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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QP23

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 21549

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245611**

2.STATE VENDOR OR MEDICAID NO.
(L2) **577468300**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE COLONY AT EDEN PRAIRIE**
(L4) **431 PRAIRIE CENTER DRIVE**
(L5) **EDEN PRAIRIE, MN** (L6) **55344**

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) **04/01/2013**

6. DATE OF SURVEY **02/27/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **25** (L18)

13.Total Certified Beds **25** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	25			
(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):
Mandatory DOPNA, effective March 30, 2015, is discontinued.

17. SURVEYOR SIGNATURE Date :
Elizabeth Nelson, SFMO 03/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/30/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/19/2003
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/29/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245611

Electronically Delivered: March 30, 2015

Ms. Jennifer Kuhn, Administrator
The Colony at Eden Prairie
431 Prairie Center Drive
Eden Prairie, Minnesota 55344

Dear Ms. Kuhn:

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 February 23, 2015 the above facility is certified for:

25 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 25 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions about this electronic notice.

Sincerely,

Anne K. Kleppe

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

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: March 30, 2015

Ms. Jennifer Kuhn, Administrator
The Colony at Eden Prairie
431 Prairie Center Drive
Eden Prairie, Minnesota 55344

RE: Project Number S5611015, F5611013 & F5611014

Dear Ms. Kuhn:

On January 15, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 30, 2014. 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.

Further, in our notice dated January 15, 2015, MDH informed you that your facility could avoid the imposition of remedies if substantial compliance was achieved by February 8, 2015. Before a revisit was conducted, however, surveyors representing the Centers for Medicare & Medicaid Services (CMS) completed Federal Monitoring Surveys (FMS) of your facility on January 27, 2015 (Life Safety Code) and January 30, 2015 (health). As the survey teams informed you during the exit conferences, the FMS revealed that your facility continued to not be in substantial compliance. The FMS found additional deficiencies, with the most serious being at scope and severity level F, cited as follows:

- K25 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K52 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K62 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K144 -- S/S: F -- NFPA 101 -- Life Safety Code Standard

On February 10, CMS forwarded the results of the Life Safety Code (LSC) and health Federal Monitoring Surveys and notified you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and that they were imposing the following enforcement remedy:

- Mandatory Denial of Payment for New Admissions effective March 30, 2015. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of February 10, 2015 in accordance with

Federal law, as specified in the Act at Sections 1819 (f)(2)(B)(iii)(I)(b) and 1919 (f)(2)(B)(iii)(I)(b), your facility would be prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 30, 2015.

On February 27, 2015, a Health Post Certification Revisit (PCR) was conducted. Based on the PCR, it was determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed December 30, 2015.

Additionally, on February 27, 2015, an FMS Health PCR conducted. Based on the PCR, it was determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed December 30, 2015 and FMS completed January 30, 2015.

On March 26, 2015, the Minnesota Departments of Health and Public Safety completed revisits to verify that your facility had achieved and maintained compliance with health federal certification deficiencies issued pursuant to the standard survey completed on December 30, 2014 and the Life Safety Code (LSC) FMS survey completed January 27, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 23, 2015. Based on the revisits, we have determined that your facility has achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on December 30, 2014 and the Life Safety Code (LSC) FMS survey completed January 27, 2015.

As a result of these findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of January 15, 2015. 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 March 30, 2015, 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 March 30, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective March 30, 2015, is to be rescinded.

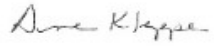
In the CMS letter of February 10, 2015, you were advised that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 30, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance, 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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from the aforementioned visits are enclosed.

