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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RNX6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 27752

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245619**

2.STATE VENDOR OR MEDICAID NO.
(L2) **753490000**

3. NAME AND ADDRESS OF FACILITY
(L3) **SAINT THERESE AT OXBOW LAKE**
(L4) **5200 OAK GROVE PARKWAY**
(L5) **BROOKLYN PARK, MN** (L6) **55443**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/10/2014** (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)
06/13

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

12.Total Facility Beds **64** (L18)

13.Total Certified Beds **64** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(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 :
Lou Anne Page, HFE-NE II 06/09/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/09/2014 (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
07/16/2013
(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
03/03/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN#: 24-5619

On 04/10/14, a second Post Certification Revisit (PCR) was completed by the Department of Health. Based on the PCR, it has been determined that the facility had achieved substantial compliance pursuant to the standard 01/10/14 survey, effective 04/09/14. Refer to the CMS 2567B for both health and life safety code.

Effective 04/09/14, the facility is certified for 64 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5619

June 9, 2014

Ms. Dinah Martin, Administrator
Saint Therese at Oxbow Lake
5200 Oak Grove Parkway
Brooklyn Park, Minnesota 55443

Dear Ms. Martin:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 9, 2014, the above facility is certified for:

64 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 64 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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,

Anne Kleppe

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered: April 11, 2014

Ms. Dinah Martin, Administrator
Saint Therese at Oxbow Lake
5200 Oak Grove Parkway
Brooklyn Park, Minnesota 55443

RE: Project Number S5619001

Dear Ms. Martin:

On April 9, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective April 12, 2014. (42 CFR 488.422)

On April 9, 2014, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 24, 2014. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in our letter of April 9, 2014, 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 April 24, 2014.

This was based on the deficiencies cited by this Department for a standard survey completed on January 10, 2014, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on March 19, 2014. The most serious deficiencies at the time of the revisit 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 April 10, 2014, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on March 19, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 9, 2014. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on March 19, as of April 9, 2014. As a result of the revisit findings, the Department is rescinding the Category 1 remedy of state monitoring effective April 9, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of April 9, 2014. 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 April 24, 2014, 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 April 24, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective April 24, 2014, is to be rescinded.

In our letter of April 9, 2014, 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 April 24, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on April 9, 2014, 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.

Feel free to contact me if you have questions about this e-Notice.

Sincerely,

Anne Kleppe

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

AH Form Approved
6/9/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
27752	A. Building B. Wing	4/10/2014

Name of Facility	Street Address, City, State, Zip Code
SAINT THERESE AT OXBOW LAKE	5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443

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 **21630** Reg. # **MN Rule 4658.1350 Subp. :** LSC	Correction Completed **04/09/2014**	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** GD/AK	**Date:** 06/09/2014	**Signature of Surveyor:** 18622	**Date:** 04/10/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 1/10/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245619	A. Building B. Wing	4/10/2014

Name of Facility	Street Address, City, State, Zip Code
SAINT THERESE AT OXBOW LAKE	5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443

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 F0425 Reg. # 483.60(a),(b) LSC	04/09/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** GD/AK	**Date:** 06/09/2014	**Signature of Surveyor:** 18622	**Date:** 04/10/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 1/10/2014		**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**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RNX6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 27752

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245619**

2.STATE VENDOR OR MEDICAID NO.
(L2) **753490000**

3. NAME AND ADDRESS OF FACILITY
(L3) **SAINT THERESE AT OXBOW LAKE**
(L4) **5200 OAK GROVE PARKWAY**
(L5) **BROOKLYN PARK, MN** (L6) **55443**

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 **03/19/2014** (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)
06/13

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

12.Total Facility Beds **64** (L18)

13.Total Certified Beds **64** (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
	64			
(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 :
Patrick Sheehan, Supervisor, SFMO 04/08/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/09/2014 (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
07/16/2013
(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
03/03/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN#: 24-5619

On 03/19/14, a Post Certification Revisit (PCR) was completed by the Minnesota Department of Health and on 02/12/14, the Minnesota Department of Public Safety completed a PCR. Based on these PCRs, it has been determined that the facility has not achieved substantial compliance pursuant to the 01/10/14 standard survey. Refer to the CMS 2567 (For health), CMS 2567B for both health and life safety code.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered: April 9, 2014

Ms. Dinah Martin, Administrator
Saint Therese at Oxbow Lake
5200 Oak Grove Parkway
Brooklyn Park, Minnesota 55443

RE: Project Number S5619001

Dear Ms. Martin:

On January 28, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 10, 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.

