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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PF24

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00189

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245556**
2.STATE VENDOR OR MEDICAID NO.
(L2) **376724800**

3. NAME AND ADDRESS OF FACILITY
(L3) **PRESBYTERIAN HOMES OF BLOOMINGTON**
(L4) **9889 PENN AVENUE SOUTH**
(L5) **BLOOMINGTON, MN** (L6) **55431**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/27/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **98** (L18)

13.Total Certified Beds **98** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	98			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Supervisor 04/27/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 04/27/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/21/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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,

Anne Kleppe

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: 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,

Anne K. Kleppe

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245556	A. Building B. Wing	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
ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **04/14/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/14/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **04/14/2015**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **04/14/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/14/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **04/14/2015**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **04/14/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **04/14/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **04/14/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/14/2015**	ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **04/14/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/AK	04/27/2015	15507	04/27/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

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? **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245556	A. Building B. Wing **1N - NEW BUILDING**	4/16/2015

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
ID Prefix Reg. # **NFPA 101** LSC K0076	Correction Completed **04/14/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	04/27/2015	28120	04/16/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/5/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PF24

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00189

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245556**
2.STATE VENDOR OR MEDICAID NO.
(L2) **376724800**

3. NAME AND ADDRESS OF FACILITY
(L3) **PRESBYTERIAN HOMES OF BLOOMINGTON**
(L4) **9889 PENN AVENUE SOUTH**
(L5) **BLOOMINGTON, MN** (L6) **55431**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/05/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **98** (L18)

13.Total Certified Beds **98** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	98			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Douglas Stevens, HFE NE II 04/03/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 04/21/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: 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;

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

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

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

DEPARTMENT CONTACT

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

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

Email: gayle.lantto@state.mn.us
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

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.

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

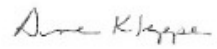
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

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

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

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245556	A. BUILDING _____ B. WING _____	03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a call light was within reach for 1 of 1 resident (R89) who was reviewed for hospice care. Findings include: R89 was seated in a specialized wheelchair in her room on 3/5/15, at 9:22 a.m. The resident's knees were bent as she lifted her legs up and	F 246	Resident□s care plan was reviewed by the care team for safety and call light accessibility. Call light was pinned to gown and corrected as soon as identified and is current. Resident is on hospice care and her cares are collaborated with a hospice agency. The hospice agency was immediately notified about this incident and asked to offer education to it□s staff to ensure	4/14/15

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

Electronically Signed | 04/02/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245556	A. BUILDING _____ B. WING _____	03/05/2015

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F 246	Continued From page 1 down while calling out in a distressed tone, "Ah, ah, ah, ah." The call light was behind the resident, and was wedged between the mattress and bed rail, approximately five feet from her reach. R89 stated she did not know the location of her call light. A nursing assistant (NA)-C explained at 9:27 a.m. "We clip her call light on her clothing here," as the NA proceeded to take the call light from between the mattress and bed rail and clip it to R89's upper jacket and then place it in the resident's hand. NA-C further stated, "She does not see well. That is why we put the call light in her hand." NA-C reported R89 was capable of using and used her call light. A registered nurse (RN)-H then stated R89's call light was always clipped onto the front of her clothing, as she was legally blind. R89's Minimum Data Set (MDS) dated 1/21/15, indicated the resident had severely impaired vision due to retinopathy and glaucoma (both causing vision loss), had moderately impaired vision, and was able to make herself understood. She required extensive assistance with activities of daily living (ADLs). R89's 8/9/13, care plan directed staff to clip the resident's call light to her sweater on the chest area so she could locate it to call for help. A 2/24/15, hospice care also noted, "I am legally blind. Place my call light on my gown, guide my hands and show me where it is...I am at risk for falls with injuries. I want my call light pinned to my sweater so am able to reach it easily." On 3/5/15, at 9:44 a.m. the director of nursing (DON) stated call lights should have been within a	F 246	collaborative care for hospice residents. Review of this resident□s specific care plan needs regarding the call light was also completed with facility staff. All residents are assessed for safety and call light use upon admission, with quarterly MDS assessments, with significant change, annually with outside vendors and as needed as part of the RAI process. A review of this resident□s care plan, My Best day was completed to ensure resident□s needs are met. Staff will educated through in-services and household meetings to be completed by 4/10/15. Staff are trained in competency class upon hire and as needed. Collaboration of care with hospice agencies will continue being completed between facility staff and hospice staff to ensure both parties understand resident□s plan of care. Staff will monitor for call light placement with rounding for all residents. Audits of the resident□s plan of care and call light placement will be conducted for 4 weeks and results reported to facility QA committee to ensure ongoing compliance. The Clinical Coordinators and Clinical Administrator are responsible for compliance. Date certain compliance is April 14th, 2015.	

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F 246	Continued From page 2 residents' reach at all times.	F 246		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure care plans were followed for 1 of 1 resident (R89) reviewed for hospice, 1 of 2 residents (R205) reviewed for pressure ulcers, and 1 of 3 residents (R339) reviewed for activities of daily living (ADLs). Findings include: R89's 8/9/13, care plan directed staff to clip the resident's call light to her sweater on the chest area so she could locate it to call for help. A 2/24/15, hospice care also noted, "I am legally blind. Place my call light on my gown, guide my hands and show me where it is...I am at risk for falls with injuries. I want my call light pinned to my sweater so am able to reach it easily." R89 was seated in a specialized wheelchair in her room on 3/5/15, at 9:22 a.m. The resident's knees were bent as she lifted her legs up and down while calling out in a distressed tone, "Ah, ah, ah, ah." The call light was behind the resident, and was wedged between the mattress and bed rail, approximately five feet from her reach. R89 stated she did not know the location of her call	F 282	Residents R89, R225 & R339 care plans were reviewed by the care team for safety and call light accessibility; repositioning and grooming. Resident R089 is on hospice care and her cares are in collaboration with a hospice agency. For resident R89, the call was immediately corrected once identified and placed within reach per resident's preference. The hospice agency was immediately notified about this incident and asked to offer education to its staff to ensure collaborative care for hospice residents. Review of this resident□s specific care plan needs regarding the call light was also completed with facility staff and the care plan was updated and my best day is current. Resident's care plans and My Best Day are updated per RAI process and with change of condition or change of preference. Staff are reminded to follow care plan at stand up and shift change and through other on-going communication. Resident 225□s was reassessed for skin risk and individual preferences for	4/14/15

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F 282	Continued From page 3 light. A nursing assistant (NA)-C explained at 9:27 a.m. "We clip her call light on her clothing here," as the NA proceeded to take the call light from between the mattress and bed rail and clip it to R89's upper jacket and then place it in the resident's hand. NA-C further stated, "She does not see well. That is why we put the call light in her hand." NA-C reported R89 was capable of using and used her call light. A registered nurse (RN)-H then stated R89's call light was always clipped onto the front of her clothing, as she was legally blind. On 3/5/15, at 9:44 a.m. the director of nursing (DON) stated call lights should have been within a residents' reach at all times. R205's 2/1/15, Quick Guide to ADLs (activities of daily living) available in the resident's room directed staff to reposition the resident every two hours and as needed. The care plan noted "I have the potential for alteration in skin integrity r/t [related to] Decreased mobility, Incontinence, pressure ulcers on left buttock, right buttock and right sacral area." The care plan goal read, "My wounds will heal with out getting infected," and the interventions included offering repositioning every two hours and as needed. R205 was continuously observed on 3/4/15, from 6:58 to 10:05 a.m. (3 hours, 7 minutes). Although she was dependent on staff for repositioning and had three Stage IV (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcers she was not offered or encouraged to change positions during the observation.	F 282	repositioning. The repositioning care plan was reviewed and updated to reflect resident□s preference of extended sleep times and refusal of repositioning while sleeping. Resident sleeps in until late in the morning. Resident has supportive surfaces on her bed that support her tissue tolerance and does not require every two hour repositioning. Resident also has the ability to make slight changes in her position and has grab bars on her bed to enhance her bed mobility. Resident□s care plan will now require repositioning only while awake during the day and as needed, to meet resident□s choices while supporting the wound healing process. Resident skin integrity will be monitored daily during cares and with RAI process. For all residents, skin is assessed daily with cares, weekly through body audits, and as needed with change of condition and in coordination with the RAI process. All residents with wounds were reviewed and care plans current. Resident 339 was immediately offered nail care and she declined nail trimming stating I like my nails long. Resident R339 care plan was reviewed for grooming and staff were re-educated on the need to complete all ADLs daily and as needed. Care Plan and My best Day was updated for preferences. Staff were educated to report to nurse of residents□ refusal for re-approach and documentation. She allowed cleaning underneath her nails. Resident is now deceased; she expired on 3/20/15. A review of these residents□ care plan, My Best day, and assignment sheets was	

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F 282	Continued From page 4 On 3/4/15, at 7:50 a.m. RN-J explained R205 usually ate brunch at noon, preferring to sleep in, and was provided supplements. RN-J further stated R205's daily wound care was typically completed at 10:30 a.m. at the earliest. On 3/4/15, at 9:24 a.m. NA-E stated R205 was to be repositioned when in bed every two hours, because she had wounds on her buttocks. When NA-D was asked on 3/4/15, at 10:37 a.m. what time R205 had last been repositioned, NA-D answered, "The repositioning worksheet didn't say for last night. Usually she is repositioned last on the night shift at six a.m." RN-J then stated she did not know when R205 had last been repositioned, but that the night staff usually repositioned her before leaving for the day. RN-J and NA-D verified the night shift staff had not noted the time R205 had been repositioned that morning. NA-D explained the repositioning worksheet was how staff tracked when a resident had been and was due for repositioning. On 3/4/15, at 10:56 a.m. NA-C stated R205 was supposed to be competed every two hours and was consistent with the NA care sheets. On 3/4/15, at 2:58 p.m. RN-G stated R205 was supposed to have been repositioned every two hours according to her care plan. R339's care plan dated 2/18/15, indicated R339 needed verbal cues with grooming and bathing. The daily report sheet dated 3/5/15, indicated R338's bath days were Tuesday and Saturday mornings. R339 was in her room on Monday 3/2/15, at 3:15	F 282	completed to ensure their needs are met. All residents are reviewed and care plan updated upon admission, with quarterly MDS assessments, with significant change, annually and as needed as part of the RAI process. Care conferences are scheduled with each resident and family to hear feedback on their plan of care and to provide updates. Staff will be educated through in-services and household meetings completed by April 10, 2015. New staff are trained upon hire and as needed. Audits of the resident□s plan of care and following plan of care will be conducted for 4 weeks and results reported to facility QA committee to ensure ongoing compliance. The Clinical Coordinators and Clinical Administrator are responsible for compliance. Date certain compliance is April 14th, 2015.	

