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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PY6X

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00122

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245417**

2.STATE VENDOR OR MEDICAID NO.
(L2) **516842200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ROBBINSDALE REHAB & CARE CENTER**
(L4) **3130 GRIMES AVENUE NORTH**
(L5) **ROBBINSDALE, MN** (L6) **55422**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/27/2012** (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 IMR	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 **100** (L18)

13.Total Certified Beds **100** (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	IMR
	100			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 04/02/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 04/10/2012 (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
03/01/1987
(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.
00450
(L31)

30. REMARKS
Posted 04/16/2012 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/19/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

CCN #24-5417

A standard OTC survey was completed at this facility on February 2, 2012. The most serious deficiency was cited at a S/S level of F.

On February 22, 2012, an abbreviated standard OTC survey was conducted. The most serious deficiency was cited at a S/S level of D. Since the facility was not found in substantial compliance, we recommended the following to the CMS RO and CMS concurred:

- Mandatory DOPNA effective 05/02/12

If DOPNA goes into effect, the facility will also be subject to a loss of NATCEP for a two year period beginning 05/02/12.

A PCR was completed for the standard survey on March 23, 2012 and a PCR was completed for the abbreviated standard survey on March 27, 2012 and the facility was found in substantial compliance, effective March 27, 2012. As a result, we are recommended the following action to the CMS RO and CMS concurred:

- Mandatory DOPNA effective 05/02/12, be rescinded

The facility would not be subject to the loss of NATCEP, since DOPNA was rescinded.

See attached 2567B's for the results of the March 23, 2012 and March 27, 2012 revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5417 April 10, 2012

Ms. Kathleen Pankratz, Administrator
Robbinsdale Rehabilitation and Care Center
3130 Grimes Avenue North
Robbinsdale, Minnesota 55422

Dear Ms. Pankratz:

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 March 27, 2012 the above facility is certified for:

100 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 100 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 2, 2012

Ms. Kathleen Pankratz, Administrator
Robbinsdale Rehabilitlation and Care Center
3130 Grimes Avenue North
Robbinsdale, Minnesota 55422

RE: Project Number S5417021 and H5417165

Dear Ms. Pankratz:

On February 29, 2012, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 2, 2012. (42 CFR 488.417 (b))

Also, we notified you in our letter of February 29, 2012, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 2, 2012.

This was based on the deficiencies cited by this Department for a standard survey completed on February 2, 2012, and the most serious deficiencies at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) and an abbreviated standard survey completed on February 22, 2012. The most serious deficiencies at the time of the abbreviated survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On March 15, 2012 and March 27, 2012, the Minnesota Department of Health completed a PCR, and on March 23, 2012, the Minnesota Department of Public Safety completed a PCR by review of the plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey completed on February 2, 2012 and the abbreviated standard survey completed on March 15, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 27, 2012. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCRs completed on March 15, 2012, March 27, 2012 and March 23, 2012, as of March 27, 2012.

As a result of the revisit findings, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of February 29, 2012. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 2, 2012, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective May 2, 2012, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective May 2, 2012, is to be rescinded.

In our letter of February 29, 2012, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 2, 2012, due to denial of payment for new admissions. Since your facility attained substantial compliance on March 27, 2012, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

Feel free to contact me if you have questions.

Sincerely,

Gloria Derfus

Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3792 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File 5417r112.rtf

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 5066

February 29, 2012

Ms. Kathleen Pankratz, Administrator
Robbinsdale Rehabilitation and Care Center
3130 Grimes Avenue North
Robbinsdale, Minnesota 55422

RE: Project Number H5417165

Dear Ms. Pankratz:

On February 17, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 2, 2012. 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 February 22, 2012, an abbreviated standard survey was completed by the Minnesota Department of Health, Office of Health Facility Complaints, to determine if your facility was in compliance with the Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This surveye found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective May 2, 2012. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective May 2, 2012. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 2, 2012. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Robbinsdale Rehabilitation and Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective May 2, 2012. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver Potts, Chief
330 Independence Avenue, SE
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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:

Kris Lohrke, Assistant Director
Minnesota Department of Health
Office of Health Facility Complaints
Division of Compliance Monitoring
P.O. Box 64970
St. Paul, Minnesota 55164-0970

Telephone: (651) 201-4215

Fax: (651) 281-9796

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, if your PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 August 2, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

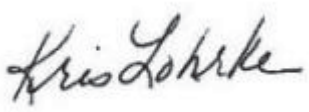
This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,



Kris Lohrke, Assistant Director
Office of Health Facility Complaints
Division of Compliance Monitoring
Telephone: (651) 201-4215 Fax: (651) 281-9796

Enclosure

cc: Licensing and Certification File 5417c12.rtf

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
245417	A. Building B. Wing	3/15/2012

Name of Facility	Street Address, City, State, Zip Code
ROBBINSDALE REHAB & CARE CENTER	3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0204** Reg. # **483.12(a)(7)** LSC	**03/13/2012**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	**03/13/2012**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**03/13/2012**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	**03/13/2012**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	**03/13/2012**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**03/13/2012**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	**03/13/2012**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	**03/13/2012**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**03/13/2012**
ID Prefix **F0463** Reg. # **483.70(f)** LSC	**03/13/2012**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	**03/13/2012**	ID Prefix Reg. # LSC	Completed
ID Prefix Reg. # LSC	Completed	ID Prefix Reg. # LSC	Completed	ID Prefix Reg. # LSC	Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/sd	04/02/12	18623	03/15/12
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
2/2/2012			

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
245417	A. Building B. Wing 01 - MAIN BUILDING 01	3/23/2012