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

Sincerely,



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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245611	A. Building B. Wing	2/27/2015

Name of Facility	Street Address, City, State, Zip Code
THE COLONY AT EDEN PRAIRIE	431 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

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 **F0322** Reg. # **483.25(g)(2)** LSC	Correction Completed **01/29/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **01/29/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **01/29/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **01/29/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** GL/AK	**Date:** 03/30/2015	**Signature of Surveyor:** 13603	**Date:** 02/27/2015
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 12/30/2014

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245611	A. Building B. Wing	2/27/2015

Name of Facility	Street Address, City, State, Zip Code
THE COLONY AT EDEN PRAIRIE	431 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

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 **F0309** Reg. # **483.25** LSC	**02/20/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	**02/20/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PS/AK	**Date:** 03/30/2015	**Signature of Surveyor:** 13603	**Date:** 02/27/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 1/30/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245228	A. Building B. Wing 02 - NEW BUILDING AND RENOVATED EXI	3/23/2015

Name of Facility	Street Address, City, State, Zip Code
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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 K0143	Correction Completed 02/06/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 2/4/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245611	A. Building B. Wing **01 - 01 MAIN BUILDING**	3/26/2015

Name of Facility	Street Address, City, State, Zip Code
THE COLONY AT EDEN PRAIRIE	431 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

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	Correction Completed **02/23/2015**	ID Prefix	Correction Completed **02/23/2015**	ID Prefix	Correction Completed **02/23/2015**
Reg. # **NFPA 101** LSC K0011		Reg. # **NFPA 101** LSC K0025		Reg. # **NFPA 101** LSC K0038	
ID Prefix	Correction Completed **02/23/2015**	ID Prefix	Correction Completed **02/23/2015**	ID Prefix	Correction Completed **02/23/2015**
Reg. # **NFPA 101** LSC K0052		Reg. # **NFPA 101** LSC K0062		Reg. # **NFPA 101** LSC K0144	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/AK	03/30/2015	21012	03/26/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/27/2015			

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: April 23, 2015

Ms. Jennifer Kuhn, Administrator
The Colony At Eden Prairie
431 Prairie Center Drive
Eden Prairie, Minnesota 55344

Re: Reinspection Results - Project Number S5611015

Dear Ms. Kuhn:

On February 27, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 30, 2014. At this time these correction orders were found corrected and are listed on the Revisit Report Form submitted to you electronically on January 15, 2015.

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

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

Sincerely,

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

AH Form Approved
3/27/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
21549	A. Building B. Wing	2/27/2015

Name of Facility	Street Address, City, State, Zip Code
THE COLONY AT EDEN PRAIRIE	431 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 20930 Reg. # MN Rule 4658.0525 Subp. LSC	Correction Completed 01/29/2015	ID Prefix 21375 Reg. # MN Rule 4658.0800 Subp. LSC	Correction Completed 01/29/2015	ID Prefix 21610 Reg. # MN Rule 4658.1340 Subp. LSC	Correction Completed 01/29/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/AK	03/30/2015	13603	02/27/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/30/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QP23

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 21549

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245611**
2.STATE VENDOR OR MEDICAID NO.
(L2) **577468300**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE COLONY AT EDEN PRAIRIE**
(L4) **431 PRAIRIE CENTER DRIVE**
(L5) **EDEN PRAIRIE, MN** (L6) **55344**

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) **04/01/2013**

6. DATE OF SURVEY **12/30/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **25** (L18)

13.Total Certified Beds **25** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	25			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Shawn Soucek, HPR Social Work Specialist 01/20/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 01/27/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/19/2003
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: January 15, 2015

Ms. Jennifer Kuhn, Administrator
The Colony at Eden Prairie
431 Prairie Center Drive
Eden Prairie, Minnesota 55344

RE: Project Number S5611015

Dear Ms. Kuhn:

On December 30, 2014, 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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 8, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by February 8, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 30, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 30, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245611	A. BUILDING _____ B. WING _____	12/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLONY AT EDEN PRAIRIE	431 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322		1/29/15