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F 282	Continued From page 5 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. 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. On 3/4/15, at 2:45 p.m. the DON stated she expected staff to follow the residents' care plans. 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 fingernails. 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. The facility's 6/14, Resident Care Plan policy indicated staff were to communicate information in resident care plans to all staff providing direct resident care, and to "list preventative measures."	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of	F 312		4/14/15

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F 312	Continued From page 6 daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide grooming assistance for 1 of 3 residents (R339) reviewed for activities of daily living (ADLs). Findings include: 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. 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 nursing assistants (NAs) knew resident bath days, as they were indicated on the daily report sheets the NAs carried. 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 fingernails. The skin on her lower	F 312	Resident R339 was immediately offered nail care and she declined nail trimming stating I like my nails long. Resident R339□s care plan was reviewed for activities of daily living and staff was re-educated on the need to complete all ADL aspects with routine cares, and as needed. Staff was educated to report to nurse whenever resident□s refuse care for re-approach and documentation. She allowed cleaning underneath her nails. Resident is now deceased; she expired on 3/20/15. A review of this resident□s care plan and assignment sheets was immediately completed to ensure resident□s grooming needs were met. All residents are assessed for need for all ADLS upon admission, with quarterly MDS assessments, with significant change, annually and as needed as part of the RAI process. Staff will be educated through in-service and household meetings to be completed by 4/10/15. New staff will be trained upon hire and as needed. Audits of all other resident□s ADL plan of cares will be conducted for 4 weeks and results reported to facility QA committee to ensure ongoing compliance. The Clinical Coordinators and Clinical	

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F 312	Continued From page 7 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. R339's care plan dated 2/18/15, indicated R339 needed verbal cues with grooming, and needed assistance with bathing. The admission Minimum Data Set (MDS) dated 2/25/15, indicated R339 was cognitively intact. The MDS as well as the corresponding Care Area Assessment dated 3/3/15, indicated the resident required extensive assist with personal hygiene and partial help with bathing. The daily report sheet dated 3/5/15, indicated R338's bath days were Tuesday and Saturday mornings. On 3/5/15, at 8:50 a.m. the director of nursing stated she expected residents to be groomed daily and as needed. Facility's 9/3/10, Resident Care policy directed staff as follows: "Every resident to have A.M. and HS [evening] cares done daily...Wash residents face and hands and dry...Shave residents in am."	F 312	Administrator are responsible for compliance. Date certain compliance is April 14th, 2015.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		4/14/15

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F 314	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure appropriate care and treatment to promote healing of pressure ulcers for 1 of 2 residents (R205) reviewed for pressure ulcers. Findings include: R205 was continuously observed on 3/4/15, from 6:58 to 10:05 a.m. (3 hours, 7 minutes). Although she was dependent on staff for repositioning and had three Stage IV (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcers she was not offered or encouraged to change positions during 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 placed on either side of the resident, and the head of bed (HOB) was slightly elevated. At 7:40 a.m. a registered nurse (RN)-J entered R205's room. R205 asked RN-J to adjust her pillow. RN-J adjusted the pillow and raised the HOB slightly. R205 was asked whether she was experiencing any pain. Her medications and an inhaler were administered, and then the HOB was lowered slightly. At no time did RN-J suggest repositioning. At 8:05 a.m. R205 used her call light and requested lip balm. At 9:30 a.m. the surveyor asked a nursing assistant if she would see if RN-J could return to R205's room, as the surveyor planned to question the resident's need for repositioning. At 9:59 a.m. RN-J was observed in the vicinity of R205's room, when the surveyor intervened and informed RN-J R205 had not been repositioned. At 10:01 a.m. NA-D and RN-J	F 314	Resident 225□s was repositioned upon identification and was re-assessed for skin risk. Repositioning care plan was reviewed and updated to reflect resident□s preference of her extended sleep-in times and her choice not to receive nay repositioning support while sleeping. Resident has supportive surfaces on her bed that support her tissue tolerance and does not require every two hour repositioning. She has the ability to make slight body movements using grab bars on her bed to enhance her bed mobility. Her wounds are also healing. Resident has grab bars on her bed that enables her to adjust her body while in bed. Resident□s care plan will now require repositioning only while awake during the day and as needed, to meet resident□s choices while supporting the wound healing process. All residents are assessed for skin risk upon admission, with quarterly MDS assessments, with significant change, annually and as needed as part of the RAI process. A review of resident□s care plan and My Best day was completed to ensure resident□s skin integrity is supported and protected. Staff will continue to offer repositioning when resident is awake per request and as needed to honor her sleep preferences and monitor for skin integrity. Staff will ensure she has supportive surfaces to ensure her skin is supported during sleep hours. Her skin	

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F 314	Continued From page 9 entered R205's room. R205 was lying nearly flat in the bed. She reported she had pain in her legs and "a little" pain in her wounds (on her buttocks). R205 stated, "I like lying on my back and my sides, but not my stomach." At 10:05 a.m. RN-J removed the soiled dressings from R205's buttocks. The resident had three pressure ulcers. Greenish-red drainage was present on one of the dressings, and red drainage was present on a second dressing. The skin on R205's buttocks was reddened in color with additional redness around the wounds. Additionally, the left buttocks left indentations in the skin from the dressing. At 10:18 a.m. the resident's buttocks remained reddened. NA-D asked RN-J in what manner the resident should have been positioned. They then proceeded to position the resident nearly flat on her back and slightly to the left with pillows on either side of the resident. Although the resident was on her right side for approximately 30 minutes during the dressing changes, she was returned to the same position she had been in for at least three hours. On 3/4/15, at 7:50 a.m. RN-J explained R205 usually ate brunch at noon, preferring to sleep in, and was provided supplements. RN-J further stated R205's daily wound care was typically completed at 10:30 a.m. at the earliest. On 3/4/15, at 9:24 a.m. NA-E stated R205 was to be repositioned when in bed every two hours, because she had wounds on her buttocks. NA-E also stated the resident allowed repositioning, and she had never known R205 to refuse repositioning and in fact liked to be repositioned. NA-E said, "No one likes to stay on the same spot."	F 314	integrity will be monitored with routine cares, ordered treatments and scheduled weekly audits. Nursing staff will be educated on repositioning and skin risk through household meetings and in-service to be completed by 4/10/15. All residents with skin risk are assessed weekly for skin integrity and care plans are reviewed and updated as needed., weekly Quality Improvement Meetings, upon hire and as needed. All residents are monitored for skin integrity upon admission, with quarterly MDS assessments, with significant change, annually and as needed as part of the RAI process. Audits of residents□ plan of care and skin risk will be conducted for 4 weeks and results reported to facility QA committee to ensure ongoing compliance. The Clinical Coordinators and Clinical Administrator are responsible for compliance. Date certain for compliance is April 14th, 2015.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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When NA-D was asked on 3/4/15, at 10:37 a.m. what time R205 had last been repositioned, NA-D answered, "The repositioning worksheet didn't say for last night. Usually she is repositioned last on the night shift at six a.m." RN-J then stated she did not know when R205 had last been repositioned, but that the night staff usually repositioned her before leaving for the day. RN-J and NA-D verified the night shift staff had not noted the time R205 had been repositioned that morning. NA-D explained the repositioning worksheet was how staff tracked when a resident had been and was due for repositioning.

On 3/4/15, at 10:56 a.m. NA-C stated R205 liked to sleep late and was "always okay" with being repositioned, which was supposed to be competed every two hours and was consistent with the NA care sheets.

On 3/4/15, at 2:58 p.m. RN-G stated R205 was supposed to have been repositioned every two hours according to her care plan.

R205's significant change Minimum Data Set (MDS) dated 12/3/14, indicated R205 was cognitively intact, required extensive assist of two staff for bed mobility, and rejection of care was not exhibited.

R205's 2/1/15, Quick Guide to ADLs (activities of daily living) available in the resident's room directed staff to reposition the resident every two hours and as needed. The care plan noted "I have the potential for alteration in skin integrity r/t [related to] Decreased mobility, Incontinence, pressure ulcers on left buttock, right buttock and right sacral area." The care plan goal read, "My wounds will heal with out getting infected," and

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F 314	Continued From page 11 the interventions included offering repositioning every two hours and as needed. On 3/4/15, at 2:45 p.m. the director of nursing stated she expected staff to follow the residents' care plans and to update and revise the plans as needed. The facility's 8/13, Skin Risk Policy noted, "It is the policy of Presbyterian Homes to properly identify, assess and monitor residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for ulcers according industry standards of care...Encourage ambulation, activity, and mobility as tolerated...Establish an individualized turning and repositioning schedule if the resident is immobile."	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329		4/14/15

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F 329	Continued From page 12 as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents prescribed antipsychotic medications were adequately monitored for efficacy and/or medication side effects for 3 of 5 residents (R184, R155, R18) reviewed for unnecessary medication use. Findings include: R184 was observed on 3/3/15, at 8:27 a.m. while seated in the dining room eating her breakfast. The resident was quietly visiting with another resident. Later that day at 1:43 p.m. R184 was observed sitting calmly watching television in her room when she agreed to be interviewed. Throughout the interview the resident's demeanor was calm and relaxed. She did not display any signs of anxiety or behavior that suggested she wanted to leave during the 20 minutes the resident spoke to the surveyor. R184 reportedly had been feeling well and was sleeping the whole night without waking. R184's Medication Administration Record (MAR) for the months of 2/15 and 3/15, revealed the	F 329	Residents R184, R155 & R18□s care plans were re-assessed and reviewed by the care team for unnecessary medication use. All of the three resident□s side effects monitoring tools were reviewed to ensure they each had side-effect monitoring in their medical records. Each of the records indicated daily side effect monitoring for their psychoactive medications. Records also indicated that except for R 184, who fairly new to the building, attempts to reduce resident□s psychoactive medications had been made within the last four quarters for the other two residents. Ortho Blood Pressures were conducted for residents R184, R155 and R18 by March 31st, 2015. All residents were audited for completion of orthostatic blood pressures as indicated on 3/6/15. All residents requiring orthostatic blood pressures were conducted and results reviewed for further intervention. An immediate action to ensure a Point Click Care software demand for nurses to enter Orthostatic blood pressures was put in place to	

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F 329	Continued From page 13 resident had received the antipsychotic Seroquel 6.25 milligrams at bedtime since 1/22/15, for insomnia. R184's admission Minimum Data Set dated 1/28/15, indicated the resident had moderate cognitive impairment with a diagnosis of unspecified psychosis and anxiety. R184's care plan dated 2/10/15, directed staff to monitor for behaviors of wandering in the hallway or others rooms. The plan, however, did not include directions for staff to monitor for behavior that would have warranted antipsychotic use, nor for potential medication side effects. During an interview on 3/4/15, at 2:47 p.m. the registered nurse (RN)-A stated she had not observed R184 wandering "lately." RN-A explained that she had talked to R184's primary physician, and the plan was for the resident to be transferred to the long term care unit. Because of this, they did not wish to make changes in the resident's medication regime until after the move. RN-A confirmed that although the medication had been used since 1/22/15, they had not been monitoring R184's behaviors to provide justification for the continued use of antipsychotic medication nor were they monitoring for potential medication side effects. R155 reported on 3/4/15, at 10:16 a.m. she walked short distances with her walker outside her room. When she stood she felt lightheadedness, which resolved when she sat down again. She said she had reported it to the staff, and had been instructed to use her call light to request help.	F 329	trigger the nurse to complete this action. A new process for alerts in the EMR was initiated. Nursing staff were educated on need to check Ortho blood pressures monthly for all residents with psychotropic medications on 3/27/15. The policy and procedure was reviewed and is current. Weekly audits to ensure Orthostatic BPs are completed will be done weekly x 4weeks and on going to ensure on-going compliance and submitted to QA committee for review. The Clinical Coordinators and Clinical Administrator are responsible for compliance. Date certain for compliance is April 14th, 2015.	

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Physician orders for R155 dated 1/8/15, revealed medications including quetiapine (antipsychotic) 12.5 milligram (mg) at bedtime for dementia with hallucinations, mirtazapine 15 mg at bedtime for depression, donepezil 10 mg daily for Lewy Body dementia, as well as the following medications for high blood pressure (BP): Atenolol 50 mg daily, hydrochlorothiazide 25 mg daily, Lisinopril 20 mg daily, and hydralazine hydrochloride 25 mg three times daily.

