul riewed by telep	nt's drug regimen must be fre drugs. Unnecessary drugs ar dWithout adequate fect monitoring will be sychotherapeutic medications hedication the side effect ide a monthly orthostatic bloc ltant pharmacist (CP)-A was ohone on 3/5/15, at 4:10 p.m.	ee e s. od			
viewed by tele	ohone on 3/5/15, at 4:10 p.m.				
ssarily taken r beted quarterly	tatic blood pressures were no nonthly, but should have been y, as this was linked to the data gathering.	ot			
cation record ulting pharma ularities had b	2/5/15 of R18's monthly reviews by the facility's cist from 7/14 to 3/15 no een noted by the pharmacist of orthostatic BPs in R18's				
consulting pha cation regimes hale is identifie effective dose nducted. Appr uditing tool con ts of those aud	rmacist could review to ensure an appropriate of for the use of medication, a s, and side effect monitoring opriate staff could be trained. Ind be developed and the dits could be brought to the				
E PERIOD FOI days.	R CORRECTION: Twenty-on	e			
	d. GESTED MET onsulting pha cation regimes ale is identifie effective dose iducted. Appro- iditing tool cou- s of those aud y committee for PERIOD FOR	d. GESTED METHOD OF CORRECTION: onsulting pharmacist could review cation regimes to ensure an appropriate ale is identified for the use of medication, a effective doses, and side effect monitoring iducted. Appropriate staff could be trained. iditing tool could be developed and the s of those audits could be brought to the y committee for review. PERIOD FOR CORRECTION: Twenty-on	d. GESTED METHOD OF CORRECTION: onsulting pharmacist could review cation regimes to ensure an appropriate ale is identified for the use of medication, at effective doses, and side effect monitoring iducted. Appropriate staff could be trained. iditing tool could be developed and the s of those audits could be brought to the y committee for review. PERIOD FOR CORRECTION: Twenty-one	d. GESTED METHOD OF CORRECTION: onsulting pharmacist could review cation regimes to ensure an appropriate ale is identified for the use of medication, at effective doses, and side effect monitoring iducted. Appropriate staff could be trained. iditing tool could be developed and the s of those audits could be brought to the y committee for review. PERIOD FOR CORRECTION: Twenty-one	d. GESTED METHOD OF CORRECTION: onsulting pharmacist could review cation regimes to ensure an appropriate ale is identified for the use of medication, at effective doses, and side effect monitoring iducted. Appropriate staff could be trained. iditing tool could be developed and the s of those audits could be brought to the y committee for review. PERIOD FOR CORRECTION: Twenty-one

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
		00189	B. WING		03/0	5/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF	RLOOMINGTON	NN AVENUE S NGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLET DATE
21540	Continued From pa	age 32	21540			
21540	MN Rule 4658.131 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			4/14/15
	home's policies and pharmacist must re- resident's attending physician does not home's recommend adequate justification believes the reside adversely affected, matter to the medic medical director is the medical director physician does not the order and if the change the order, t review to the Qualit (QAA) committee re- the attending phys the consulting phar directly to the QAA.					
	by: Based on observat review the facility fa prescribed antipsyc adequately monitor medication side eff	ent is not met as evidenced ion, interview and document ailed to ensure residents chotic medications were red for efficacy and/or ects for 3 of 5 residents (R184, ed for unnecessary medication		Corrected		
	Findings include:					
	B184 was observed	d on 3/3/15, at 8:27 a.m. while				