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

Electronically Signed | 01/16/2015

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F 322	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure gastrostomy tube (GT) placement was checked prior to administration of medications and to ensure medication was not administered together via the tube unless determined the best practice for the individual for 1 of 1 resident (R148) observed for medications administered through at gastric feeding tube. Findings include: R148's medications administration was observed on 12/29/14, at 7:30 p.m. by a licensed practical nurse (LPN)-A. LPN-A set up the resident's evening medication by placing the following medications into a medication cup: aspirin (stroke/heart attack prevention) 81 milligrams (mg) chewable, Lipitor (high cholesterol) 80 mg, Coumadin (blood thinner) 2 mg, Zantac (antacid) 150 mg Doxycycline (antibiotic) 100 mg capsule and Tylenol (pain) 1000 mg. The Doxycycline capsule was opened and the five remaining medications were then crushed and placed into the cup. LPN-A then proceeded to R148's room. After explaining to the resident she was going to administer her medication, LPN-A added water to the mixture of medication, and drew it up through a 30 cubic centimeter (cc) syringe. She opened the cap at the end of the GT and placed the syringe on in the tube. The surveyor intervened to stop LPN-A from administering the medications, as she had not checked the tube placement according to standards of practice. LPN-A then left the room and returned with a stethoscope and a 30 cc syringe, and the tube placement was	F 322	There are currently no residents with G-tube feedings at the center. Should a resident with G-tube feedings be admitted to the center the placement will be checked prior to administration of medications thru the tube. All G-tube medications will be administered per MD order, medications will not be combined unless an appropriate MD order is in place. All Licensed Staff have been re-educated regarding checking tube placement and administration of G-tube medications DON/Designee will audit 2 medication administrations via g-tube weekly for any patients admitted with a g-tube. Results of audits will be reviewed at QAPI.	

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F 322	Continued From page 2	F 322		

checked. LPN-A then attempted to administer all medications together through the tube. The surveyor inquired as to whether R148 had physician orders to administer the medications together. LPN-A responded with the question, "Am I not suppose to?" and said she had always administered the medication in that manner, since they were scheduled at the same time. LPN-A then asked, "Is it the Coumadin? Should I give the Coumadin separately?" LPN-A then left the room to check R148's physician orders and the facility policy and procedures regarding medication administration via GT.

At 7:45 p.m. LPN-A said she planed to "dump all of that and start over." LPN-A then washed her hands, crushed the medications separately, and entered R148's room. She checked the tube placement, and flushed the tube with 30 ccs of water and gave each medication separately with five ccs of water in between each medication. When all medications were administered, LPN-A again flushed the GT with 30 ccs water.
At 8: 02 p.m. LPN-A reported she had not been trained to administer medications separately when administering via a GT.

The ENTERAL TUBE ADMINISTRATION PROCEDURE (Merwin LTC Pharmacy Policy and Procedure Manual page 87) directed staff to verify tube placement and administer each medication separately, flushing the tube with 5 ccs of water after each dose.

On 12/30/14, at 12:08 p.m. the director of nursing (DON) stated she expected staff to administer medications individually according to facility policy, and not in a "cocktail" (meaning together) unless a specific physician order was received

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F 322	Continued From page 3 allowing this for a resident. She verified R148 had no such physician order. In addition, the DON said the staff should have checked the tube placement prior to medication administration.	F 322		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356		1/29/15

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F 356	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure nurse staffing information was posted as required. This had the potential to affect all 17 residents residing in the facility as well as visitors. Findings include: Initial observations were conducted at the facility on 12/28/14, at approximately 8:30 a.m. The facility's licensed and nursing assistant staffing information was posted on a wall adjacent to the desk in the hallway leading to the nursing unit. The posting was from two days earlier and was dated 12/26/14. Although the data posted included the number of staff by discipline including registered nurses (RNs), licensed practical nurses (LPNs), and nursing assistant (NAs) by shift and resident census, the posting did not reflect current and accurate information. Later that day at 9:05 a.m. the incorrect information was still posted. At 12:27 p.m. the posting reflected the updated and current nursing staff information and census. During an interview with the director of nursing (DON) on 12/30/14, at 1:00 p.m. she verified the nurse staffing data was incorrect at the time of the initial tour and each morning it should have been updated and posted for the public. The DON also stated the staff scheduler was responsible for posting on the on weekdays, which was completed a week in advance. The DON was then responsible for making any changes and posting the daily schedule prior to each shift during week days. On weekends, the charge nurse was responsible for posting the	F 356	Nursing Staffing hours are being posted daily. All licensed staff have been re-educated regarding posting of daily staffing. DON/Designee will audit 3 times per week to ensure posting is accurate. Results of audits will be reviewed by QA&A.	