Name of Facility	Street Address, City, State, Zip Code
ROBBINSDALE REHAB & CARE CENTER	3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0038	Correction Completed 02/24/2012	ID Prefix Reg. # NFPA 101 LSC K0066	Correction Completed 02/24/2012	ID Prefix Reg. # NFPA 101 LSC K0076	Correction Completed 02/24/2012
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 State Agency	Reviewed By PS/sd	Date: 04/02/12	Signature of Surveyor: 28120	Date: 03/23/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/1/2012		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
245417	A. Building B. Wing	3/27/2012

Name of Facility	Street Address, City, State, Zip Code
ROBBINSDALE REHAB & CARE CENTER	3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 03/27/2012	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 State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	KL/sd	04/02/12	10567	03/27/12
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
2/22/2012				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PY6X

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00122

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245417**

2.STATE VENDOR OR MEDICAID NO.
(L2) **516842200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ROBBINSDALE REHAB & CARE CENTER**
(L4) **3130 GRIMES AVENUE NORTH**
(L5) **ROBBINSDALE, MN** (L6) **55422**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/02/2012** (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 IMR	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 **100** (L18)

13.Total Certified Beds **100** (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	IMR
	100			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Angela Richey, HFE NE II 03/05/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 03/15/2012 (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
03/01/1987
(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.
00450
(L31)

30. REMARKS
Posted 3/192012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

CCN #24-5417

At the time of the standard survey completed February 2, 2012, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 8432

February 17, 2012

Ms. Kathleen Pankratz, Administrator
Robbinsdale Rehabilitation and Care Center
3130 Grimes Avenue North
Robbinsdale, Minnesota 55422

RE: Project Number S5417021

Dear Ms. Pankratz:

On February 2, 2012, 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>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:

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

Telephone: (651) 201-3792

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 March 13, 2012, 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 March 13, 2012 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 2, 2012 (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 August 2, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

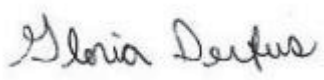
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3792 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File 5417s12.rtf

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Informal Dispute Requested

This facility has requested an Informal Dispute on the tag(s) identified below.

Facility (City) HFID#	Exit Date Being Disputed	Tag# - Scope/Severity Disputed
Robbinsdale Rehab & Care Center 00122	2/2/12	F204 = D F272 =D F314 =D

All tags remain as is.

Larson, Monica (MDH)

From: sstmary@good-sam.com
Sent: Tuesday, February 28, 2012 12:12 PM
To: *MDH_FPC-IDR
Subject: IDR Form

PROVIDER - 00890, GOOD SAM SOCTY UNIV SPEC CARE

IDR Type - IIDR

Tags: FF226
Survey Date(Exit Date): 1/27/12

Review will be conducted - In person

Dates when facility cannot participate: 3/20-3/30; 4/19;5/7-5/11;6/18-6/21

Will attorney for facility be attending: Yes

No of persons attending: 5
Submitter Name: Sharon A. St. Mary
Email:sstmary@good-sam.com

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 28, 2012

Ms. Kathleen Pankratz,
Robbinsdale Rehab & Care Center
3130 Grimes Avenue North
Robbinsdale, MN 55422

Dear Ms. Pankratz:

This letter acknowledges receipt of your request for Informal Dispute Resolution (IDR) of the deficiencies issued at a recent Minnesota Department of Health survey of your facility.

It is my understanding that you are contesting the validity of the following:

F204 =D
F272 =D
F314 =D

I have assigned the responsibility for the IDR to Christy Johnson. Christy will contact you regarding the scheduling of the meeting or feel free to contact her at 218-308-2114.

Sincerely,

Mary J Absolon

Mary Absolon, Program Manager
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone : (651) 201-4100 FAX: (651) 215-9697

cc: Office of Ombudsman for Long-Term Care
Pam Kerssen, Assistant Program Manager
Carol Moen, Assistant Program Manager
Christy Johnson, Unit Supervisor
Monica Larson

00122 2/2/12

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 6575

April 16, 2012

Ms. Kathleen Pankratz,
Robbinsdale Rehabilitaiton and Care Center
3130 Grimes Avenue North
Robbinsdale, Minnesota 55422

Subject: Robbinsdale Rehab & Care Center - IDR
Provider # 24-5417
Project # S5417021

Dear Ms. Pankratz:

This is in response to your letter of February 27, 2012, in regard to your request of an informal dispute resolution (IDR) for the federal deficiencies at tags F204, F272, and F314 issued pursuant to the survey event PY6X11, completed on February 2, 2012.

The information presented with your letter, the CMS 2567 dated February 2, 2012 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F204 (D) 42 CFR § 483.12 (a)(7) Orientation for Transfer or Discharge
A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

The basis of your IDR for F204 is that R78's receiving facility was provided additional information after his transfer that included the accurate physician orders related to insulin dosage times following the discovery of the error on R78's transfer papers by the surveyor.

R78 was observed to be administered Lantus insulin 60 units on 2/2/12, at 7:57 a.m. during the surveyor's med pass observation according to the medication administration record directions. During the medication reconcilation on 2/2/12, at 1:50 p.m., the physician orders were identified to direct the Lantus insulin to be given at bedtime. At that time, LPN-B verified R78 had received the Lantus insulin at the wrong time of the day on both 2/1/12, and 2/2/12. LPN-B further reported R78 had already been transferred that day to another facility with the incorrect information. LPN-B stated the medication and treatment sheets with the inaccurate information had been sent to the receiving facility and not the current physician orders.

Inaccurate information related to the timing of the Lantus insulin was sent to the receiving facility at the time of R78's discharge. The error was identified by the surveyor at the time of the survey.