STATE FORM

PF2411

If continuation sheet 33 of 44

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00189	B. WING		03/	05/2015
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
RESBY	TERIAN HOMES OF	BLOOMINGTON	NN AVENUE SONGTON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21540	seated in the dinin The resident was of resident. Later that observed sitting car room when she ag Throughout the int was calm and rela signs of anxiety or wanted to leave du resident spoke to the had been feeling without wakin R184's Medication for the months of 2 resident had receive 6.25 milligrams at insomnia. R184's admission 1/28/15, indicated cognitive impairment unspecified psycho- plan dated 2/10/15 behaviors of wand rooms. The plan, directions for staff would have warrar potential medication During an interview registered nurse (fit	g room eating her breakfast. quietly visiting with another at day at 1:43 p.m. R184 was almly watching television in her reed to be interviewed. erview the resident's demeanor xed. She did not display any behavior that suggested she uring the 20 minutes the he surveyor. R184 reportedly vell and was sleeping the whole ng. Administration Record (MAR) 2/15 and 3/15, revealed the ved the antipsychotic Seroquel bedtime since 1/22/15, for Minimum Data Set dated the resident had moderate ent with a diagnosis of psis and anxiety. R184's care 6, directed staff to monitor for ering in the hallway or others however, did not include to monitor for behavior that need antipsychotic use, nor for				
	explained that she physician, and the transferred to the I this, they did not w resident's medicat RN-A confirmed th	had talked to R184's primary plan was for the resident to be ong term care unit. Because of ish to make changes in the ion regime until after the move. at although the medication had /22/15, they had not been				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00189	B. WING		03/	05/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PRESBY	TERIAN HOMES OF	RLOOMINGTON	NN AVENUE S NGTON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From pa	age 34	21540			
	justification for the	behaviors to provide continued use of antipsychotic re they monitoring for potential rects.				
	walked short distar her room. When sh lightheadedness, w down again. She s	3/4/15, at 10:16 a.m. she nees with her walker outside he stood she felt which resolved when she sat said she had reported it to the h instructed to use her call light				
	medications includi 12.5 milligram (mg hallucinations, mirt depression, donepo dementia, as well a for high blood pres daily, hydrochloroth	or R155 dated 1/8/15, revealed ing quetiapine (antipsychotic) ) at bedtime for dementia with azapine 15 mg at bedtime for ezil 10 mg daily for Lewy Body as the following medications sure (BP): Atenolol 50 mg niazide 25 mg daily, Lisinopril ydralazine hydrochloride 25 mg				
	for psychotropic dri adverse consequer antipsychotic and a care plan dated 11/ depression and rec medications. In add	Care Area Assessment (CAA) ug use indicated a potential for nces related to the use of antidepressant medication. The /5/14, noted the resident had ceived psychotropic dition to administering those was directed side effects of the				
	the Weights and Vi through 3/4/15, nor Record dated from Side Effects Inform	had been recorded on either ital Summary dated for 5/3/14 the Electronic Medication 1/1/15 through 3/5/15. The nation Sheets dated 9/6/14, ghtheadedness or fainting" as				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00189	B. WING		03/	05/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
PRESBY	TERIAN HOMES OF	BLOOMINGTON	NN AVENUE SO NGTON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From pa	ige 35	21540			
	potential medicatio	n side effects.				
	(RN)-C reviewed R verified orthostatic on 12/9/14, after R <sup>2</sup> On 3/5/15, at 11:03 explained that the f to a new computer and the staff was fi interventions, such talked to the compa changes. The clinic acknowledged orth	a.m. a registered nurse 155's medical record and BPs had only been measured 155 had experienced a fall. a.m. the clinical administrator acility had just switched over system the previous month, nding it difficult to read the as orthostatic BPs. They had any regarding initiating cal administrator ostatic BPs had not been or 2/15, despite the resident				
	effects of both psyc medications. R18 was observed seated in the dining (a hospice nurse). dayroom, and RN-f until she could get s	ledness and the potential side chotropic and anti-hypertensive on 3/3/15, at 1:19 p.m. while g room conversing with RN-F R18 wanted to go to the <sup>-</sup> instructed the resident to wai someone to assist her. A NA) arrived to assist the				
	resident, but told R gait belt. Instead, th wish to sit any long the resident despite NA returned with th	18 to wait until she brought a ne resident stated she did not er and stood, as RN-F helped e instruction to wait. When the e gait belt, R18 walked a short the right and with short				
	p.m. that R18 had f while trying to get to	n interview on 3/2/15, at 4:36 fallen that morning apparently the bathroom. He clarified, the floor, so it may not have vas after."				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00189	B. WING		03/	05/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
RESBY	TERIAN HOMES OF	BLOOMINGION	NN AVENUE S NGTON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From pa	age 36	21540			
	impaired cognition Staff were instructed signs "per protocol" addition, the care p medications as ord side effectsMonit physician as needed A review of R18's r were documented monthly documentation was located in the During an interview verified R18's orthor routinely measured see orthostatic BPs month. They haver resident has refuse staff would try agai reported he was un orthostatic BPs in F	plan noted the resident had due to Alzheimer's disease. ed to take the resident's vital " and physician orders. In plan read, "Administer my lered. Monitor/document for or/record/report to my ed in regards to side effects." ecord revealed orthostatic BPs only for 3/4/15 and 8/2/14. No ation of other orthostatic BPs resident's record. o on 3/5/15, at 9:30 a.m., RN-A ostatic BPs were not being d. He stated, "I would expect to s for antipsychotic use every o't been consistent. The ed at times, but I would expect n." At 10:53 a.m. RN-A nable to locate additional R18's record, and stated they taken monthly.				
	The facility's Psych noted "Each reside from unnecessary any drug when use monitoredSide ef conducted for all ps For antipsychotic m monitoring will inclu pressure."	notropic Medication Use policy ent's drug regimen must be free drugs. Unnecessary drugs are edWithout adequate ifect monitoring will be sychotherapeutic medications. nedication the side effect ude a monthly orthostatic blooc				
	The director of nurs and the consulting medication regimes	sing (DON) with the physicians pharmacist could review s to ensure an appropriate of for the use of medication, at				