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F 356	Continued From page 5 correct staff nursing hours. Although a written policy was requested, is was not provided.	F 356		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		1/29/15

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F 431	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure lorazepam intensol (for anxiety) for R108 and R24 was stored using a double-lock system as required, and medications with shortened expiration dates were appropriately labeled with opened dates for R36 for insulin and R152 for eye medication, as well as pnuemovax vaccination and tuberculin testing in one of one medication storage refrigerators, potentially affecting newly admitted residents. Findings include: On 12/28/14, at approximately 9:00 a.m. the medication room was observed for storage with a licensed practical nurse (LPN)-B. The medication refrigerator contained two opened vials of pneumovax solution that were filled by the pharmacy on 4/29/14, but had not been labeled when opened. Each vial had a small amount of solution remaining. In addition, four opened vials of Apisol (for tuberculin testing) were not labeled when opened. Two vials had been filled by the pharmacy on 7/11/14, and the other two on 11/26/14. Each opened vial had approximately half of the solution remaining. In an unlocked refrigerator on the bottom shelf, two boxes of lorazepam intensol for R108 were stored and in the doorway another box was stored for R24. Although the medication room was locked, the anti-anxiety medication was not stored behind a second lock. LPN-B verified the observations at the time.	F 431	All multi-dose preparations have been dated with date open. A lock was applied on 12/29/14 to the medication room refrigerator allowing for double locking of refrigerated controlled substances. Licensed staff and TMAs have been re-educated regarding dating of multi-dose preparations and securing controlled substances. Don/Designee will audit medication cart and refrigerator 2 times per week to ensure appropriate dating of multi-dose preparations and securing of controlled substances. Results of audits will be reviewed at QAPI	

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F 431	Continued From page 7 On 12/28/14, at 9:34 a.m. a medication cart for rooms 111 to 121 was observed to contain Latanoprost eye medication (to manage eye pressure associated with glaucoma) for R152. R152's current physician's orders indicated the medication was ordered 12/16/14 and was currently being used. The treatment cart also contained an opened Novalog insulin vial for R36. The current order listing report for R36 revealed Novalog 100U/ML per sliding scale was a current order written 12/16/14. The vial was not dated when opened. The findings were verified by a registered nurse (RN)-A at the time of the observation. A registered nurse explained on 12/28/14 at 9:45 a.m. that lorazepam intensol should have been double-locked. She further stated all vials on the cart and in the medication room would need to be discarded because it could not be verified when the medication had been opened. On 12/29/14, at 5:16 p.m. the director of nursing (DON) stated lorazepam intensol should have been stored by a double-locked system. She further stated all multi-use medications with a shortened expiration date should have been dated when opened including eye medication, insulin vials, as well as house stock vials (e.g. pneumovax and Apisol). An undated Medication Storage in the Facility (Merwin LTC Pharmacy Policy and Procedure Manual) directed staff to store Schedule II ,III, IV and V controlled medications separately from other medications in a locked drawer or compartment designated for that purpose. The policy lacked direction regarding double locking	F 431		

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F 431	Continued From page 8 Scheduled medications. During a conversation via telephone on 12/30/14, at approximately 2:30 p.m. the pharmacy consultant (O)-2 stated she would have expected all multi-use medications including pneumovax, Apisol and insulin to have been labeled when opened, and then discarded when no longer viable. She further stated Lanoprost eye drops have been discarded six weeks after opening. If lacking an opened date on the label, then the date the medication was filled should have been considered the opened date. O-2 would have also expected lorazepam intensol to be secured with two locks.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441		1/29/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245611	A. BUILDING _____ B. WING _____	12/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLONY AT EDEN PRAIRIE	431 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 9 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control methods were used during catheter care to minimize the risk of infection for 1 of 1 resident (R4) observed for catheter care, and to ensure oxygen tubing was replaced or disinfected after contamination for 1 of 1 resident (R143) receiving oxygen. Findings include: R4 was provided evening cares on 12/29/14, at 7:00 p.m. by a a nursing assistant (NA)-A. NA-A washed and gloved her hands. She explained to the resident what cares she intended to perform. NA-A then emptied the contents of the catheter leg bag into a graduated cylinder, removed off her gloves, opened an alcohol wipe and proceeded to clean around catheter tubing port. NA-A donned a clean pair of gloves assisted R4 to stand,	F 441	Handwashing is occurring when changing gloves. Patient supplies/equipment is being properly sanitized or replaced to maintain infection control practices. All staff have been re-educated regarding infection control practices. DON/Designee will audit the unit 2 times per week to ensure appropriate infection control practices are being utilized. Results of audits will be reviewed by QAPI	