R155's 10/24/14, Care Area Assessment (CAA) for psychotropic drug use indicated a potential for adverse consequences related to the use of antipsychotic and antidepressant medication. The care plan dated 11/5/14, noted the resident had depression and received psychotropic medications. In addition to administering those medications, staff was directed side effects of the medication.

No orthostatic BPs had been recorded on either the Weights and Vital Summary dated for 5/3/14 through 3/4/15, nor the Electronic Medication Record dated from 1/1/15 through 3/5/15. The Side Effects Information Sheets dated 9/6/14, listed "dizziness, lightheadedness or fainting" as potential medication side effects.

On 3/5/15, at 10:23 a.m. a registered nurse (RN)-C reviewed R155's medical record and verified orthostatic BPs had only been measured on 12/9/14, after R155 had experienced a fall.

On 3/5/15, at 11:03 a.m. the clinical administrator explained that the facility had just switched over to a new computer system the previous month, and the staff was finding it difficult to read the interventions, such as orthostatic BPs. They had

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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's vital signs "per protocol" and physician orders. In addition, the care plan read, "Administer my medications as ordered. Monitor/document 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 were documented only for 3/4/15 and 8/2/14. No

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F 329	Continued From page 16 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 routinely measured. He stated, "I would expect to see orthostatic BPs for antipsychotic use every month. They haven't been consistent. The resident has refused at times, but I would expect staff would try again." At 10:53 a.m. RN-A reported he was unable to locate additional orthostatic BPs in R18's record, and stated they should have been taken monthly. The facility's Psychotropic Medication Use policy noted "Each resident's drug regimen must be free from unnecessary drugs. Unnecessary drugs are any drug when used...Without adequate monitored...Side effect monitoring will be conducted for all psychotherapeutic medications. For antipsychotic medication the side effect monitoring will include a monthly orthostatic blood pressure."	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides.	F 356		4/14/15

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F 356	Continued From page 17 o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to post daily staffing to reflect the current census and actual nursing hours as required. This had the potential to affect all 92 residents residing in the facility and their visitors. Findings include: During initial tour on 3/2/15, at 12:02 p.m. and days following 3/3/15, 3/4/15, and 3/5/15, the Report of Nursing Staff was posted without updates in census changes as well as in staffing hours. Although there were changes in the work census and schedules, these were not reflected in a review on work schedules, Daily Census Summaries, and Reports of Nursing Staff dated 2/1/14 through 3/2/15.	F 356	Policy and procedure for updating Posted Nurse Staffing Information was reviewed by interdisciplinary team. Policy was reviewed and updated to reach compliance. Staffing department will update the required posting at the beginning of the AM and PM shifts to reflect accurate census and in house staffing for nursing department for the corresponding shift and throughout the shift with changes.. The NOC long-term care nurse will be responsible to update posting throughout the NOC shift to reflect accurate census and in house staffing for nursing department for the NOC shift. On the weekends, the Weekend manager on duty will be the designee for the staffing department if	

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F 356	Continued From page 18 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." SC-B then stated at 11:03 a.m. "When we talk about the census we talk about the census at midnight. The census does change during the day, but we do not update the Report of Nursing Staff for census changes. We do not update the Report of Nursing Staff for scheduling changes such as filling a RN shift with a LPN such as what did happen on 3/1/15, when [RN-H] was replaced with [LPN-C] due to a call in." On 3/5/15, at 11:17 a.m. SC-A stated, "The residents' families look at the staffing report and who takes care of their family member. Families can't tell if the facility is short of staff if the report is not updated." On 3/5/15, at 1:04 p.m. the administrator stated, "The Report of Nursing Staff should accurately	F 356	they are not on site. Also, facility has updated the staff posting document to include acknowledgement that the posting has been updated/reviewed each shift by indicating time of update and initials of individual who has updated the document. 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 Administrator or designee. Results reviewed by QA for on-going compliance. Clinical Administrator or designee is responsible for compliance. Date certain for compliance is April 14th, 2015.	

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F 356	Continued From page 19 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."	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to serve food at proper temperatures for 9 of 18 residents (R14, R165, R209, R3, R143, R200, R127, R29, R183) in the first floor dining room. In addition, sanitary food storage was not maintained in unit kitchenettes where resident food was stored. This had the potential to affect 91 of the 92 residents residing in the facility. Findings include: Food service	F 371	The staff involved was immediately provided with retraining on practices and policies related to serving food at proper temperatures on the date of the incident. The policy and procedure was reviewed and is current. In-services were completed on March 16, 2015 with all culinary services staff re-educated on proper food temperatures, proper procedure on taking accurate food temperatures, proper procedure on what to do if food does not reach adequate	4/14/15

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F 371	Continued From page 20 On 3/2/15, at 4:52 p.m. dietary aide (DA)-A was observed uncovering individual pans of food out of the Cambrose carts (food transport containers) and placing them in the electric steam table. When DA-A checked the temperature of the veal, the thermometer touched the bottom of the pan. . The surveyor instructed DA-A to measure the temperature in the middle of the food as this could have artificially raised the temperature reading. The temperature registered 130 degrees. DA-A reported they did not use covers on individual pans of food. She explained, "While the veal is warming up I will make salads...If food is less than 140 degrees I usually let it sit longer on the steam table because the steam table will heat up the food. I will serve the veal last--let it get hotter. I have had to deal with this before." DA-A then proceeded to serve residents who requested turkey versus veal. At 5:25 p.m. DA-A scooped up the last turkey to be served. The veal was then checked and the temperature registered 122 degrees. When asked what he planned to do next, DA-A answered, "I am going to serve it." Surveyor then intervened and suggested notifying his supervisor before serving the last nine residents. At 5:33 p.m. the dietary supervisor told DA-A, "We have talked about this before," and instructed DA-A to put the veal on a plate, cover with plastic and heat up the veal in the microwave for three minutes and then take the temperature again. After reheating temperature registered 160 degrees. DA-A finished dishing the residents' food. The dietary supervisor then stated, "We do mention to our staff about how to reheat foods, and if need be call up the cook for new food." At 6:01 p.m. in the kitchen the cook stated the first floor food was hot earlier when the	F 371	temperature, and proper procedure on transporting the food to each household to ensure keeping food at temperature. Dietary supervisors will conduct daily audits of all serving kitchens during meal service to ensure proper procedures are 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 culinary supervisor as needed. Results will be reviewed by QA committee. IDT team reviewed and updated policy related to cleaning procedures for kitchenette refrigerators and microwaves. Daily cleaning tasks were added to culinary servers to clean and sanitize all refrigerators on their household weekly. Housekeeping staff task lists were updated to include cleaning and sanitizing of microwaves on each household weekly. All staff including culinary, housekeeping, clinical, and therapy provided in-service to not keep staff food or non food products stored in household refrigerators to be completed by 4/10/15. Dietary supervisors will conduct daily audits of household kitchenette cleanliness x 4 weeks and ongoing. Results reported to QA committee. The Director of Nutrition and Culinary Services or their designee is responsible for compliance. Date certain for compliance is April 14th, 2015.	

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temperature was checked. The cook also stated, "Sometimes the staff uncover the food too soon and the food gets cold."At 6:05 p.m. DA-B added, "The food gets cold when not using covers on the steam table."

On 3/4/15, at 3:53 p.m. the dietary director (DD) explained the staff should have been leaving the food covered on the steam tables to ensue hot foods did not cool, to heat food in the microwave or asking the cook for a replacement if food had cooled.

Kitchenettes

On 3/3/15, from 12:59 to 1:31 the unit kitchenettes were observed with the assistant dietary director (ADD) and the following was noted:

Pathway kitchenette refrigerator freezer spilled food was noted on the shelving and doors, as well as standing water. The ADD stated, It needs to be cleaned. We clean weekly."

Arbor kitchenette freezer had splatters on the sides where ice cream and french toast was stored. The ADD verified it needed cleaning.

Bridgeway freezer where resident food was stored had sticky spills on the shelving and crumbs. The ADD stated, "This is much cleaner than the other one." An ice pack was stored with the food. The ADD said she would throw the ice pack away, and said it was likely used for one of the residents. She also added, "Sometimes will see staff lunch bags in the refrigerator." In addition, the microwave was not clean.

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PRESBYTERIAN HOMES OF BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431

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The Transitional Care Unit freezer was unclean. It contained a blue gel ice pack was stored in the freezer and was tabled for use in the laboratory cooler. The microwave was also unclean. The ADD explained, "We have weekly cleaning schedules. The servers are responsible for cleaning the unit kitchenettes."

Crossway kitchenette refrigerator/freezer had crumbs and red splatters, and a yellow sticky substance on the door shelf and bottom shelf. The microwave had a spilled white food substance on the interior of the door.

On 3/4/15 at 4:21 p.m. the DD stated she was constantly training and retraining staff because of turnover.

The facility's 10/11, Recording and Monitoring Food Temperatures policy indicated, "Minimum internal cooking temperatures and holding temperatures of potentially hazardous food will be recorded and monitored by Nutrition and Culinary Staff to ensure safe food products during cooking and holding...Food will be: Covered until ready for service. Holding temperatures: Hot food 145 degrees F (Fahrenheit) or higher.
Troubleshooting: If the hot food is not at 145 degrees F or higher, You must reheat the food to 165 degrees F for 15 seconds by the following two methods: Microwaving up on the community, Call the cook that prepared the food to bring food back to the kitchen to reheat".

The facility's 2/2/15 Community Refrigerators policy noted, "Refrigerators in the Care Center be maintained to ensure they are routinely cleaned/sanitized and are in safe working condition...Community Kitchen Refrigerators will

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F 371	Continued From page 23 be routinely cleaned by Nutrition and Culinary once a week per AM side job server cleaning list." A 5/11/10 Community Microwaves policy directed staff to ensure "...Microwaves in the Care Center be maintained to ensure they are routinely disinfected and are in safe working condition..Microwaves will be routinely cleaned by the Nutrition and Culinary and/or housekeeper staff once a week and/or as needed."	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the consultant pharmacist identified irregularities for 3 of 5 residents (R184, R155, R18) reviewed for unnecessary medication use. Findings include: R184's hospital discharge physician orders dated 1/21/15, indicted Seroquel (antipsychotic medication) 6.25 milligrams (mg) was initiated for	F 428	Residents R184, R155 & R18□s were re-assessed/reviewed by pharmacist consultant and the care team for unnecessary medication use. All of the three resident□s side effect monitoring tools was reviewed to ensure they each had side-effect monitoring in their records. Each of the records indicated daily side effect monitoring for their psychoactive medications. Records also indicated that except for R 184 who fairly new to the	4/14/15

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F 428	Continued From page 24 "agitation." R184's Medication Administration Record (MAR) for the months of 2/15 and 3/15, indicated R184 was receiving Seroquel (antipsychotic medication) 6.25 milligrams by mouth at bed time with a start date of 1/22/15 for a diagnosis of "insomnia." R184's admission Minimum Data Set (MDS) dated 1/28/15, indicated the resident had moderate cognitive impairment with a diagnosis of unspecified psychosis and anxiety. R184's care plan dated 2/10/15, indicated psychotropic medication was prescribed and staff was to monitor for behaviors of "wandering in the hallway or others rooms," but lacked specific behavior monitoring that would have warranted the use of antipsychotic medications, as well as for potential side effects. R184's behavior monitoring for the months for 2/15 and 3/15, noted staff was to monitor target behaviors of episodes of wandering in hallway or others rooms for R184. R184's behavior monitor for 2/15 revealed R184 wandered three times and in 3/15, no wandering was noted. Nursing notes from 2/1/15 to 3/4/15, lacked documentation a trial or attempt at a gradual dose reduction (GDR) of R184's Seroquel had been considered. R184's medical chart lacked documentation of monthly consulting pharmacist review or recommendations for possible GDR. During an interview on 3/4/15, at 2:47 p.m. the registered nurse (RN)-A reported R184's antipsychotic medication had been increased from as needed to scheduled nightly due to her wandering into others rooms. RN-A stated she had not observed R184 wandering "lately." RN-A	F 428	building, attempts to reduce resident□s psychoactive medications had been made within the last four quarters for the other two residents. The policy and procedure was reviewed and is current. The Pharmacist consultant reviewed all resident records and made recommendations as appropriate. Results of the survey findings were shared with the consultant Pharmacist who was asked to ensure review of each resident□s chart monthly per requirements. The pharmacists will review records monthly for side effect monitoring and will continue with monthly visits and share his/her recommendations and findings with the care team to ensure all unnecessary medications are reviewed for all residents. Weekly audits to ensure Orthostatic BPs are completed will be done weekly x 4weeks and on going to ensure on-going compliance. The pharmacist will provide a report of all resident to the Clinical administration with a summary of recommendations made. The Clinical Coordinators and Clinical Administrator are responsible for compliance. Date certain for compliance is April 14th, 2015.	