This is a valid deficiency at this tag and at the correct scope and severity of D.

F272 (D) 42 CFR § 483.20 Resident Assessment
The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:
Identification and demographic information;
Customary routine;
Cognitive patterns;
Communication;
Vision;
Mood and behavior patterns;
Psychosocial well-being;
Physical functioning and structural problems;
Continence;
Disease diagnosis and health conditions;
Dental and nutritional status;
Skin conditions;
Activity pursuit;
Medications;
Special treatments and procedures;
Discharge potential;
Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and
Documentation of participation in assessment.

The basis of your IDR for F272 is that your facility was unable to obtain a visual assessment of the resident's oral cavity and therefore could not complete a comprehensive assessment of oral care needed by R170.

Upon admission on 1/4/12, R170 was identified to have a prior history of treatment for gingivitis/periodontal disease and the use of Nystatin for the treatment of oral fungal infection. The medications were discontinued upon admission without an assessment as to why they were no longer needed. At the time of the survey, R170 was observed with a white film on his tongue. R170's family member also expressed concerns related to oral cares and R170's horrible mouth odor.

R170 lacked an assessment of oral care needs that included a review of pertinent oral medical history and treatments in order to ensure adequate interventions had been implemented related to oral cares.

This is a valid deficiency at this tag and at the correct scope and severity of D.

F314 (G) 42 CFR § 483.25(c) 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.

The basis of your IDR request for F314 is that R20 did not develop a pressure sore.

R20 was identified at risk for the development of pressure sores and had a history of a Stage 2 pressure sore on 10/29/11, according to the MDS dated 11/3/11. The care plan dated 11/11, also identified R20 at risk for skin breakdown associated with diagnoses including cerebral palsy. The care plan directed staff to implement a turning schedule of every two hours and as needed and to encourage the resident to off load/tilt wheelchair every hour. R20 was observed in the electric wheelchair at 10:00 a.m. on 2/1/12. At 1:45 p.m. R20 was observed at the nursing station crying and reporting that no one had taken care of her since she had gotten up in the electric wheelchair at 10:00 a.m. The nursing assistant confirmed R20 had not received a position change or off load/tilt in the wheelchair.

R20 had been identified at risk for pressure sores and a repositioning scheduled had been implemented according to her assessed need. However, R20 did not receive repositioning according to her assessed need on 2/1/12.

This is a valid deficiency at this tag and at the correct scope and severity of D.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Christy Johnson

Christy Johnson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 218-308-2114 Fax: 218-308-2122

cc: Office of Ombudsman for Long-Term Care
Pam Kerssen, Assistant Program Manager
Licensing and Certification File
Gloria Derfus, Metro Team C Unit Supervisor

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245417	A. BUILDING _____ B. WING _____	02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBBINSDALE REHAB & CARE CENTER	3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	The submission of this Plan of Correction is not an admission by the provider of any fact or conclusion set forth in the Statement of Deficiency. This Plan of Correction is being submitted because it is required by law. However, evidencing Robbinsdale Rehab and Care Center good faith, the facility offers the following Plan of Correction and have achieved substantial compliance in each of the areas addressed on March 13, 2012	
F 204 SS=D	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to provide sufficient and accurate preparation to ensure safe and orderly transfer from the facility for 1 of 4 residents (R78) in the sample who was discharged to a group home. Findings include: The facility did not provide accurate medical records at the time of transfer, which included accurate physician's orders for R78. R78 was admitted to the facility from home on 11/4/11, with diagnoses which included end stage renal disease and type II diabetes. R78 was blind	F 204	1. Resident #78 has had appropriate medical records forwarded to her new d/c location. 2. Center will review any upcoming residents who d/c on insulin to assure they have provided appropriate medical records to the new d/c location. 3. Licensed nurses have been re-educated on sending proper medical records to d/c locations for residents on insulin. 4. D/c residents on insulin will be audited weekly via the clinical meeting process to assure proper medical records were sent.	3/13/12

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

Kathleen Lindahl | Administrator | 2-27-12

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
	245417	A. BUILDING _____ B. WING _____	02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBBINSDALE REHAB & CARE CENTER	3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 1 and only saw shadows. R78 had dialysis three times a week, was on 1200 milliliter (cc) fluid restrictions and received a controlled carbohydrate diet. At 7:57 a.m. on 2/2/12, a random medication administration audit was conducted with licensed practical nurse (LPN-B). LPN-B administered 60 units of Lantus (a long acting insulin that lowers sugar in the blood) insulin and 25 units of Novolog insulin (a fast acting insulin that controls high blood sugar) to R78. At 1:50 p.m. on 2/2/12, the observation was reconciled with physician's orders in the medical record. The physician orders dated 1/31/12, indicated, "Lantus 100 units/1 milliliter (ml), inject 60 units sub-q (subcutaneous - under the skin) every bedtime." At 1:50 p.m. on 2/2/12, LPN-B verified the medication administration record/treatment sheet and physician's orders. LPN-B stated the Lantus insulin was scheduled at the wrong time on the treatment sheet. LPN-B acknowledged for the past two days (2/1/12 and 2/2/12), R78 received the Lantus insulin at the wrong time. LPN-B also stated R78 was already discharged to a group home. The discharge records were reviewed at 2:45 p.m. on 2/2/12. The interdisciplinary resident discharge note" under the section "medication you will continue to take at home and the number of doses you need today" indicated, "see copy of med+tx (treatment) sheets attached". The facility sent the February 2012 medication record with the wrong Lantus information and not the physician's order dated 1/31/12. The receiving facility did not receive the most current physician	F 204	5. Director of Nursing or designee will report audit results to the Quality Assurance Committee Monthly as appropriate. RECEIVED MAR 1 - 2012 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245417	A. BUILDING _____ B. WING _____	02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBBINSDALE REHAB & CARE CENTER	3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 2 order for the Lantus Insulin. During interview with the nurse manager (NM-B) at 2:45 p.m. on 2/2/12, the NM-B stated the February 2012 medication/treatment sheets came printed from the pharmacy. The nurse who checked the February 2012 medication sheets did not catch the error. LPN-B stated she sent the February 2012 medication and treatment sheets as physician's orders with the resident, and acknowledged she did not send the signed and most current physician orders. During interview with the Social Worker (SW-B) at 2:50 p.m. on 2/2/12, the SW-B stated R78's family was not able to manage her diabetes at home, and came to the facility to stabilize her diabetes. R78 was discharged to a group home on 2/2/12. The transfer/ Discharge Notification policy, dated with revision date 2/12, indicated "transfers and discharges will be conducted according to state and federal regulations". The policy did not have instructions related to what discharge paperwork should be sent with the resident.	F 204		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at	F 272	1. Resident #170 has been comprehensively assessed for oral care. 2. All Residents who being provided oral care with a toothette have been reassessed regarding their oral care needs. 3. Licensed nurses have been re-educated on properly assessing oral care	3/13/12