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	245611	A. BUILDING _____ B. WING _____	12/30/2014

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THE COLONY AT EDEN PRAIRIE	431 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

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F 441	Continued From page 10	F 441		

removed the resident's pants, and underwear. She again opened an alcohol antiseptic wipe and cleaned the catheter port near R4's penis. NA-A removed her gloves and assisted the resident to pull up his pants and adjust his clothing. After R4 sat down, NA-A gave the resident his remote control and raised his footrest. NA-A placed a pillow behind R4's head and emptied the contents of the urine in the graduated cylinder into the toilet. NA-A then washed her hands.

At 7:07 p.m. NA-A verified she had not washed her hands between glove changes. She stated she was aware she should have washed her hands before and after catheter care and between glove changes.

R4's admission Minimum Data Set (MDS) dated 11/25/14, revealed diagnoses of neurogenic bladder and end stage renal failure and insufficiency. The MDS indicated R4 had an indwelling Foley catheter, and required extensive assist of two staff for toileting needs.

During an interview on 12/30/14, at 12:05 p.m. the director of nursing (DON) stated she she would have expected staff to wash their hands every time gloves were changed during catheter cares.

R143 was observed on 12/29/14, at 7:20 p.m. The resident was using the toilet in her room and the nasal cannula (applied to the face to administer oxygen) was laying on the bathroom floor. When R43 attempted to self-transfer and the surveyor informed her she would summon assistance for her and activated the call system. At 7:21 p.m. NA-B entered the room to assist R143 off the toilet. Both NA-B and the resident

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLONY AT EDEN PRAIRIE	431 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

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F 441	Continued From page 11	F 441		

stepped on the nasal cannula. The surveyor left the room while NA-B assisted the resident to bed. At 7:31 p.m. NA-B left the room and reported she had had placed the cannula that had been on the floor on the resident's face. NA-B stated, "I know, I should have changed it or at least cleaned it." She then replaced the nasal cannula.

R143 was admitted on 12/24/14, with diagnoses including influenza with other respiratory manifestations and chronic obstructive pulmonary disease.

During an interview on 12/30/14, at 12:05 p.m. the director of nursing (DON) stated she she would have expected staff to have replaced a nasal cannula should it have been on the floor.

When a policy was requested on 12/30/14, at 12:16 p.m. the DON reported the facility had no hand washing or glove use policy, as it was considered standard of practice and staff knew when to wash their hands. Furthermore, she would not have expected staff to go to the nursing station to look up a policy on how to wash their hands or utilize gloves.

An undated Introduction to Infection Control, Version 4.02 was provided. Chapter 7 directed staff to to "remove your gloves and wash your hands before applying another pair. Using gloves is not a substitute for hand washing. Proper hand washing is still required before and after you use gloves."