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explained that she had talked to R185's primary physician and the plan was for R184 to be transferred to the long term care unit. Because of this, they did not wish to make changes to the resident's medication regime until after the move. RN-A confirmed that although the antipsychotic medication had been used since 1/22/15, they had not been monitoring R184's behaviors to provide justification for the continued use of antipsychotic medications nor for potential medication side effects. RN-A stated she added to R184 care plan for staff to monitor for side effects of antipsychotic starting on 3/3/15, after the lack of documentation was brought to her 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.

R155 reported on 3/4/15, at 10:16 a.m. she walked short distances with her walker outside her room. When she stood she felt lightheadedness, which resolved when she sat down again. She said she had reported it to the staff, and had been instructed to use her call light to request help.

Physician orders for R155 dated 1/8/15, revealed medications including quetiapine (antipsychotic) 12.5 milligram (mg) at bedtime for dementia with hallucinations, mirtazapine 15 mg at bedtime for depression, donepezil 10 mg daily for Lewy Body dementia, as well as the following medications for high blood pressure (BP): Atenolol 50 mg daily, hydrochlorothiazide 25 mg daily, Lisinopril 20 mg daily, and hydralazine hydrochloride 25 mg

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F 428	Continued From page 26 three times daily. R155's 10/24/14, Care Area Assessment (CAA) for psychotropic drug use indicated a potential for adverse consequences related to the use of antipsychotic and antidepressant medication. The care plan dated 11/5/14, noted the resident had depression and received psychotropic medications. In addition to administering those medications, staff was directed side effects of the medication. No orthostatic BPs had been recorded on either the Weights and Vital Summary dated for 5/3/14 through 3/4/15, nor the Electronic Medication Record dated from 1/1/15 through 3/5/15. The Side Effects Information Sheets dated 9/6/14, listed "dizziness, lightheadedness or fainting" as potential medication side effects. On 3/5/15, at 10:23 a.m. a registered nurse (RN)-C reviewed R155's medical record and verified orthostatic BPs had only been measured on 12/9/14, after R155 had experienced a fall. On 3/5/15, at 11:03 a.m. the clinical administrator explained that the facility had just switched over to a new computer system the previous month, and the staff was finding it difficult to read the interventions, such as orthostatic BPs. They had 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. On 3/5/15, at 4:10 p.m. via a telephone call the	F 428		

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consultant pharmacist (CP)-A. When the consultant pharmacist was informed R155 had no orthostatic blood pressure measured since 5/1/14, last year except after a fall 12/9/14, the consultant pharmacist stated it was an oversight and R155 should have had orthostatic blood pressures completed at least quarterly. When asked if she was aware R155 was reporting feeling lightheadedness, the consultant pharmacist stated "I don't have any notations regarding the blood pressure."

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's vital signs "per protocol" and physician orders. In addition, the care plan read, "Administer my medications as ordered. Monitor/document for side effects...Monitor/record/report to my

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F 428	Continued From page 28 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 routinely measured. He stated, "I would expect to see orthostatic BPs for antipsychotic use every month. They haven't been consistent. The resident has refused at times, but I would expect staff would try again." At 10:53 a.m. RN-A reported he was unable to locate additional orthostatic BPs in R18's record, and stated they should have been taken monthly. The facility's Psychotropic Medication Use policy noted "Each resident's drug regimen must be free from unnecessary drugs. Unnecessary drugs are any drug when used...Without adequate monitored...Side effect monitoring will be conducted for all psychotherapeutic medications. For antipsychotic medication the side effect monitoring will include a monthly orthostatic blood pressure." The facility's consultant pharmacist (CP)-A was interviewed by telephone on 3/5/15, at 4:10 p.m. CP-A stated orthostatic blood pressures were not necessarily taken monthly, but should have been competed quarterly, as this was linked to the MDS assessment data gathering. During a review on 2/5/15 of R18's monthly medication record reviews by the facility's consulting pharmacist from 7/14 to 3/15 no irregularities had been noted by the pharmacist	F 428		

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F 428	Continued From page 29 regarding the lack of orthostatic BPs in R18's record.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		4/14/15

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F 431	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure expired medication of insulin vials (used to manage diabetes) were removed from the medication cart for 1 of 2 residents (R14) reviewed for medication storage. Findings include: An observation of the facility's medication storage system was conducted on 3/2/15, at 1:18 p.m. A vial of Lantus labeled for R14 was stored for use at room temperature in the medication cart. The vial had a handwritten opened date of 1/29/15, and a handwritten expiration date of 2/29/15. However, according to expiration guidelines the Lantus vial would have expired on 2/26/15 instead of 2/29/15. A licensed practical nurse (LPN)-A and a registered nurse (RN)-C both confirmed the Lantus had expired and should have been removed for destruction. R14's physician orders dated 11/21/15, directed staff to administer Lantus 100/milliliters 5 units every morning by subquentanious injection. The medication administration record for the months of 2/15 and 3/15 revealed the resident had been receiving Lantus every morning as ordered. A 4/14 Medication Storage and Expiration Guidelines policy noted that insulin vials stored at room temperature had an expiration date of 28 days after the first use.	F 431	Resident R14□s expired Lantus insulin was immediately removed from the cart 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 side effects of using the expired Lantus and none were observed. Family was also updated. Policy and procedure was reviewed and is current. Nurses were immediately educated on the medication storage and medication expiration process. Storage of 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-going compliance. The Clinical Coordinators and Clinical Administrator are responsible for compliance. Date certain for compliance is April 14th, 2015.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		4/14/15

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F 441	Continued From page 31 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control measures were used during cares for 2 of 2 residents (R218, R205) reviewed for activities of daily living (ADLs), and during pressure ulcer care for 1 of 2 residents (R65) reviewed for pressure ulcers. Findings include: R218 was observed on 3/4/15, at 7:18 a.m. while lying in bed. The resident informed the surveyor she had planned to get out of bed and use the bathroom, but had not made it in time. A nursing assistant (NA)-A reported she had never worked with R218, but was "filling in" until 8:00. NA-A donned gloves and assisted R218 to the bathroom. R218's incontinent brief was removed and placed in the garbage can. The brief was notable soaked with urine. NA-A then removed her gloves and without performing hand washing left the room. NA-A returned with a brief, applied gloves, and handed R218 a wash cloth to wash her face. She then assisted the resident to dress. NA-A then obtained a graduate cylinder and emptied stool from R218's colostomy bag as R218 assisted and provided instruction. While R218 continued holding the graduate, NA-A removed her gloves, obtained water in a syringe and rinsed the colostomy bag. Greenish colored liquid was removed from the bag and spilled onto NA-A's gloves, which she changed periodically. The NA, however, did not wash her hands when finished assisting the resident with colostomy cares. She instead donned clean gloves and proceeded to look in R218's closet. NA-A then assisted R218 with pericare, and assisted her to	F 441	Residents R218, R205 & R65□s care plans was reviewed by the care team for infection control prevention during cares. Initial staff involved were re-educated immediately. Infection control policies and procedures were reviewed and are current. Staff are all expected to adhere to the infection control process during resident care that includes washing of hands in between cares. All staff have been re-educated on the need to wash their hands in between cares especially when gloves are changed. Staff have individually been audited for this practice during cares and reminded about standard precautions. All staff are educated on infection control upon hire, with annual compliance review, weekly Quality Improvement team meetings and as needed. Audits of infection control practices will be conducted with routine cares and services for 10% of residents for 4 weeks and results reported to facility QA committee to ensure ongoing compliance. Staff will continue being educated during weekly Quality Improvement meetings, annually with annual training, upon hire and as needed for compliance. The Clinical Coordinators, Household Coordinators and Clinical Administrator are responsible for compliance. Date certain compliance is April 14th, 2015.	

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pull up her pants. The handles of the wheelchair were again touched by NA-A. The graduate cylinder was cleaned in the bathroom. NA-A then donned a clean pair of gloves, wiped the toilet seat of spills, and gathered the soiled incontinent product and gown into plastic bags that were then tossed on the floor. NA-A again touched the wheelchair handles, proceeded to bring R218 a cup of water, and made the bed. NA-A then brought the soiled linens to the utility room, and upon leaving the room, used the hand sanitizing foam near the door.

Following the observations at 8:00 a.m. NA-A reported she was aware she should have washed her hands after removing her gloves (when going from soiled to clean tasks), but thought instead she would just wash her hands when finished. NA-A stated, "I kept changing my gloves--it's too much."

On 3/4/15, at 8:06 a.m. a licensed practical nurse (LPN)-B stated the staff were supposed to have washed their hands depending on what they were doing. "Like for example...if they were cleaning the colostomy bag they are supposed to wash hands with glove changes."

On 3/5/15, at 10:59 a.m. a registered nurse (RN)-C explained the staff were supposed to have washed hands in between all cares, before donning gloves, and when coming into contact with any bodily fluids. RN-C reported all staff had received training at orientation, annually, and when infection control issues arose. She expected the staff to appropriately wash their hands. RN-C further stated the facility had also developed a quick reminder for staffs' name tags related to hand washing.