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F 272	Continued From page 3 least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility did not comprehensively assess and determine effective interventions for oral care for 1 of 1 resident (R170), who required total assistance with oral care. Findings include:	F 272	4. Five residents per week who require oral care assistance will be audited through the clinical meeting process each week to assure a proper oral assessment is completed . 5. The Director of Nursing or designee will report the success of the process to the Quality Assurance Committee Monthly as appropriate.	

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F 272	Continued From page 4 R170 was admitted on 1/4/12, with diagnoses of encephalopathy, diabetes, and dysphagia (difficulty swallowing). The facility did not comprehensively assess R170 for specific oral care relative to R170 diagnoses of dysphagia and gastrostomy tube feeding placement for nourishment. Family member (F)-A interview at 3:30 p.m. on 1/31/12, the family expressed concern oral cares could not be occurring since R170 had such a horrible mouth odor. F-A stated, "He would be horrified if he knew his breath was so bad." R170 oral cavity was observed at 5:00 p.m. on 1/31/12, and there was a white film covering the top of R170's tongue surface. The restorative aide-A verified the white film covering the surface of R170 tongue at 11:00 a.m. on 2/2/12, during another observation of the oral cavity. The initial admission minimum data set (MDS) dated 1/10/12, read unable to examine oral/dental status. The MDS noted R170 needed extensive assist with hygiene which oral cares. A Physician's Order Review form dated 1/4/12 read, R170 had a prior history of Chlorhexidine Gluconate (a treatment for gingivitis/periodontal disease) and prior use of Nystatin 100,000 units per millimeter (ml) suspension oral swish and swallow used to treat oral fungal infection. The oral medications were discontinued on admission of R170 with no assessment as to why the medications were no longer needed. An interview with the nurse manager (NM)-A at	F 272		

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F 272	Continued From page 5 12:40 p.m. on 2/2/12, revealed the resident's mouth had not been examined and there was not a comprehensive assessment completed for oral care. A oral care policy and procedure was requested but not received at the time of the exit conference with the facility.	F 272		
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, document review, and interview, the facility did not ensure 1 of 1 resident (R170) in review for positioning, received positioning as directed by the plan of care. Findings include: R170 did not receive assistance to turn and position every two hours and whenever necessary and to encourage the resident to off load/tilt wheel chair every hour according to the plan of care interventions. During observation at 10:00 a.m. on 2/1/12, R170 was up in the electric wheel chair moving self about in the bedroom, hallway, and dining room. At 1:45 p.m. on 2/1/12, R170 was at the nursing station crying, and said to the social worker no one has taken care of her since getting up that	F 282	1. Resident #20 being properly turned and repositioned per care plan. 2. Residents who require turning and repositioning every 2 hrs are being properly repositioned per care plan. 3. Nursing staff have been re-educated on properly following the plan of care for 2 hr repositioning. 4. Five residents who require 2hr turning are being audited each week to assure a proper turning is occurring . 5. The Director of Nursing or designee will report the success of the process to the Quality Assurance Committee Monthly as appropriate.	3/13/12

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F 282	Continued From page 6 morning, referring to the time of 10:00 a.m. The resident's care plan dated 11/11, titled Skin Integrity Assessment: Prevention and Treatment, indicated R170 was at risk of skin break down associated with diagnoses of cerebral palsy and a re-occurring history of bilateral lower extremity cellulitis. The resident's care plan read, turn and position every two hours and whenever necessary. Interview with nursing assistant (NA)-B at 1:45 p.m. on 2/1/12, confirmed R170 did not have any position change, or off load/tilt in the wheelchair to relieve pressure to buttocks and posterior thighs since 10:00 a.m. on 2/1/12. When interviewed at 1:48 p.m. on 2/1/12, the nurse manager-A verified R170 was to have a position change every two hours.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not ensure resident's who were unable to carry out activities of daily living were provided adequate assistance to maintain good personal hygiene for 1 of 1 resident (R170) reviewed.	F 312	1. Resident #170 is receiving proper oral hygiene. 2. All residents who require total assistance for oral care are receiving proper oral hygiene. 3. Nursing staff have been re-educated providing proper oral care for residents that require total assistance.	3/13/12