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	245611	A. BUILDING **01 - 01 MAIN BUILDING** B. WING _____	**12/30/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLONY AT EDEN PRAIRIE	**431 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344**

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K 000	INITIAL COMMENTS 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, The Colony at Eden Prairie 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: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us	K 000	EPOC	

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

Electronically Signed — 01/16/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245611	A. BUILDING **01 - 01 MAIN BUILDING** B. WING _____	**12/30/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLONY AT EDEN PRAIRIE	**431 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344**

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K 000	Continued From page 1 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 1-story building was determined to be of Type V(111) construction. It has no basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 25 beds and had a census of 19 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		1/29/15

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	245611	A. BUILDING **01 - 01 MAIN BUILDING** B. WING _____	**12/30/2014**

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K 052	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility's fire alarm system is not maintained in conformance with NFPA 72, (99). This deficient practice could affect the residents. Findings include: On facility tour between 10:30 AM and 12:30 PM on 12/30/2014, Observation revealed that when the nurses station was moved, the remote fire alarm annunciator remained in the room that is no longer constantly attended. This deficienct practice was verified by the administrator at the time of the inspection.	K 052	The remote fire alarm annunciator was moved to the nursing station to ensure constant monitoring on 1/14/15. TCU staff were informed of this move. Director of Maintenance and/or designee will remind staff of this move with monthly fire drills. They will also be responsible to monitor and assure with any future moves the genset remains in an area that is constantly attended.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on record review and interview, the facility's emergency generators do not comply with NFPA 99 Health Care Facilities (1999 edition) nor NFPA 110 Standard for Standby	K 144	The remote genset panel was moved to an area that is constantly attended on 1/14/15. TCU staff were informed of this move.	1/29/15

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	245611	A. BUILDING **01 - 01 MAIN BUILDING** B. WING _____	**12/30/2014**

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K 144	Continued From page 3 Power Systems (1998 edition). This deficient practice could affect all residents. Findings include: During facility tour between 10:30 AM and 12:30 PM on 12/30/2014, observation revealed that when the nurses station was moved, the remote genset panel remained in the room that is no longer constantly attended. This deficient practice was verified by the administrator at the time of the inspection.	K 144	Director of Maintenance and/or designees will be responsible to monitor and assure with any future moves the genset remains in an area that is constantly attended.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: January 15, 2015

Ms. Jennifer Kuhn, Administrator
The Colony at Eden Prairie
431 Prairie Center Drive
Eden Prairie, Minnesota 55344

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5611015

Dear Ms. Kuhn:

The above facility was surveyed on December 28, 2014 through December 30, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21549	A. BUILDING: _____ B. WING _____	12/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLONY AT EDEN PRAIRIE	431 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On December 28th, 29th and 30th, 2014 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure gastrostomy tube (GT) placement was checked prior to administration of medications and to ensure medication was not administered together via the tube unless determined the best practice for the individual for 1 of 1 resident (R148) observed for medications administered through at gastric feeding tube. Findings include:	2 930	Corrected	1/29/15

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2 930	Continued From page 3 R148's medications administration was observed on 12/29/14, at 7:30 p.m. by a licensed practical nurse (LPN)-A. LPN-A set up the resident's evening medication by placing the following medications into a medication cup: aspirin (stroke/heart attack prevention) 81 milligrams (mg) chewable, Lipitor (high cholesterol) 80 mg, Coumadin (blood thinner) 2 mg, Zantac (antacid) 150 mg Doxycycline (antibiotic) 100 mg capsule and Tylenol (pain) 1000 mg. The Doxycycline capsule was opened and the five remaining medications were then crushed and placed into the cup. LPN-A then proceeded to R148's room. After explaining to the resident she was going to administer her medication, LPN-A added water to the mixture of medication, and drew it up through a 30 cubic centimeter (cc) syringe. She opened the cap at the end of the GT and placed the syringe on in the tube. The surveyor intervened to stop LPN-A from administering the medications, as she had not checked the tube placement according to standards of practice. LPN-A then left the room and returned with a stethoscope and a 30 cc syringe, and the tube placement was checked. LPN-A then attempted to administer all medications together through the tube. The surveyor inquired as to whether R148 had physician orders to administer the medications together. LPN-A responded with the question, "Am I not suppose to?" and said she had always administered the medication in that manner, since they were scheduled at the same time. LPN-A then asked, "Is it the Coumadin? Should I give the Coumadin separately?" LPN-A then left the room to check R148's physician orders and the facility policy and procedures regarding medication administration via GT. At 7:45 p.m. LPN-A said she planed to "dump all of that and start over." LPN-A then washed her	2 930		