PF2411

If continuation sheet 37 of 44

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00189	B. WING		03/	05/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF	RECOMINGION	NN AVENUE NGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
21540	least effective dose is conducted. Appro An auditing tool cou results of those aud quality committee for	es, and side effect monitoring opriate staff could be trained. Ind be developed and the dits could be brought to the	21540			
21640	Medications;Return Subp. 4. Returned prescribed medicat may be returned to	0 Subp. 4 Disposition of ned to Pharm I to pharmacy. Drugs and ions used in nursing homes the dispensing pharmacy 800.2700, subpart 2.	21640			4/14/15
	by: Based on observat review the facility fa medication of insuli diabetes) were rem	ent is not met as evidenced ion, interview and document ailed to ensure expired in vials (used to manage loved from the medication cart (R14) reviewed for medication		Corrected		
	system was conduct vial of Lantus labeled at room temperatur vial had a handwritt and a handwritten of However, according Lantus vial would h 2/26/15 instead of 2	he facility's medication storage cted on 3/2/15, at 1:18 p.m. A ed for R14 was stored for use re in the medication cart. The ten opened date of 1/29/15, expiration date of 2/29/15. g to expiration guidelines the ave instead expired on 2/29/15. A licensed practical a registered nurse (RN)-C				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00189	B. WING		03/	05/2015
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
PRESBY	TERIAN HOMES OF I	RECOMINGION	NN AVENUE SO NGTON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21640	Continued From pa	ge 38	21640			
		Lantus had expired and emoved for destruction.				
	staff to administer I every morning by ir administration reco	ders dated 11/21/15, directed Lantus 100/milliliters 5 units njection. The medication rd for the months of 2/15 and esident had been receiving ng as ordered.				
	Guidelines policy ne	Storage and Expiration oted that insulin vials stored at nad an expiration date of fter the first use.				
	The director of nurse ensure policies and measures to ensure Appropriate staff co tool could be develo	THOD OF CORRECTION: sing (DON) or designee could I procedures address e care plans are followed. build be trained. An auditing oped and the results of those ught to the quality committee				
	TIME PERIOD FOR (14) days.	R CORRECTION: Fourteen				
21810	MN St. Statute 144 Residents of HC Fa	.651 Subd. 6 Patients & ac.Bill of Rights	21810			4/14/15
	residents shall have medical and person needs. Appropriate care designed to en highest level of phy This right is limited	riate health care. Patients and e the right to appropriate hal care based on individual e care for residents means hable residents to achieve their sical and mental functioning. where the service is not blic or private resources.				

PF2411

If continuation sheet 39 of 44

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00189	B. WING		03/0	5/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRESBY	TERIAN HOMES OF I	BLOOMINGTON	IN AVENUE S IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21810	Continued From pa	ge 39	21810			
	by: Based on observati review the facility fa within reach for 1 o reviewed for hospic	ent is not met as evidenced on, interview and document ailed to ensure a call light was f 1 resident (R89) who was se care.		Corrected		
	Findings include:					
	room on 3/5/15, at 8 knees were bent as down while calling of ah, ah, ah." The ca and was wedged be rail, approximately	a specialized wheelchair in her 9:22 a.m. The resident's s she lifted her legs up and but in a distressed tone, "Ah, Il light was behind the resident, etween the mattress and bed five feet from her reach. R89 know the location of her call				
	"We clip her call lig NA proceeded to ta the mattress and be upper jacket and th hand. NA-C further well. That is why we NA-C reported R89 used her call light. A then stated R89's c onto the front of he blind. R89's Minimum Da indicated the reside vision due to retino causing vision loss vision, and was able	(NA)-C explained at 9:27 a.m. ht on her clothing here," as the ke the call light from between ed rail and clip it to R89's en place it in the resident's stated, "She does not see e put the call light in her hand." was capable of using and A registered nurse (RN)-H all light was always clipped r clothing, as she was legally ta Set (MDS) dated 1/21/15, ent had severely impaired pathy and glaucoma (both ), had moderately impaired e to make herself understood. sive assistance with activities				