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F 312	Continued From page 7 Findings include: R170 was admitted on 1/4/12, with diagnoses of encephalopathy, diabetes, and dysphagia (difficulty swallowing). The facility did not comprehensively assess R170 for specific oral care relative to R170 diagnoses of dysphagia and gastrostomy tube feeding placement for nourishment. Family member (F)-A interview at 3:30 p.m. on 1/31/12, the family expressed concern oral cares could not be occurring since R170 had such a horrible mouth odor. F-A stated, "He would be horrified if he knew his breath was so bad." R170 oral cavity was observed at 5:00 p.m. on 1/31/12, and there was a white film covering the top of R170's tongue surface. The restorative aide-A verified the white film covering the surface of R170 tongue at 11:00 a.m. on 2/2/12, during another observation of the oral cavity. The restorative aide confirmed R170 would benefit from attempts to clean R170's mouth with a different approach and staff would need to be educated on specific oral care interventions. The initial admission minimum data set (MDS) dated 1/10/12, read unable to examine oral/dental status. The MDS noted R170 needed extensive assist with hygiene which oral cares. Review of the ADL/ Mobility: (activities of daily living) Plan of Care form dated 1/9/12, read physical assist, provide oral care daily and whenever necessary.	F 312	4. 5 residents who require total assistance with oral cares are being audited each week to assure a proper oral hygiene. 3. The Director of Nursing or designee will report to the Quality Assurance Committee for comments/review at least quarterly.	

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F 312	Continued From page 8 The form, Physician Order Review dated 1/4/12, read R170 had a prior use history of Chlorhexidine Gluconate, a treatment for gingivitis/periodontal disease, and prior use of Nystatin 100,000 units per millimeter suspension oral swish and swallow used to treat oral fungal infection, An interview with the speech therapist at 1:30 p.m. on 2/1/12, confirmed R170 had a strong mouth odor and that was discussed with the nurse manager (NM)-A last week to develop a better approach for oral care. An interview with the NM-A at 12:40 p.m. on 2/2/12, revealed the resident's mouth had not been examined and she was not aware of the white film on the surface of R170 tongue. NM-A revealed there was not a comprehensive assessment completed for oral care. An oral care policy was requested from medical records, but not received at the time of the exit conference.	F 312		
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	1. Resident #20 does not have a pressure ulcer. 2. All residents are assessed to assure they do not develop pressure ulcers. 3. All nursing employees have been re-educated regarding repositioning every two hours as individual care plans specify.	3/13/12

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F 314	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility did not ensure 1 of 1 resident (R20) reviewed for pressure areas did not develop a pressure area. Findings include: R20 did not receive assistance to turn and position every two hours and whenever necessary (PRN) and to encourage resident to off load/tilt wheel chair every hour according to the plan of care interventions. During observation at 10:00 a.m. on 2/1/12, R20 was up in the electric wheel chair, self-propelling about in the bedroom, hallway, and dining room areas. At 1:45 p.m. on 2/1/12, R20 was observed at the nurses' station, crying, and telling the social worker no one has taken care of her since getting up that morning and into the wheel chair at 10:00 a.m. R20 quarterly minimum data set (MDS) 11/3/11, indicated resident was at risk for developing pressure ulcers and the date of the oldest stage II pressure ulcer (Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater) was 10/29/11. The Skin and Ulcer Treatment section of the MDS identified that a turning and repositioning program was indicated. The resident's care plan dated 11/11, titled Skin Integrity Assessment: Prevention and Treatment, indicated R20 was at risk of skin break down	F 314	4. 5 residents who require 2hr turning are being audited each week to assure a proper turning/repositioning is occurring. 5. The Director of Nursing or designee will report to the Quality Assurance Committee Monthly as appropriate.	

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F 314	Continued From page 10 associated with diagnoses of cerebral palsy and a re-occurring history of bilateral lower extremity cellulitis. The intervention read to implement an individualized turning schedule of every two hours and PRN (whenever necessary) and to encourage resident to off load/tilt wheelchair every hour. The form for skin risk titled, Braden Skin Risk Assessment and Score (a tool used to assess a resident's risk of developing a pressure ulcer) indicated a low risk score of 15. A score of 16 out of 18 indicated a low risk for the development of pressure ulcers. Interview with nursing assistant (NA)-B confirmed R20 did not have any position change or off load/tilt in the wheelchair since 10:00 a.m. on 2/1/12. NA-B stated, "I have not done any cares for her." The nurse manager (NM)-A verified at 9:30 a.m. on 2/2/12, R20 had a stage 1 pressure ulcer (an area of redness that does not temporarily blanch, or turn white, when the area was pressed by a finger) was measured three centimeter (cm) by four centimeter red area that remained on R20's posterior left thigh area. NM-A updated the care plan form titled, Skin Integrity Assessment: Prevention and Treatment dated 2/2/12, indicated bilateral redness mid to upper thighs, skin irritated, area will not develop adversely, and will resolve without complications. A review of the policy and procedure, Pressure Ulcer Prevention/Treatment, revised April 2009, indicated frequent turning as an intervention according to a Braden Score of (15-18) for	F 314		

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F 314	Continued From page 11 resident's at risk for skin breakdown.	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 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 document review and interview, the facility did not monitor the use of a sleep aid for R170, and the facility did not monitor R39 who was on a blood pressure medication. Findings include:	F 329	1. Resident #170 is being properly monitored for a sleep aid. Resident #39 is being properly monitored for a blood pressure medication. 2. Residents on sleep medication and blood pressure medications are being properly monitored per pharmacy recommendation and doctor orders. 3. The clinical coordinators have been educated on follow-up to pharmacy recommendations. 4. Residents on sleep aids and blood pressure medications will be audited weekly via the clinical meeting process to assure proper monitoring is in place. 5. The Director of Nursing or designee will report to the Quality Assurance Committee Monthly as appropriate.	3/15/12