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THE COLONY AT EDEN PRAIRIE	431 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

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2 930	Continued From page 4 hands, crushed the medications separately, and entered R148's room. She checked the tube placement, and flushed the tube with 30 ccs of water and gave each medication separately with five ccs of water in between each medication. When all medications were administered, LPN-A again flushed the GT with 30 ccs water. At 8: 02 p.m. LPN-A reported she had not been trained to administer medications separately when administering via a GT. The ENTERAL TUBE ADMINISTRATION PROCEDURE (Merwin LTC Pharmacy Policy and Procedure Manual page 87) directed staff to verify tube placement and administer each medication separately, flushing the tube with 5 ccs of water after each dose. On 12/30/14, at 12:08 p.m. the director of nursing (DON) stated she expected staff to administer medications individually according to facility policy, and not in a "cocktail" (meaning together) unless a specific physician order was received allowing this for a resident. She verified R148 had no such physician order. In addition, the DON said the staff should have checked the tube placement prior to medication administration. SUGGESTED METHOD OF CORRECTION: The director of nursing could ensure all licensed staff are trained in policies related to tube placement and administering medications via a GT. Return demonstrations could be observed and random audits conducted. The results could be reviewed by the quality committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 930		

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	21549	A. BUILDING: _____ B. WING _____	12/30/2014

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21375	Continued From page 5	21375		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control methods were used during catheter care to minimize the risk of infection for 1 of 1 resident (R4) observed for catheter care, and to ensure oxygen tubing was replaced or disinfected after contamination for 1 of 1 resident (R143) receiving oxygen. Findings include: R4 was provided evening cares on 12/29/14, at 7:00 p.m. by a a nursing assistant (NA)-A. NA-A washed and gloved her hands. She explained to the resident what cares she intended to perform. NA-A then emptied the contents of the catheter leg bag into a graduated cylinder, removed off her gloves, opened an alcohol wipe and proceeded to clean around catheter tubing port. NA-A donned a clean pair of gloves assisted R4 to stand, removed the resident's pants, and underwear. She again opened an alcohol antiseptic wipe and cleaned the catheter port near R4's penis. NA-A removed her gloves and assisted the resident to pull up his pants and adjust his clothing. After R4 sat down, NA-A gave the resident his remote control and raised his footrest. NA-A placed a pillow behind R4's head and emptied the contents of the urine in the graduated cylinder into the	21375	Corrected	1/29/15

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21375	Continued From page 6 toilet. NA-A then washed her hands. At 7:07 p.m. NA-A verified she had not washed her hands between glove changes. She stated she was aware she should have washed her hands before and after catheter care and between glove changes. R4's admission Minimum Data Set (MDS) dated 11/25/14, revealed diagnoses of neurogenic bladder and end stage renal failure and insufficiency. The MDS indicated R4 had an indwelling Foley catheter, and required extensive assist of two staff for toileting needs. During an interview on 12/30/14, at 12:05 p.m. the director of nursing (DON) stated she she would have expected staff to wash their hands every time gloves were changed during catheter cares. R143 was observed on 12/29/14, at 7:20 p.m. The resident was using the toilet in her room and the nasal cannula (applied to the face to administer oxygen) was laying on the bathroom floor. When R43 attempted to self-transfer and the surveyor informed her she would summon assistance for her and activated the call system. At 7:21 p.m. NA-B entered the room to assist R143 off the toilet. Both NA-B and the resident stepped on the nasal cannula. The surveyor left the room while NA-B assisted the resident to bed. At 7:31 p.m. NA-B left the room and reported she had had placed the cannula that had been on the floor on the resident's face. NA-B stated, "I know, I should have changed it or at least cleaned it." She then replaced the nasal cannula. R143 was admitted on 12/24/14, with diagnoses including influenza with other respiratory	21375		