Minnesota Department of Health         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1)         Department of Health         (X1)         PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         00189		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED 03/05/2015	
				03/		
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
PRESBY	TERIAN HOMES OF	RLOOMINGION	NN AVENUE SO NGTON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21810	Continued From pa	age 40	21810			
	of daily living (ADL	S).				
	resident's call light area so she could l 2/24/15, hospice ca blind. Place my cal hands and show m falls with injuries. I sweater so am able	plan directed staff to clip the to her sweater on the chest ocate it to call for help. A are also noted, "I am legally I light on my gown, guide my e where it isI am at risk for want my call light pinned to my e to reach it easily." a.m. the director of nursing				
	SUGGESTED MET The director of nurs ensure policies and	THOD OF CORRECTION: sing (DON) or designee could procedures address				
	their reach at all tin could be trained. A developed and the	ent call lights are placed within nes as appropriate. All staff n auditing tool could be results of those audits could uality committee for review.				
	TIME PERIOD FOI (14) days.	R CORRECTION: Fourteen				
23010	MN Rule 4658.463 Construction	5 A Nurse Call System; New	23010			4/14/15
	communication sys from the resident a required by this par system, if electrical connected to the en Nurse calls and em of being inactivated	must be equipped with a stem designed to receive calls nd nursing service areas t. The communication ly powered, must be mergency power supply. hergency calls must be capable d only at the points of origin. A r must be provided where the				

Minnesota Department of Hea STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 03/05/2015		
		00189					
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, STATE, ZIP CODE				
PRESBY	TERIAN HOMES OF	RI OOMING LON	NN AVENUE NGTON, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLET DATE	
23010	Continued From pa	age 41	23010				
	door is not visible f	rom the nurses' station.					
	resident's bed. Ca communication der they are within read from a resident mu station, activate a l bedroom, and activ medication room, r room, soiled utility multi-corridor nursi	must be provided for each all cords, buttons, or other vices must be placed where ch of each resident. A call ust register at the nurses' light outside the resident vate a duty signal in the nourishment area, clean utility room, and sterilizing room. In ing units, visible signal lights at corridor intersections.					
	by: Based on observat failed to ensure ca of 6 residents (R33	tion and interview the facility Il lights were functioning for 1 35) reviewed for accidents.		Corrected			
	Findings include:						
	when tested on 3/2 resident pushed th outside to room to to activate the light call light did not wo was notified, and a activate the light. F with a hand held be	as not functioning properly 2/15, at 6:38 p.m. When the e call button, it did not light up alert staff. The surveyor tried t four additional times and the ork. A registered nurse (RN)-D lso tried unsuccessfully to RN-D left the room and returned ell for R335 to use as a e non-working call light, and but in a work order.	8				
	indicated the reside cognitive impairme The care plan direc	evised date of 2/25/15, ent was at risk for falls due to ent and had a history of falls. cted staff to make sure call ach and encourage R335 to use					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 03/05/2015		
		00189					
NAME OF PROVIDER OR SUPPLIER STREET AD			DDRESS, CITY, ST	TATE, ZIP CODE			
RESBY	TERIAN HOMES OF	RLOOMINGTON	NN AVENUE S NGTON, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
23010	Continued From pa	age 42	23010				
	it for assistance.						
	(E)-A and (E)-B rep R335's call light wa that when a resider was considered an staff to let the engine either a work order that an engineer wa p.m. and an on-cal 24-hours a day. Al resident's call light documentation was During the environ also stated he wou a work order and c call light was not w On 3/5/15, at 10:55	5 a.m. a registered nurse					
	light not working or hand-held bell to no for assistance.	she was unaware R355's call that the resident was using a otify nursing staff of the need					
		sted, however, the facility did policy related to call light					
	The director of nurse ensure policies and measures to ensure Appropriate staff co tool could be devel	THOD OF CORRECTION: sing (DON) or designee could d procedures address re care plans are followed. ould be trained. An auditing oped and the results of those ought to the quality committee					
	TIME PERIOD FO						

Minnesota Department of Health								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:						
00189	B. WING		03/05/2015					
NAME OF PROVIDER OR SUPPLIER STRE	ET ADDRESS, CITY, S	ADDRESS, CITY, STATE, ZIP CODE						
PRESBYTERIAN HOMES OF BLOOMINGTON 9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431								
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE					
23010 Continued From page 43	23010							
days.								
Vinnesota Department of Health								