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F 441	Continued From page 34 An Infection Control Manual 2013 Standard Precautions directed, "Hand hygiene continues to be the primary means of preventing the transmission of infection. Perform hand hygiene...15. Before and after assisting a resident with personal care...16. After contact with a resident's mucous membranes and body fluids or excretions; 17. After handling soiled and used linens, dressings, bedpans, catheters, urinals; 19. After removing gloves...." R65's dressing change was observed on 3/14/15, at 10:05 a.m. performed by RN-G. At the start of the observation, supplies had already been placed on a clean incontinence pad on a bedside table. Packaged supplies had not been pre-opened for easy access during the dressing change. RN-G assisted R65 to turn onto the right side. She then donned gloves to remove the soiled dressing from the resident's buttock wound. Without changing her gloves and washing her hands, RN-G began the "clean" part of the dressing change. Wound cleanser was sprayed on the wound, the skin was dried, and a protective skin barrier wipe was used to wipe the skin around the wound edges. RN-G then returned to the supply table, and with the same soiled gloves, picked up a tube of ointment, and used a cotton swab to dab the ointment into the wound bed. This procedure was repeated two more times where RN-G touched the tube again and again. The space of the wound was then packed with a rope-type packing, which involved touching the packing with the original gloves. RN-G then changed gloves, but did not perform hand washing prior to donning a new pair of gloves. The cover to the dressing package was	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245556	A. BUILDING _____ B. WING _____	03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 35 opened, a pen was used to date the outside of the dressing, and the dressing was applied over the packing and wound. RN-G then cleaned away a stool smear at the resident's anus and although she changed gloves, she did not perform hand washing before applying a skin cream cleanser to the resident's anal area and wiped R65's skin with a moist bath wipe. RN-G then changed gloves, but did not perform hand washing, and applied barrier cream to the skin of the buttocks. During an interview on 3/14/15, at 10:27 a.m. RN-G verified she did not wash hands between any glove changes. She stated, "Last year the surveyors said changing gloves and washing hands were not needed during the process of the dressing change."	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure call lights were functioning for 1 of 6 residents (R335) reviewed for accidents. Findings include: R335's call light was not functioning properly when tested on 3/2/15, at 6:38 p.m. When the resident pushed the call button, it did not light up outside to room to alert staff. The surveyor tried	F 463	Resident R335□s call light was repaired within 20 minutes of notification to nurse on duty. The call light was repaired by the engineer on site and was tested for functioning. The engineer was notified by the unit coordinator by phone according to our policy. Call light records indicate that the call light continued to function through remainder of survey and through the end of her stay. Resident has since	4/14/15

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F 463	Continued From page 36 to activate the light four additional times and the call light did not work. It was discovered that R335's call light would work only if the call light button was depressed and held down for a few seconds. However, R335's tried and was not able to perform the tasks of holding down the call light button for a few seconds to activate it due to her cognition. A registered nurse (RN)-D was notified, and also tried unsuccessfully to activate the light. RN-D left the room and returned with a hand held bell for R335 to use as a replacement for the non-working call light, and stated she would put in a work order. R335's care plan revised date of 2/25/15, indicated the resident was at risk for falls due to cognitive impairment and had a history of falls. The care plan directed staff to make sure call light was within reach and encourage R335 to use it for assistance. On 3/5/15, at 10:31 a.m. an environmental tour was completed. During the tour the engineers (E)-A and (E)-B reported they were unaware R335's call light was not functioning. E-A stated that when a resident's call light was not working it was considered an emergency. E-A expected staff to let the engineers know "right away" by either a work order or phone call. E-A explained that an engineer was in the building until 10:00 p.m. and an on-call engineer until morning 24-hours a day. Although they checked every resident's call light monthly, no written documentation was kept related to the audits. During the environmental tour the administrator also stated he would have expected staff to fill out a work order and call down to the engineer if a call light was not working.	F 463	transferred within the facility to long term care. All call lights checked for proper functioning. Policy and procedure reviewed related to ensuring call light functionality. The current call system does initiate a warning to nursing desk on every unit if a battery is running low in the call system by identifying Low Battery and the corresponding unit. Each household is equipped with policy related to loss of call light function which is included in emergency procedure manual. Call lights will be tested monthly by household coordinators or their designee during household rounds, as well as upon admission and as needed. Call light response will be reviewed at Resident Council meetings. Staff will review weekly call light response report and respond to concerns as identified. On-going education provided to staff on timely response at weekly QI. Audits of call light for each unit will be conducted to ensure functionality of each room. Each room will be tested once per week for a period of 4 weeks and ongoing per current procedure of upon admission, monthly, and as needed. Care Center Administrator or designee will be responsible for compliance. Date certain for compliance is April 14th, 2015	

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F 463	Continued From page 37 On 3/5/15, at 10:55 a.m. a registered nurse (RN)-B stated that she was unaware R335's call light not working or that the resident was using a hand-held bell to notify nursing staff of the need for assistance. The VisionLink Call Data from 2/23/15 to 3/2/15, revealed R335 had been using her call light multiple times each day. The data specifically showed the call light was activated on 3/1/15, at 7:57 a.m. and not activated again until 34 hours, 31 minutes later when on 3/2/15, at 6:28 p.m. the surveyor observed R335's call light was not functioning properly. A policy was requested, however, the facility staff reported a specific policy related to call light function was unavailable.	F 463		

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	245556	A. BUILDING **1N - NEW BUILDING** B. WING _____	**03/05/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Presbyterian Homes of Bloomington Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

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

Electronically Signed — 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 3-story building was determined to be of Type II(222) construction. It has a full basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 98 beds and had a census of 92 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 076 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than	K 076		4/14/15

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K 076	Continued From page 2 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 18.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the medical gas administration in accordance with NFPA 99. This deficient practice could affect all residents. Findings include: During facility tour between 10:00 AM and 12:30 PM on 03/05/2015, observation revealed that there was oxygen in use while using the beauty shop hair dryer. Further investigation revealed that the resident who was under the hair dryer while on oxygen was not a skilled nursing care resident but an assisted living resident. This deficient practice was verified by the administrator at the time of the inspection.	K 076	Upon identification of infraction, administrator immediately informed Beauty Shop staff and resident involved to discontinue hair drying while on oxygen. Resident identified was not a facility resident. Administrator met with Salon staff and manager on 3/5/15 to re-educate on policy related to oxygen use in the beauty shop. Salon employees are expected to adhere to policy which states that if resident requires the use of oxygen that they cannot be placed in the proximity of a hair drying machine, also to include hand held hair dryers. Residents who require continuous oxygen will be shampooed and set only and returned to the household to allow hair to dry. Salon employees will be expected to communicate with household clinical staff to understand oxygen needs to best serve the individual. Care Center Salon schedule which is used as communication of appointments between household staff and salon employees has been updated to include notification of residents who are on oxygen. Salon schedule will be retained for a period of one month by salon staff to assure compliance Care Center administrator or designee will audit daily salon schedule weekly for a period of 4 weeks to ensure compliance. Care Center Administrator is responsible	

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K 076	Continued From page 3	K 076	for compliance. Date certain for compliance is April 14th, 2015.	

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

and the Time Period For Correction.

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

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

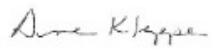
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

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

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

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

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00189	A. BUILDING: _____ B. WING _____	03/05/2015

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On 3/2/15 through 3/5/15, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure care plans were followed for 1 of 1 resident (R89) reviewed for hospice, 1 of 2 residents (R205) reviewed for pressure ulcers, and 1 of 3 residents (R339) reviewed for activities of daily living (ADLs). Findings include: R89's 8/9/13, care plan directed staff to clip the resident's call light to her sweater on the chest area so she could locate it to call for help. A 2/24/15, hospice care also noted, "I am legally blind. Place my call light on my gown, guide my hands and show me where it is...I am at risk for falls with injuries. I want my call light pinned to my sweater so am able to reach it easily." R89 was seated in a specialized wheelchair in her room on 3/5/15, at 9:22 a.m. The resident's knees were bent as she lifted her legs up and down while calling out in a distressed tone, "Ah,	2 565	Corrected	4/14/15

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2 565	Continued From page 3	2 565		

ah, ah, ah." The call light was behind the resident, and was wedged between the mattress and bed rail, approximately five feet from her reach. R89 stated she did not know the location of her call light.

A nursing assistant (NA)-C explained at 9:27 a.m. "We clip her call light on her clothing here," as the NA proceeded to take the call light from between the mattress and bed rail and clip it to R89's upper jacket and then place it in the resident's hand. NA-C further stated, "She does not see well. That is why we put the call light in her hand." NA-C reported R89 was capable of using and used her call light. A registered nurse (RN)-H then stated R89's call light was always clipped onto the front of her clothing, as she was legally blind.

On 3/5/15, at 9:44 a.m. the director of nursing (DON) stated call lights should have been within a residents' reach at all times.

R205's 2/1/15, Quick Guide to ADLs (activities of daily living) available in the resident's room directed staff to reposition the resident every two hours and as needed. The care plan noted "I have the potential for alteration in skin integrity r/t [related to] Decreased mobility, Incontinence, pressure ulcers on left buttock, right buttock and right sacral area." The care plan goal read, "My wounds will heal with out getting infected," and the interventions included offering repositioning every two hours and as needed.

R205 was continuously observed on 3/4/15, from 6:58 to 10:05 a.m. (3 hours, 7 minutes). Although she was dependent on staff for repositioning and had three Stage IV (full thickness tissue loss with exposed bone, tendon, or muscle) pressure

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PRESBYTERIAN HOMES OF BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 4 ulcers she was not offered or encouraged to change positions during the observation. On 3/4/15, at 7:50 a.m. RN-J explained R205 usually ate brunch at noon, preferring to sleep in, and was provided supplements. RN-J further stated R205's daily wound care was typically completed at 10:30 a.m. at the earliest. On 3/4/15, at 9:24 a.m. NA-E stated R205 was to be repositioned when in bed every two hours, because she had wounds on her buttocks. When NA-D was asked on 3/4/15, at 10:37 a.m. what time R205 had last been repositioned, NA-D answered, "The repositioning worksheet didn't say for last night. Usually she is repositioned last on the night shift at six a.m." RN-J then stated she did not know when R205 had last been repositioned, but that the night staff usually repositioned her before leaving for the day. RN-J and NA-D verified the night shift staff had not noted the time R205 had been repositioned that morning. NA-D explained the repositioning worksheet was how staff tracked when a resident had been and was due for repositioning. On 3/4/15, at 10:56 a.m. NA-C stated R205 was supposed to be competed every two hours and was consistent with the NA care sheets. On 3/4/15, at 2:58 p.m. RN-G stated R205 was supposed to have been repositioned every two hours according to her care plan. R339's care plan dated 2/18/15, indicated R339 needed verbal cues with grooming and bathing. The daily report sheet dated 3/5/15, indicated R338's bath days were Tuesday and Saturday mornings.	2 565		

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2 565	Continued From page 5 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. 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. On 3/4/15, at 2:45 p.m. the DON stated she expected staff to follow the residents' care plans. 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 fingernails. 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. The facility's 6/14, Resident Care Plan policy indicated staff were to communicate information in resident care plans to all staff providing direct resident care, and to "list preventative measures." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could ensure policies and procedures address	2 565		

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2 565	Continued From page 6 measures to ensure care plans are followed. Appropriate staff could be trained. An auditing tool could be developed and the results of those audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide grooming assistance for 1 of 3 residents (R339) reviewed for activities of daily living (ADLs). Findings include: R339 was in her room on Monday 3/2/15, at 3:15 p.m. She had untrimmed facial hair approximately one inch in length. R339 stated she needed staff's assistance to trim facial hair. On Wednesday 3/4/15, at 11:10 a.m. R339 was observed and facial hair continued untrimmed. On 3/4/15, at 11:22 a.m. a registered nurse (RN)-I stated facial hair was trimmed with daily cares in the morning.	2 850	Completed	4/14/15