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21375	Continued From page 7 manifestations and chronic obstructive pulmonary disease. During an interview on 12/30/14, at 12:05 p.m. the director of nursing (DON) stated she she would have expected staff to have replaced a nasal cannula should it have been on the floor. When a policy was requested on 12/30/14, at 12:16 p.m. the DON reported the facility had no hand washing or glove use policy, as it was considered standard of practice and staff knew when to wash their hands. Furthermore, she would not have expected staff to go to the nursing station to look up a policy on how to wash their hands or utilize gloves. An undated Introduction to Infection Control, Version 4.02 was provided. Chapter 7 directed staff to to "remove your gloves and wash your hands before applying another pair. Using gloves is not a substitute for hand washing. Proper hand washing is still required before and after you use gloves." SUGGESTED METHOD OF CORRECTION: The director of nursing could ensure facility policies were available and all staff were trained in practices to minimize infections. Return demonstrations for hand washing and glove use could be observed and random audits conducted. The results could be reviewed by the quality committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21375		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage	21610		1/29/15

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21610	Continued From page 8 Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure lorazepam intensol (for anxiety) for R108 and R24 was stored using a double-lock system as required, and medications with shortened expiration dates were appropriately labeled with opened dates for R36 for insulin and R152 for eye medication, as well as pnuemovax vaccination and tuberculin testing in one of one medication storage refrigerators, potentially affecting newly admitted residents. Findings include: On 12/28/14, at approximately 9:00 a.m. the medication room was observed for storage with a licensed practical nurse (LPN)-B. The medication refrigerator contained two opened vials of pneumovax solution that were filled by the pharmacy on 4/29/14, but had not been labeled when opened. Each vial had a small amount of solution remaining. In addition, four opened vials of Apisol (for tuberculin testing) were not labeled when opened. Two vials had been filled by the pharmacy on 7/11/14, and the other two on 11/26/14. Each opened vial had approximately half of the solution remaining. In an unlocked refrigerator on the bottom shelf, two boxes of lorazepam intensol for R108 were stored and in the doorway another box was stored for R24. Although the medication room was locked, the	21610	Corrected	

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21610	Continued From page 9	21610		

anti-anxiety medication was not stored behind a second lock. LPN-B verified the observations at the time.

On 12/28/14, at 9:34 a.m. a medication cart for rooms 111 to 121 was observed to contain Latanoprost eye medication (to manage eye pressure associated with glaucoma) for R152. R152's current physician's orders indicated the medication was ordered 12/16/14 and was currently being used. The treatment cart also contained an opened Novalog insulin vial for R36. The current order listing report for R36 revealed Novalog 100U/ML per sliding scale was a current order written 12/16/14. The vial was not dated when opened. The findings were verified by a registered nurse (RN)-A at the time of the observation.

A registered nurse explained on 12/28/14 at 9:45 a.m. that lorazepam intensol should have been double-locked. She further stated all vials on the cart and in the medication room would need to be discarded because it could not be verified when the medication had been opened.

On 12/29/14, at 5:16 p.m. the director of nursing (DON) stated lorazepam intensol should have been stored by a double-locked system. She further stated all multi-use medications with a shortened expiration date should have been dated when opened including eye medication, insulin vials, as well as house stock vials (e.g. pneumovax and Apisol).

An undated Medication Storage in the Facility (Merwin LTC Pharmacy Policy and Procedure Manual) directed staff to store Schedule II ,III, IV and V controlled medications separately from other medications in a locked drawer or

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21610	Continued From page 10 compartment designated for that purpose. The policy lacked direction regarding double locking Scheduled medications. During a conversation via telephone on 12/30/14, at approximately 2:30 p.m. the pharmacy consultant (O)-2 stated she would have expected all multi-use medications including pneumovax, Apisol and insulin to have been labeled when opened, and then discarded when no longer viable. She further stated Lanoprost eye drops have been discarded six weeks after opening. If lacking an opened date on the label, then the date the medication was filled should have been considered the opened date. O-2 would have also expected lorazepam intensol to be secured with two locks. SUGGESTED METHOD OF CORRECTION: The director of nursing could ensure a system is in place for labeling, storing, and disposing of expired medication Licensed staff could be trained as to their responsibilities. Audits could be conducted and the results reviewed by the quality committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21610		