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F 329	Continued From page 12 R170 received Ambien (a sleeping aid) for insomnia without adequate indications or monitoring of sleep patterns. A review of documents revealed the physician ordered Ambien 5 milligrams (mg) orally at bed time for insomnia. The medication administration record identified the resident had received the hypnotic medication since admission 1/4/12. At 3:00 p.m. on 2/2/12, the clinical manager-A indicated the resident was admitted with the medication order. The clinical manager acknowledged a sleep assessment was not completed on R170. The facility policy and procedure for Sleep Assessment dated effective 12/12, indicated a resident using a sleep aide was to have a sleep assessment to assess a resident's sleep history and potential factors that affect sleep patterns. R39 received a medication for hypertension (high blood pressure) without monitoring for the efficacy of the medication or parameters for use. R39 had multiple diagnoses which included hypertension and orders for Metoprolol (an anti-hypertensive medication) 75 mg BID (twice a day). The current physician's order indicated the medication was to be administered at the same dose and frequency. The physician's order did not include parameters for use and there was no evidence of monitoring the resident's blood pressure (BP) and heart rate (HR). Record review revealed a pharmacy recommendation dated 7/29/09, to consider	F 329		

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F 329	Continued From page 13 monitoring a blood pressure and pulse prior to the administration of the Metoprolol. The pharmacy recommendation further indicated to consider clarifying with the physician if there was a threshold HR and /or BP when the medication should be held and the physician notified. There was no indication of HR or BP monitoring or parameters for use of the medication for R39. At 11:45 a.m. on 2/2/12, licensed practical nurse-C stated the resident's HR and BP were checked on a weekly basis and confirmed they were last recorded on 1/23/12. At 12:15 p.m. on 2/2/12, the registered nurse (RN)-A confirmed the lack of parameters for use and monitoring for the efficacy of the medication for R39.	F 329		
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 observation, document review, and interview, the facility failed to follow equipment sanitation and food storage procedures that would minimize the possibility of food borne illness and which included 3 of 3 Scotsman ice/water machines in the dining rooms that had a	F 371	1. The items identified in the 2567 have been addressed and equipment is being maintained in a sanitary manner. 2. Equipment that is involved in food storage is being maintained in a sanitary manner. 3. The dietary and maintenance staff have been re-educated on proper maintenance and cleaning of dietary equipment. 4. Weekly audits are being conducted to assure equipment is maintained in a sanitary manner. 5. The Administrator or designee will report to the Quality Assurance Committee Monthly as appropriate.	3/13/12

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F 371	Continued From page 14 white, brown debris buildup on the ice chutes and water dispensers. This also had the potential to affect 90 of 92 residents in the facility. Findings include: The facility did not store and prepare all foods in a sanitary manner; specifically the stand mixer had debris on the shaft observed on 1/31/12, and 2/2/12. Two of six cutting boards had visible stains, along with pits, and groves. Six of six cutting boards have groves, no longer a cleanable surface. The facility entrance kitchen tour was completed at 11:50 a.m. on 1/31/12, with Other-M, the large standalone mixer had debris on the shaft (cream colored thick texture on shaft, there was no mixing bowl present. The debris was moist; Other-M states it was used that morning. Six cutting boards are lying stacked on the bottom shelf of a steel counter. The red cutting board was the top cutting board; the surface was worn to the point of faded color in the center of the board, and a noticeably uneven surface and an uncleanable surface. The ice machine was observed at 4:30 p.m. on 1/31/12, in the 2nd floor dining room. The observation revealed a buildup of a white substance with brown areas on the Scotsman ice machine, ice chute and the water chute. R42 entered the dining room with a juice sized glass, rinsed the glass then filled it with ice and water from the Scotsman ice machine. The ice machine was observed at 5:00 p.m. on 1/31/12, in the 3rd floor dining room. The	F 371		

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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
F 371	Continued From page 15 observation noted a buildup of a white substance with areas of brown on the Scotsman ice machine chute, and also a buildup on the water dispenser tube and water chute. The ice machine was observed at 7:20 p.m. on 1/31/12, in the 4th floor dining room. The observation noted a buildup of a white substance on the Scotsman ice chute and water chute. The rest of the kitchen tour was completed at 11:25 a.m. on 2/2/12. The observation revealed the debris remained on mixer (cake batter stated by Other-M) that was visible on 1/31/12, and now was now dried on. Other-M was able to flake some off with a fingernail. A visual inspection of the cutting boards revealed: two of six cutting boards that had pits, groves and visible stains. Six of six cutting boards were worn and uneven, and are no longer a cleanable surface. At 1:55 p.m. on 2/2/12, Other-M verified 3 of 3 Scotsman ice machines had a buildup of whitish material with brown debris on the ice chutes. Also there was a buildup on the water dispenser tube and water chute of whitish brown debris. A buildup of white material on the drain grates and drain pans were also noted. Other-M stated the kitchen staff was supposed to clean them weekly, or with visible buildup. The ice machines are supported by maintenance in that task. Other-M verified the icemachines appered not be cleaned. At 2:30 on 2/2/12, Other-N supplied the Scotsman ice machine service manual (2008, November) On pages 11 and 12 of the Scotsman ice machine service manual recommended the ices machines be maintained and	F 371		

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	245417	A. BUILDING _____ B. WING _____	02/02/2012