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2 850	Continued From page 7 R339's care plan dated 2/18/15, indicated R339 needed verbal cues with grooming. The admission Minimum Data Set (MDS) dated 2/25/15, indicated R339 was cognitively intact. The MDS as well as the corresponding Care Area Assessment dated 3/3/15, indicated the resident required extensive assist with personal hygiene. On 3/5/15, at 8:50 a.m. the director of nursing stated she expected residents to be groomed daily and as needed. Facility's 9/3/10, Resident Care policy directed staff as follows: "Every resident to have A.M. and HS [evening] cares done daily...Shave residents in am." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could ensure policies and procedures address measures to ensure residents are groomed appropriately each day. Appropriate staff could be trained. An auditing tool could be developed and the results of those audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 850		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed.	2 860		4/14/15

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2 860	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide grooming assistance for 1 of 3 residents (R339) reviewed for activities of daily living (ADLs). Findings include: R339 was in her room on Monday 3/2/15, at 3:15 p.m. Her fingernails were unclean with black debris underneath the nails and were untrimmed varying in length 3/4 to 1 inch long. R339 stated she needed staff's assistance for nail care. On Wednesday 3/4/15, at 11:10 a.m. R339 was observed in her room and her fingernails still unclean and untrimmed. 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 nursing assistants (NAs) knew resident bath days, as they were indicated on the daily report sheets the NAs carried. On Thursday 3/5/15, at 9:39 a.m. R339 was again observed with long, unclean fingernails. Her toenails were thick and long, approximately 1/4 to 1/2 inch in length. R339 reported she needed help with toenail trimming. R339's care plan dated 2/18/15, indicated R339 needed verbal cues with grooming, and needed assistance with bathing. The admission Minimum Data Set (MDS) dated 2/25/15, indicated R339 was cognitively intact. The MDS as well as the corresponding Care Area Assessment dated	2 860	Corrected	

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2 860	Continued From page 9 3/3/15, indicated the resident required extensive assist with personal hygiene and partial help with bathing. The daily report sheet dated 3/5/15, indicated R338's bath days were Tuesday and Saturday mornings. On 3/5/15, at 8:50 a.m. the director of nursing stated she expected residents to be groomed daily and as needed. Facility's 9/3/10, Resident Care policy directed staff as follows: "Every resident to have A.M. and HS [evening] cares done daily." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could ensure policies and procedures address measures to ensure nail care is provided to residents on bath days and as needed to ensure nails are trimmed and cleaned. Appropriate staff could be trained. An auditing tool could be developed and the results of those audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 860		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval.	2 905		4/14/15

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2 905	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure appropriate care and treatment to promote healing of pressure ulcers for 1 of 2 residents (R205) reviewed for pressure ulcers. Findings include: R205 was continuously observed on 3/4/15, from 6:58 to 10:05 a.m. (3 hours, 7 minutes). Although she was dependent on staff for repositioning and had three Stage IV (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcers she was not offered or encouraged to change positions during 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 placed on either side of the resident, and the head of bed (HOB) was slightly elevated. At 7:40 a.m. a registered nurse (RN)-J entered R205's room. R205 asked RN-J to adjust her pillow. RN-J adjusted the pillow and raised the HOB slightly. R205 was asked whether she was experiencing any pain. Her medications and an inhaler were administered, and then the HOB was lowered slightly. At no time did RN-J suggest repositioning. At 8:05 a.m. R205 used her call light and requested lip balm. At 9:30 a.m. the surveyor asked a nursing assistant if she would see if RN-J could return to R205's room, as the surveyor planned to question the resident's need for repositioning. At 9:59 a.m. RN-J was observed in the vicinity of R205's room, when the surveyor intervened and informed RN-J R205 had not been repositioned. At 10:01 a.m. NA-D and RN-J entered R205's room. R205 was lying nearly flat	2 905	Corrected	

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2 905	Continued From page 11	2 905		

in the bed. She reported she had pain in her legs and "a little" pain in her wounds (on her buttocks). R205 stated, "I like lying on my back and my sides, but not my stomach." At 10:05 a.m. RN-J removed the soiled dressings from R205's buttocks. The resident had three pressure ulcers. Greenish-red drainage was present on one of the dressings, and red drainage was present on a second dressing. The skin on R205's buttocks was reddened in color with additional redness around the wounds. Additionally, the left buttocks left indentations in the skin from the dressing. At 10:18 a.m. the resident's buttocks remained reddened. NA-D asked RN-J in what manner the resident should have been positioned. They then proceeded to position the resident nearly flat on her back and slightly to the left with pillows on either side of the resident. Although the resident was on her right side for approximately 30 minutes during the dressing changes, she was returned to the same position she had been in for at least three hours.

On 3/4/15, at 7:50 a.m. RN-J explained R205 usually ate brunch at noon, preferring to sleep in, and was provided supplements. RN-J further stated R205's daily wound care was typically completed at 10:30 a.m. at the earliest.

On 3/4/15, at 9:24 a.m. NA-E stated R205 was to be repositioned when in bed every two hours, because she had wounds on her buttocks. NA-E also stated the resident allowed repositioning, and she had never known R205 to refuse repositioning and in fact liked to be repositioned. NA-E said, "No one likes to stay on the same spot."

When NA-D was asked on 3/4/15, at 10:37 a.m. what time R205 had last been repositioned, NA-D

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2 905	Continued From page 12 answered, "The repositioning worksheet didn't say for last night. Usually she is repositioned last on the night shift at six a.m." RN-J then stated she did not know when R205 had last been repositioned, but that the night staff usually repositioned her before leaving for the day. RN-J and NA-D verified the night shift staff had not noted the time R205 had been repositioned that morning. NA-D explained the repositioning worksheet was how staff tracked when a resident had been and was due for repositioning. On 3/4/15, at 10:56 a.m. NA-C stated R205 liked to sleep late and was "always okay" with being repositioned, which was supposed to be competed every two hours and was consistent with the NA care sheets. On 3/4/15, at 2:58 p.m. RN-G stated R205 was supposed to have been repositioned every two hours according to her care plan. R205's significant change Minimum Data Set (MDS) dated 12/3/14, indicated R205 was cognitively intact, required extensive assist of two staff for bed mobility, and rejection of care was not exhibited. R205's 2/1/15, Quick Guide to ADLs (activities of daily living) available in the resident's room directed staff to reposition the resident every two hours and as needed. The care plan noted "I have the potential for alteration in skin integrity r/t [related to] Decreased mobility, Incontinence, pressure ulcers on left buttock, right buttock and right sacral area." The care plan goal read, "My wounds will heal with out getting infected," and the interventions included offering repositioning every two hours and as needed.	2 905		

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2 905	Continued From page 13 On 3/4/15, at 2:45 p.m. the director of nursing stated she expected staff to follow the residents' care plans and to update and revise the plans as needed. The facility's 8/13, Skin Risk Policy noted, "It is the policy of Presbyterian Homes to properly identify, assess and monitor residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for ulcers according industry standards of care...Encourage ambulation, activity, and mobility as tolerated...Establish an individualized turning and repositioning schedule if the resident is immobile." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could ensure policies and procedures address measures to ensure residents are repositioned as needed. Those identified as having or are at risk of developing pressure ulcers have plans in place and those plans are followed for individualized repositioning needs. Appropriate staff could be trained. An auditing tool could be developed and the results of those audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all	21015		4/14/15

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21015	Continued From page 14 times. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure sanitary food storage was maintained in unit kitchenettes where resident food was stored. This had the potential to affect 91 of the 92 residents residing in the facility. Findings include: On 3/3/15, from 12:59 to 1:31 the unit kitchenettes were observed with the assistant dietary director (ADD) and the following was noted: Pathway kitchenette refrigerator freezer spilled food was noted on the shelving and doors, as well as standing water. The ADD stated, It needs to be cleaned. We clean weekly." Arbor kitchenette freezer had splatters on the sides where ice cream and french toast was stored. The ADD verified it needed cleaning. Bridgeway freezer where resident food was stored had sticky spills on the shelving and crumbs. The ADD stated, "This is much cleaner than the other one." An ice pack was stored with the food. The ADD said she would throw the ice pack away, and said it was likely used for one of the residents. She also added, "Sometimes will see staff lunch bags in the refrigerator." In addition, the microwave was not clean. The Transitional Care Unit freezer was unclean. It contained a blue gel ice pack was stored in the freezer and was tabled for use in the laboratory	21015	Corrected	

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21015	Continued From page 15 cooler. The microwave was also unclean. The ADD explained, "We have weekly cleaning schedules. The servers are responsible for cleaning the unit kitchenettes." Crossway kitchenette refrigerator/freezer had crumbs and red splatters, and a yellow sticky substance on the door shelf and bottom shelf. The microwave had a spilled white food substance on the interior of the door. On 3/4/15 at 4:21 p.m. the DD stated she was constantly training and retraining staff because of turnover. The facility's 2/2/15 Community Refrigerators policy noted, "Refrigerators in the Care Center be maintained to ensure they are routinely cleaned/sanitized and are in safe working condition...Community Kitchen Refrigerators will be routinely cleaned by Nutrition and Culinary once a week per AM side job server cleaning list." A 5/11/10 Community Microwaves policy directed staff to ensure "...Microwaves in the Care Center be maintained to ensure they are routinely disinfected and are in safe working condition..Microwaves will be routinely cleaned by the Nutrition and Culinary and/or housekeeper staff once a week and/or as needed." SUGGESTED METHOD OF CORRECTION: The registered dietitian and food service director could ensure policies and procedures are in place and appropriate staff are trained. Refrigerators and freezers in kitchenettes could be monitored on a more frequent basis to ensure policies are followed. Random audits could be conducted and the results of the audits reported to the quality committee.	21015		

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21015	Continued From page 16 TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21015		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to serve food at proper temperatures for 9 of 18 residents (R14, R165, R209, R3, R143, R200, R127, R29, R183) in the first floor dining room. Findings include: On 3/2/15, at 4:52 p.m. dietary aide (DA)-A was observed uncovering individual pans of food out of the Cambrose carts (food transport containers) and placing them in the electric steam table. When DA-A checked the temperature of the veal, the thermometer touched the bottom of the pan. . The surveyor instructed DA-A to measure the temperature in the middle of the food as this could have artificially raised the temperature reading. The temperature registered 130 degrees. DA-A reported they did not use covers on individual pans of food. She explained, "While the veal is warming up I will make salads...If food is less than 140 degrees I usually let it sit longer	21025	Corrected	4/14/15

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PRESBYTERIAN HOMES OF BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431

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on the steam table because the steam table will heat up the food. I will serve the veal last--let it get hotter. I have had to deal with this before." DA-A then proceeded to serve residents who requested turkey versus veal. At 5:25 p.m. DA-A scooped up the last turkey to be served. The veal was then checked and the temperature registered 122 degrees. When asked what he planned to do next, DA-A answered, "I am going to serve it." Surveyor then intervened and suggested notifying his supervisor before serving the last nine residents. At 5:33 p.m. the dietary supervisor told DA-A, "We have talked about this before," and instructed DA-A to put the veal on a plate, cover with plastic and heat up the veal in the microwave for three minutes and then take the temperature again. After reheating temperature registered 160 degrees. DA-A finished dishing the residents' food. The dietary supervisor then stated, "We do mention to our staff about how to reheat foods, and if need be call up the cook for new food."

At 6:01 p.m. in the kitchen the cook stated the first floor food was hot earlier when the temperature was checked. The cook also stated, "Sometimes the staff uncover the food too soon and the food gets cold."At 6:05 p.m. DA-B added, "The food gets cold when not using covers on the steam table."

On 3/4/15, at 3:53 p.m. the dietary director (DD) explained the staff should have been leaving the food covered on the steam tables to ensue hot foods did not cool, to heat food in the microwave or asking the cook for a replacement if food had cooled.

On 3/4/15 at 4:21 p.m. the DD stated she was constantly training and retraining staff because of turnover.

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21025	Continued From page 18 The facility's 10/11, Recording and Monitoring Food Temperatures policy indicated, "Minimum internal cooking temperatures and holding temperatures of potentially hazardous food will be recorded and monitored by Nutrition and Culinary Staff to ensure safe food products during cooking and holding...Food will be: Covered until ready for service. Holding temperatures: Hot food 145 degrees F (Fahrenheit) or higher. Troubleshooting: If the hot food is not at 145 degrees F or higher, You must reheat the food to 165 degrees F for 15 seconds by the following two methods: Microwaving up on the community, Call the cook that prepared the food to bring food back to the kitchen to reheat." SUGGESTED METHOD OF CORRECTION: The registered dietitian and food service director could ensure policies and procedures are in place and appropriate staff are trained. Temperature records could be monitored and the results reviewed. Random audits could be conducted of staff at meal service and the results of the audits reported to the quality committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21025		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases;	21390		4/14/15

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21390	Continued From page 19 C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control measures were used during cares for 2 of 2 residents (R218, R205) reviewed for activities of daily living (ADLs), and during pressure ulcer care for 1 of 2 residents (R65) reviewed for pressure ulcers. Findings include: R218 was observed on 3/4/15, at 7:18 a.m. while lying in bed. The resident informed the surveyor she had planned to get out of bed and use the bathroom, but had not made it in time. A nursing assistant (NA)-A reported she had never worked with R218, but was "filling in" until 8:00. NA-A	21390	Corrected	

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donned gloves and assisted R218 to the bathroom. R218's incontinent brief was removed and placed in the garbage can. The brief was notable soaked with urine. NA-A then removed her gloves and without performing hand washing left the room. NA-A returned with a brief, applied gloves, and handed R218 a wash cloth to wash her face. She then assisted the resident to dress. NA-A then obtained a graduate cylinder and emptied stool from R218's colostomy bag as R218 assisted and provided instruction. While R218 continued holding the graduate, NA-A removed her gloves, obtained water in a syringe and rinsed the colostomy bag. Greenish colored liquid was removed from the bag and spilled onto NA-A's gloves, which she changed periodically. The NA, however, did not wash her hands when finished assisting the resident with colostomy cares. She instead donned clean gloves and proceeded to look in R218's closet. NA-A then assisted the resident with pericare, and assisted her to pull up her pants. The handles of the wheelchair were again touched by NA-A. The graduate cylinder was cleaned in the bathroom. NA-A then donned a clean pair of gloves, wiped the toilet seat of spills, and gathered the soiled incontinent product and gown into plastic bags that were then tossed on the floor. NA-A again touched the wheelchair handles, proceeded to bring R218 a cup of water, and made the bed. NA-A then brought the soiled linens to the utility room, and upon leaving the room, used the hand sanitizing foam near the door.

Following the observations at 8:00 a.m. NA-A reported she was aware she should have washed her hands after removing her gloves (when going from soiled to clean tasks), but thought instead she would just wash her hands when finished. NA-A stated, "I kept changing my gloves--it's too

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21390	Continued From page 21 much." On 3/4/15, at 8:06 a.m. a licensed practical nurse (LPN)-B stated the staff were supposed to have washed their hands depending on what they were doing. "Like for example...if they were cleaning the colostomy bag they are supposed to wash hands with glove changes." On 3/5/15, at 10:59 a.m. a registered nurse (RN)-C explained the staff were supposed to have washed hands in between all cares, before donning gloves, and when coming into contact with any bodily fluids. RN-C reported all staff had received training at orientation, annually, and when infection control issues arose. She expected the staff to appropriately wash their hands. RN-C further stated the facility had also developed a quick reminder for staffs' name tags related to hand washing. An Infection Control Manual 2013 Standard Precautions directed, "Hand hygiene continues to be the primary means of preventing the transmission of infection. Perform hand hygiene...15. Before and after assisting a resident with personal care...16. After contact with a resident's mucous membranes and body fluids or excretions; 17. After handling soiled and used linens, dressings, bedpans, catheters, urinals; 19. After removing gloves...." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and infection control nurse could ensure policies and procedures are consistent with standards of practice for infection control. Appropriate staff could be trained on when to utilize gloves and when to change gloves and perform hand washing. An auditing tool could be developed and	21390		

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21390	Continued From page 22 the results of those audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based of observation, interview and document review, the facility failed to ensure required baseline tuberculosis (TB) screening for 2 of 5 residents (R341, R344) within 72 hours of admission or three months prior to admission to	21426	Corrected	4/14/15

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21426	Continued From page 23 the facility. Findings include: R341 was admitted to the facility on 2/24/15. The medical record revealed the TB Screening had been completed on the date of admission. Review of the hospital discharge After Visit Summary dated 2/24/15, it was revealed R341 had a chest X-ray completed during the hospital stay on 2/17/15, due to acute congestive heart failure (CHF) and questionable aspiration pneumonia. On 3/5/15, at 8:04 a.m. a registered nurse (RN)-B stated R341 had refused testing, and this had been communicated to the resident's physician. RN-B showed the surveyor the physician's signature. RN-B further stated sometimes if a resident had a chest X-ray completed which did not show any concerns in his lungs, they used the X-ray as evidence of TB screening. RN-B, however, acknowledged the X-ray had not been reviewed by a physician to rule out active disease. R344 was admitted to the facility on 2/17/15 to the facility. The medical record revealed the TB screening had been completed on the date of admission. Review Immunization record indicated "Consent Refused" for TB 2-Step skin test. The hospital discharge Interagency Transfer Form Notes History and Physical dated 2/16/15, revealed R344 had a chest X-ray completed during the hospital stay. During further document review it was revealed R344 had been seen by both the nurse practitioner and the physician on 2/19/15, 2/2/26/15, 2/27/15, and 3/2/15. However, during those visits it had not been documented the chest X-ray showed the resident was free	21426		

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21426	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 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 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 cannot be substituted for the TST. Chest x-ray screening does not serve to establish a resident's baseline TST..." The plan did not indicate who was responsible to ensure resident's records were reviewed for required screening. SUGGESTED METHOD OF CORRECTION:	21426		

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21426	Continued From page 25 The director of nursing (DON) or designee could ensure policies and procedures address measures to ensure care plans are followed. Appropriate staff could be trained. An auditing tool could be developed and the results of those audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must	21530		4/14/15

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21530	Continued From page 26 refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the consultant pharmacist identified irregularities for 3 of 5 residents (R184, R155, R18) reviewed for unnecessary medication use. Findings include: R184's hospital discharge physician orders dated 1/21/15, indicted Seroquel (antipsychotic medication) 6.25 milligrams (mg) was initiated for "agitation." R184's Medication Administration Record (MAR) for the months of 2/15 and 3/15, indicated R184 was receiving Seroquel (antipsychotic medication) 6.25 milligrams by mouth at bed time with a start date of 1/22/15 for a diagnosis of "insomnia." R184's admission Minimum Data Set (MDS) dated 1/28/15, indicated the resident had moderate cognitive impairment with a diagnosis of unspecified psychosis and anxiety. R184's care plan dated 2/10/15, indicated psychotropic medication was prescribed and staff was to	21530	Corrected	

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monitor for behaviors of "wandering in the hallway or others rooms," but lacked specific behavior monitoring that would have warranted the use of antipsychotic medications, as well as for potential side effects.

R184's behavior monitoring for the months for 2/15 and 3/15, noted staff was to monitor target behaviors of episodes of wandering in hallway or others rooms for R184. R184's behavior monitor for 2/15 revealed R184 wandered three times and in 3/15, no wandering was noted.

Nursing notes from 2/1/15 to 3/4/15, lacked documentation a trial or attempt at a gradual dose reduction (GDR) of R184's Seroquel had been considered. R184's medical chart lacked documentation of monthly consulting pharmacist review or recommendations for possible GDR.

During an interview on 3/4/15, at 2:47 p.m. the registered nurse (RN)-A reported R184's antipsychotic medication had been increased from as needed to scheduled nightly due to her wandering into others rooms. RN-A stated she had not observed R184 wandering "lately." RN-A explained that she had talked to R185's primary physician and the plan was for R184 to be transferred to the long term care unit. Because of this, they did not wish to make changes to the resident's medication regime until after the move. RN-A confirmed that although the antipsychotic medication had been used since 1/22/15, they had not been monitoring R184's behaviors to provide justification for the continued use of antipsychotic medications nor for potential medication side effects. RN-A stated she added to R184 care plan for staff to monitor for side effects of antipsychotic starting on 3/3/15, after the lack of documentation was brought to her

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21530	Continued From page 28 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. R155 reported on 3/4/15, at 10:16 a.m. she walked short distances with her walker outside her room. When she stood she felt lightheadedness, which resolved when she sat down again. She said she had reported it to the staff, and had been instructed to use her call light to request help. Physician orders for R155 dated 1/8/15, revealed medications including quetiapine (antipsychotic) 12.5 milligram (mg) at bedtime for dementia with hallucinations, mirtazapine 15 mg at bedtime for depression, donepezil 10 mg daily for Lewy Body dementia, as well as the following medications for high blood pressure (BP): Atenolol 50 mg daily, hydrochlorothiazide 25 mg daily, Lisinopril 20 mg daily, and hydralazine hydrochloride 25 mg three times daily. R155's 10/24/14, Care Area Assessment (CAA) for psychotropic drug use indicated a potential for adverse consequences related to the use of antipsychotic and antidepressant medication. The care plan dated 11/5/14, noted the resident had depression and received psychotropic medications. In addition to administering those medications, staff was directed side effects of the medication. No orthostatic BPs had been recorded on either the Weights and Vital Summary dated for 5/3/14 through 3/4/15, nor the Electronic Medication	21530		

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21530	Continued From page 29 Record dated from 1/1/15 through 3/5/15. The Side Effects Information Sheets dated 9/6/14, listed "dizziness, lightheadedness or fainting" as potential medication side effects. On 3/5/15, at 10:23 a.m. a registered nurse (RN)-C reviewed R155's medical record and verified orthostatic BPs had only been measured on 12/9/14, after R155 had experienced a fall. On 3/5/15, at 11:03 a.m. the clinical administrator explained that the facility had just switched over to a new computer system the previous month, and the staff was finding it difficult to read the interventions, such as orthostatic BPs. They had 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. On 3/5/15, at 4:10 p.m. via a telephone call the consultant pharmacist (CP)-A. When the consultant pharmacist was informed R155 had no orthostatic blood pressure measured since 5/1/14, last year except after a fall 12/9/14, the consultant pharmacist stated it was an oversight and R155 should have had orthostatic blood pressures completed at least quarterly. When asked if she was aware R155 was reporting feeling lightheadedness, the consultant pharmacist stated "I don't have any notations regarding the blood pressure." 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	21530		

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21530	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 effects...Monitor/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 routinely measured. He stated, "I would expect to see orthostatic BPs for antipsychotic use every month. They haven't been consistent. The resident has refused at times, but I would expect staff would try again." At 10:53 a.m. RN-A reported he was unable to locate additional orthostatic BPs in R18's record, and stated they should have been taken monthly.	21530		