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F 371	Continued From page 16 cleaned/sanitized at a minimum of twice per year, and more frequently in areas with hard water. At 10:43 a.m. on 2/3/12, Ice Machine Maintenance Log was requested by voice mail of Other-M and director of maintenance at 10:45 a.m A review of additional documentation of the Scotsman icemachine cleaning logs dated 9/24/11 through 2/4/12, revealed icemachine(s) had been cleaned between 1/17-1/30/12. The log did not identify which icemachnie(s) were cleaned as the log only indicated a date when cleaned. It could not be determined if the date was for one icemachine or all three icemachines. The task description was as follows: ice machines: check filters (if present), clean coils, sanitize interior, delime as necessary. All three icemachines had observations of a white brownish buildup on the ice chutes and water dispensers on 1/31/12 and 2/2/12.	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 record review and interview, the facility	F 428	1. Resident #39 is being properly monitored for the efficacy of the hypertension medication. 2. Residents on hypertension medications are being properly monitored for the efficacy of the medication. 3. Licensed nurses and pharmacist have been re-educated on assuring residents on hypertension medications are being properly monitored blood pressure/heart rate per doctor orders.	3/13/12

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F 428	Continued From page 17 did not ensure the consultant pharmacist reported irregularities in the monitoring of medications for 1 of 10 residents (R39) in the sample reviewed for unnecessary medications. Findings include: R39 received a medication for hypertension (high blood pressure) without monitoring for the efficacy of the medication or parameters for use. R39 was admitted with diagnoses which included hypertension and orders for Metoprolol (an anti-hypertensive medication) 75 mg BID (twice a day). The current physician's order indicated the medication was to be administered at the same dose and frequency. The physician's order did not include parameters for use and there was no evidence of monitoring the resident's blood pressure (BP) and heart rate (HR). Record review revealed a pharmacy recommendation dated 7/29/09, to consider monitoring a blood pressure and pulse prior to the administration of the Metoprolol. The pharmacy recommendation further indicated to consider clarifying with the physician if there is a threshold HR and/or BP when the medication should be held and the physician notified. There was no indication of follow through with the pharmacy recommendations. R39 had a history of numerous hospitalizations since the original admission date. However review of the consultant pharmacist's documentation revealed no indication of any follow up on the recommendation of 7/29/09, for R39. At 11:45 a.m. on 2/2/12, licensed practical nurse	F 428	4. Residents on hypertension medications will be audited weekly via the clinical meeting process to assure proper blood pressure/heart rate monitoring is in place per doctor orders. 5. The Director of Nursing or designee will report to the Quality Assurance Committee Monthly as appropriate.	

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F 428	Continued From page 18 (LPN)-C stated the resident's HR and BP were checked on a weekly basis and confirmed they were last recorded on 1/23/12. On 2/2/12, at 12:15 p.m. the registered nurse (RN)-A confirmed the most recent pharmacist recommendation related to the Metoprolol for R39 was 7/29/09.	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	F 431	1. Tubersol medication was discarded. 2. Medications are being dated when opened. 3. Licensed nurses have been re-educated on assuring medications are dated when opened. 4. Weekly medication and med rooms audits are being conducted to assure opened medications have open dates on them. 5. The Director of Nursing or designee will report to the Quality Assurance Committee Monthly as appropriate.	3/15/12

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F 431	Continued From page 19 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were labeled with the date opened. This had the potential to affect newly admitted residents. Finding include: Tubersol (used to test for tuberculosis) was not correctly dated when opened. The medication storage areas were inspected at 11:55 a.m. on 2/1/12, on the 4th floor in the presence of the floor Nurse Manager (NM)-B. There was an open house stock Tubersol vial in the refrigerator, that was opened, but was not labeled with the date when it was opened. The NM-B verified missing opening date and stated staff were supposed to date multi-dose vials when they first open it. The "Storage and expiration dating of medications, biologicals, syringes and needles" policy dated 1/10/10, indicated, "Facility staff should record the date on the medication container when the medication has a shortened expiration date once opened." The "Recommended minimum medication storage parameters" policy dated 3/29/10, indicated for Tubersol injection directed staff to "date when opened and discard unused portion	F 431		

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F 431	Continued From page 20 after 30 days." The consultant pharmacy was contacted at 10:30 a.m. on 2/3/12, but no return phone call was received.	F 431		
F 463 SS=E	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 observations, interviews, and document review, the facility failed to ensure the emergency call light system in 1 of 9 shower rooms was in working order. That had the potential to affect 19 of 90 residents who might have utilized this area. Findings include: The environmental tour of the facility was done at 10:05 a.m. on 2/2/12, with the maintenance director, housekeeping supervisor, Registered Nurse (RN-B) and District Manager for housekeeping and laundry. The emergency call light system in the second shower room on the 2nd floor south end was not functioning. The maintenance director and housekeeping supervisor verified the non-functioning call light. The maintenance director was not aware of the problem and explained that daily rounds were done on the	F 463	1. The emergency call light in the shower room south hall is in working order. 2. Shower rooms have working call lights. 3. Staff educating on completing maintenance repair slips if call light issue identified. 4. Shower room call lights are being audited weekly for proper working order. 5. The Director of Maintenance or designee will report to the Quality Assurance Committee Monthly as appropriate.	3/15/12

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F 463	Continued From page 21 units to identify problems, and checking of the call light was also part of the Caring Partners program weekly. The "Nurse call system test: conduct a test of the nurse call system" policy undated, from the logbook documentation indicated, "For each department, notify the appropriate person in charge that the call system is being tested. Check wall station in each patient room. Repair as necessary. Check call cords in bathrooms and shower rooms. Ensure call cord length is no more than 6" (inch) from the floor. Repair as necessary."	F 463		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 6 soiled utility rooms were maintained in clean and sanitary manner. That had the potential to affect staff and residents residing on 4th floor north hallway, and 2nd floor north hallway. Findings include: The environmental tour of the facility was done at 10:05 a.m. on 2/2/12, with the maintenance director, housekeeping supervisor, registered nurse (RN)-B and district manager (DM) for	F 465	1. The 2 identified soiled utility rooms and the 4th floor women's bathroom were updated and are in clean/sanitary manner. 2. All utility rooms and visitor bathrooms are maintained in a clean/sanitary manner. 3. Staff educated on completing maintenance repair slips if they identify issues with utility rooms and/or visitor bathrooms.	3/13/12