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21530	Continued From page 31 The facility's Psychotropic Medication Use policy noted "Each resident's drug regimen must be free from unnecessary drugs. Unnecessary drugs are any drug when used...Without adequate monitored...Side effect monitoring will be conducted for all psychotherapeutic medications. For antipsychotic medication the side effect monitoring will include a monthly orthostatic blood pressure." The facility's consultant pharmacist (CP)-A was interviewed by telephone on 3/5/15, at 4:10 p.m. CP-A stated orthostatic blood pressures were not necessarily taken monthly, but should have been competed quarterly, as this was linked to the MDS assessment data gathering. During a review on 2/5/15 of R18's monthly medication record reviews by the facility's consulting pharmacist from 7/14 to 3/15 no irregularities had been noted by the pharmacist regarding the lack of orthostatic BPs in R18's record. SUGGESTED METHOD OF CORRECTION: The consulting pharmacist could review medication regimes to ensure an appropriate rationale is identified for the use of medication, at least effective doses, and side effect monitoring is conducted. Appropriate staff could be trained. An auditing tool could be developed and the results of those audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		

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21540	Continued From page 32	21540		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents prescribed antipsychotic medications were adequately monitored for efficacy and/or medication side effects for 3 of 5 residents (R184, R155, R18) reviewed for unnecessary medication use. Findings include: R184 was observed on 3/3/15, at 8:27 a.m. while	21540	Corrected	4/14/15

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seated in the dining room eating her breakfast. The resident was quietly visiting with another resident. Later that day at 1:43 p.m. R184 was observed sitting calmly watching television in her room when she agreed to be interviewed. Throughout the interview the resident's demeanor was calm and relaxed. She did not display any signs of anxiety or behavior that suggested she wanted to leave during the 20 minutes the resident spoke to the surveyor. R184 reportedly had been feeling well and was sleeping the whole night without waking.

R184's Medication Administration Record (MAR) for the months of 2/15 and 3/15, revealed the resident had received the antipsychotic Seroquel 6.25 milligrams at bedtime since 1/22/15, for insomnia.

R184's admission Minimum Data Set dated 1/28/15, indicated the resident had moderate cognitive impairment with a diagnosis of unspecified psychosis and anxiety. R184's care plan dated 2/10/15, directed staff to monitor for behaviors of wandering in the hallway or others rooms. The plan, however, did not include directions for staff to monitor for behavior that would have warranted antipsychotic use, nor for potential medication side effects.

During an interview on 3/4/15, at 2:47 p.m. the registered nurse (RN)-A stated she had not observed R184 wandering "lately." RN-A explained that she had talked to R184's primary physician, and the plan was for the resident to be transferred to the long term care unit. Because of this, they did not wish to make changes in the resident's medication regime until after the move. RN-A confirmed that although the medication had been used since 1/22/15, they had not been

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monitoring R184's behaviors to provide justification for the continued use of antipsychotic medication nor were they monitoring for potential medication side effects.

R155 reported on 3/4/15, at 10:16 a.m. she walked short distances with her walker outside her room. When she stood she felt lightheadedness, which resolved when she sat down again. She said she had reported it to the staff, and had been instructed to use her call light to request help.

Physician orders for R155 dated 1/8/15, revealed medications including quetiapine (antipsychotic) 12.5 milligram (mg) at bedtime for dementia with hallucinations, mirtazapine 15 mg at bedtime for depression, donepezil 10 mg daily for Lewy Body dementia, as well as the following medications for high blood pressure (BP): Atenolol 50 mg daily, hydrochlorothiazide 25 mg daily, Lisinopril 20 mg daily, and hydralazine hydrochloride 25 mg three times daily.

R155's 10/24/14, Care Area Assessment (CAA) for psychotropic drug use indicated a potential for adverse consequences related to the use of antipsychotic and antidepressant medication. The care plan dated 11/5/14, noted the resident had depression and received psychotropic medications. In addition to administering those medications, staff was directed side effects of the medication.

No orthostatic BPs had been recorded on either the Weights and Vital Summary dated for 5/3/14 through 3/4/15, nor the Electronic Medication Record dated from 1/1/15 through 3/5/15. The Side Effects Information Sheets dated 9/6/14, listed "dizziness, lightheadedness or fainting" as

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21540	Continued From page 35 potential medication side effects. On 3/5/15, at 10:23 a.m. a registered nurse (RN)-C reviewed R155's medical record and verified orthostatic BPs had only been measured on 12/9/14, after R155 had experienced a fall. On 3/5/15, at 11:03 a.m. the clinical administrator explained that the facility had just switched over to a new computer system the previous month, and the staff was finding it difficult to read the interventions, such as orthostatic BPs. They had 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."	21540		

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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 effects...Monitor/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 routinely measured. He stated, "I would expect to see orthostatic BPs for antipsychotic use every month. They haven't been consistent. The resident has refused at times, but I would expect staff would try again." At 10:53 a.m. RN-A reported he was unable to locate additional orthostatic BPs in R18's record, and stated they should have been taken monthly.

The facility's Psychotropic Medication Use policy noted "Each resident's drug regimen must be free from unnecessary drugs. Unnecessary drugs are any drug when used...Without adequate monitored...Side effect monitoring will be conducted for all psychotherapeutic medications. For antipsychotic medication the side effect monitoring will include a monthly orthostatic blood pressure."

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) with the physicians and the consulting pharmacist could review medication regimes to ensure an appropriate rationale is identified for the use of medication, at

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21540	Continued From page 37 least effective doses, and side effect monitoring is conducted. Appropriate staff could be trained. An auditing tool could be developed and the results of those audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21640	MN Rule 4658.1350 Subp. 4 Disposition of Medications;Returned to Pharm Subp. 4. Returned to pharmacy. Drugs and prescribed medications used in nursing homes may be returned to the dispensing pharmacy according to part 6800.2700, subpart 2. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure expired medication of insulin vials (used to manage diabetes) were removed from the medication cart for 1 of 2 residents (R14) reviewed for medication storage. Findings include: An observation of the facility's medication storage system was conducted on 3/2/15, at 1:18 p.m. A vial of Lantus labeled for R14 was stored for use at room temperature in the medication cart. The vial had a handwritten opened date of 1/29/15, and a handwritten expiration date of 2/29/15. However, according to expiration guidelines the Lantus vial would have instead expired on 2/26/15 instead of 2/29/15. A licensed practical nurse (LPN)-A and a registered nurse (RN)-C	21640	Corrected	4/14/15

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21640	Continued From page 38 both confirmed the Lantus had expired and should have been removed for destruction. R14's physician orders dated 11/21/15, directed staff to administer Lantus 100/milliliters 5 units every morning by injection. The medication administration record for the months of 2/15 and 3/15 revealed the resident had been receiving Lantus every morning as ordered. A 4/14 Medication Storage and Expiration Guidelines policy noted that insulin vials stored at room temperature had an expiration date of twenty eight days after the first use. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could ensure policies and procedures address measures to ensure care plans are followed. Appropriate staff could be trained. An auditing tool could be developed and the results of those audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21640		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources.	21810		4/14/15

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21810	Continued From page 39 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a call light was within reach for 1 of 1 resident (R89) who was reviewed for hospice care. Findings include: R89 was seated in a specialized wheelchair in her room on 3/5/15, at 9:22 a.m. The resident's knees were bent as she lifted her legs up and down while calling out in a distressed tone, "Ah, ah, ah, ah." The call light was behind the resident, and was wedged between the mattress and bed rail, approximately five feet from her reach. R89 stated she did not know the location of her call light. A nursing assistant (NA)-C explained at 9:27 a.m. "We clip her call light on her clothing here," as the NA proceeded to take the call light from between the mattress and bed rail and clip it to R89's upper jacket and then place it in the resident's hand. NA-C further stated, "She does not see well. That is why we put the call light in her hand." NA-C reported R89 was capable of using and used her call light. A registered nurse (RN)-H then stated R89's call light was always clipped onto the front of her clothing, as she was legally blind. R89's Minimum Data Set (MDS) dated 1/21/15, indicated the resident had severely impaired vision due to retinopathy and glaucoma (both causing vision loss), had moderately impaired vision, and was able to make herself understood. She required extensive assistance with activities	21810	Corrected	

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21810	Continued From page 40 of daily living (ADLs). R89's 8/9/13, care plan directed staff to clip the resident's call light to her sweater on the chest area so she could locate it to call for help. A 2/24/15, hospice care also noted, "I am legally blind. Place my call light on my gown, guide my hands and show me where it is...I am at risk for falls with injuries. I want my call light pinned to my sweater so am able to reach it easily." On 3/5/15, at 9:44 a.m. the director of nursing (DON) stated call lights should have been within a residents' reach at all times. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could ensure policies and procedures address measures to resident call lights are placed within their reach at all times as appropriate. All staff could be trained. An auditing tool could be developed and the results of those audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21810		
23010	MN Rule 4658.4635 A Nurse Call System; New Construction The nurses' station must be equipped with a communication system designed to receive calls from the resident and nursing service areas required by this part. The communication system, if electrically powered, must be connected to the emergency power supply. Nurse calls and emergency calls must be capable of being inactivated only at the points of origin. A central annunciator must be provided where the	23010		4/14/15

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23010	Continued From page 41 door is not visible from the nurses' station. A. A nurse call must be provided for each resident's bed. Call cords, buttons, or other communication devices must be placed where they are within reach of each resident. A call from a resident must register at the nurses' station, activate a light outside the resident bedroom, and activate a duty signal in the medication room, nourishment area, clean utility room, soiled utility room, and sterilizing room. In multi-corridor nursing units, visible signal lights must be provided at corridor intersections. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure call lights were functioning for 1 of 6 residents (R335) reviewed for accidents. Findings include: R335's call light was not functioning properly when tested on 3/2/15, at 6:38 p.m. When the resident pushed the call button, it did not light up outside to room to alert staff. The surveyor tried to activate the light four additional times and the call light did not work. A registered nurse (RN)-D was notified, and also tried unsuccessfully to activate the light. RN-D left the room and returned with a hand held bell for R335 to use as a replacement for the non-working call light, and stated she would put in a work order. R335's care plan revised date of 2/25/15, indicated the resident was at risk for falls due to cognitive impairment and had a history of falls. The care plan directed staff to make sure call light was within reach and encourage R335 to use	23010	Corrected	

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23010	Continued From page 42 it for assistance. On 3/5/15, at 10:31 a.m. an environmental tour was completed. During the tour the engineers (E)-A and (E)-B reported they were unaware R335's call light was not functioning. E-A stated that when a resident's call light was not working it was considered an emergency. E-A expected staff to let the engineers know "right away" by either a work order or phone call. E-A explained that an engineer was in the building until 10:00 p.m. and an on-call engineer until morning 24-hours a day. Although they checked every resident's call light monthly, no written documentation was kept related to the audits. During the environmental tour the administrator also stated he would have expected staff to fill out a work order and call down to the engineer if a call light was not working. On 3/5/15, at 10:55 a.m. a registered nurse (RN)-B stated that she was unaware R355's call light not working or that the resident was using a hand-held bell to notify nursing staff of the need for assistance. A policy was requested, however, the facility did not have a specific policy related to call light function. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could ensure policies and procedures address measures to ensure care plans are followed. Appropriate staff could be trained. An auditing tool could be developed and the results of those audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Seven (7)	23010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00189	A. BUILDING: _____ B. WING _____	03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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23010	Continued From page 43 days.	23010		