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F 465	Continued From page 22 housekeeping and laundry. The 2nd floor north hallway dirty utility room had paint missing (paint chipped and scuffed) on the linen shoot. The hopper was void of any sealing caulk on the right side of the base, and with thick brownish rusty build up around the base. The soiled utility room also had several missing and cracked floor tiles in the front of the refrigerator creating an uncleanable surface. The 4th floor north hallway dirty utility room was missing paint on the linen shoot (paint was chipped and scuffed), which exposed the gray metal resulting it in uncleanable surface. The wall in women's bathroom on the 4th floor used by staff and visitors had reddish, brownish buildup behind the water tank and around the sink. The housekeeping supervisor indicated that area had rusty water build up. The wallpaper around the sink was torn at multiple places which created an uncleanable surface. All the above issues were viewed and confirmed by the maintenance director, housekeeping supervisor, RN-B and DM. The maintenance director stated that the maintenance staff conducts daily audits of the facility using and automated computerized system called Direct Supply TELS, and they also repaired things as they saw them or when reported to them. The DM stated that they were not aware of the above issues since they focus more on residents living areas. The DM indicated preventative maintenance program was computerized, and had no specific policy for maintaining common areas used mainly by staff. No further documentation was provided.	F 465	4. Utility rooms and visitor bathrooms are being audited weekly to assure they are maintained in a clean/sanitary manner. 5. The Administrator or designee will report to the Quality Assurance Committee Monthly as appropriate. 6. Results of caring partners audit, maintenance rounds, administrator and housekeeping rounds will be reviewed and shared at the Quality Assurance Committee on a monthly bases.	

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

F 5417020

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

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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, Robbinsdale Rehab & 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 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 St. Paul, MN 55101-5145 Pat.Sheehan@state.mn.us	K 000	The submission of this Plan of Correction is not an admission by the provider of any fact or conclusion set forth in the Statement of Deficiency. This Plan of Correction is being submitted because it is required by law. However, evidencing Robbinsdale Rehab and Care Center good faith, the facility offers the following Plan of Correction and have achieved substantial compliance in each of the areas addressed on February 24, 2012 POC ok 2-28-12 RECEIVED FEB 28 2012	

DC: 3.14.12

EXIT: 02.02.2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathleen Parks	Administrator	2-27-12

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

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K 000	Continued From page 1 <mailto:Pat.Sheehan@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 4-story building was determined to be of Type II(222) construction. It has no basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 100 beds and had a census of 95 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 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by:	K 038	1. A description of what has been, or will be, done to correct the deficiency. The three area identified for not having proper working delay of egress on 4 North, 2 South and 2 Central stairwells have been corrected on 2/1/12 by Low Voltage Contractors	2-2-12

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K 038	Continued From page 2 Based on observation and staff interview, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 7.2.1.5.4. The deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 11:30 AM on 02/01/2012, observation revealed that the delayed egress control devices located on stairwell doors 4 North, 2 South and 2 Central did not function. Doors are openable through the use of the keypad. This deficient practice was verified by the maintenance director at the time of the inspection.	K 038	2. The actual, or proposed, completion date. The correction date was 2/24/12. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Maintenance Director will be responsible to prevent a reoccurrence by monitoring the door delayed egress control device on weekly rounds.	
K 066 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.	K 066	1. A description of what has been, or will be, done to correct the deficiency. The residents and staff who smoke have been reeducated on the proper disposal and extinguishing of cigarette butts. 2. The actual, or proposed, completion date. Resident and staff education has occurred with the individuals who smoke. This was completed by February 24, 2012	

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K 066	Continued From page 3 (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observations and interview, the facility has failed to properly enforce the facility smoking policy. This deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 11:30 AM on 02/01/2012, observation revealed burning cigarettes discarded on the ground near the front entrance. Cigarette butts have been discarded in the trash cans and the ground at the north and south exterior exits. Also, smoking materials have been extinguished on the exterior of the building and on the trash cans. Policy clearly states that all persons smoking are to use the provided smoking receptacles. This deficient practice was verified by the maintenance director at the time of the inspection.	K 066	3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Maintenance Director will be responsible to prevent a reoccurrence by monitoring the smoking area on weekly rounds.	
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	K 076	1. A description of what has been, or will be, done to correct the deficiency. The oxygen storage located on 4th floor E cylinders were chained to the wall the day of the survey to prevent tipping over. The staff was educated on 2/23/12 on proper storage.	2-24-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245417	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBBINSDALE REHAB & CARE CENTER	3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 076	Continued From page 4 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observations, the facility has portable liquid oxygen tanks not properly stored in compliance with the requirements of NFPA 99. This deficient practice could affect some residents. Findings include: On facility tour between 9:30 AM and 11:30 AM hours on 02/01/2012, observation revealed that the "E" cylinders located in the 4th floor oxygen room are not secured against tipping over. This deficient practice was verified by the maintenance director at the time of the inspection.	K 076	2. The actual, or proposed, completion date. The correction was completed February 24, 2012. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Maintenance Director will be responsible to prevent a reoccurrence by monitoring the on weekly rounds and continues education.	