On March 19, 2014, the Minnesota Department of Health and on February 12, 2014, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 10, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 19, 2014 . Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on January 10, 2014.

At the time of this revisit, we identified the following deficiency:

- **0425-Pharmaceutical Svc - Accurate Procedures, Rph-483.60(a),(b)**

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective April 12, 2014 (42 CFR 488.422)

However, as we notified you in our letter of January 28, 2014, 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 January 10, 2014.

In addition, 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 April 24, 2014. (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 April 10, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 10, 2014. 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, Saint Therese At Oxbow Lake is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 10, 2014. 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: Karen R. Robinson, Director
330 Independence Avenue, SW
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:

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

Telephone: (651) 201-3792
Fax: (651) 201-3790
Email: gloria.derfus.state.mn.us

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 remedy be imposed:

• 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 July 10, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an

informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0541
Email: pat.sheehan@state.mn.us

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

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

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
245619	A. Building B. Wing	3/19/2014

Name of Facility	Street Address, City, State, Zip Code
SAINT THERESE AT OXBOW LAKE	5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443

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 **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **02/19/2014**	ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **02/19/2014**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **02/19/2014**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **02/19/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **02/19/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **02/19/2014**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **02/19/2014**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **02/19/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **02/19/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **02/19/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **02/19/2014**	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:
	GD/AK	06/09/2014	18622	03/19/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/10/2014

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

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
27752	A. Building B. Wing	3/19/2014

Name of Facility	Street Address, City, State, Zip Code
SAINT THERESE AT OXBOW LAKE	5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443

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 **20265** Reg. # **MN Rule 4658.0085** LSC	Correction Completed **02/19/2014**	ID Prefix **20555** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **02/19/2014**	ID Prefix **20570** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **02/19/2014**
ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp.** LSC	Correction Completed **02/19/2014**	ID Prefix **20965** Reg. # **MN Rule 4658.0600 Subp.** LSC	Correction Completed **02/19/2014**	ID Prefix **21525** Reg. # **MN Rule 4658.1305 A.B.C** LSC	Correction Completed **02/19/2014**
ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1** LSC	Correction Completed **02/19/2014**	ID Prefix **21980** Reg. # **MN St. Statute 626.557 Sul** LSC	Correction Completed **02/19/2014**	ID Prefix **22000** Reg. # **MN St. Statute 626.557 Su** LSC	Correction Completed **02/19/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	06/09/2014	18622	03/19/2014
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
1/10/2014			

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
245619	A. Building B. Wing **01 - MAIN BLDG**	2/12/2014

Name of Facility	Street Address, City, State, Zip Code
SAINT THERESE AT OXBOW LAKE	5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443

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 **02/11/2014**	ID Prefix	Correction Completed **01/20/2014**	ID Prefix	Correction Completed **02/05/2014**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0050		LSC K0052		LSC K0071	
ID Prefix	Correction Completed **02/04/2014**	ID Prefix	Correction Completed **01/21/2014**	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. #	
LSC K0140		LSC K0144		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/AK	04/08/2014	28120	2/12/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/15/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245619	A. BUILDING _____ B. WING _____	R 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	**5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443**

(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 A Post Certification Revisit (PCR) was completed on March 19, 2014. Based on the PCR it was determined the facility was not in substantial compliance with Federal requirements. The following deficiency is issued:	{F 000}		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure Fentanyl patches (narcotic patch) used to control pain were destroyed in a manner to prevent potential diversion for 1 of 2 residents (R134) who utilized Fentanyl patches.	F 425		4/9/14

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

Electronically Signed | 4/09/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245619	A. BUILDING _____ B. WING _____	R 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	**5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443**

(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 425	Continued From page 1 Findings include: On 3/19/14, the facility provided a document for review entitled, Plan of Correction Education Overview/Policy for Licensed staff (no date) indicated "Narcotic pain patches need to be destroyed with two nurses via the sewer system. Each nurse needs to independently place a note in the progress notes that the patch was removed and destroyed via the sewer system and who was present." According to review of the facility's education roster documentation, each of the facility's licensed nurses had received training between 2/10/14 through 2/17/14, related to the appropriate destruction, and required record keeping, related to Fentanyl patches. R134 was admitted to the facility on 3/9/14, after having a total left hip replacement. R134 had a physician's order dated 3/9/14, for a Fentanyl patch 75 micrograms (mcg) per hour which was to be applied transdermally (on the skin) every three days. A progress note dated, 3/14/14, indicated the resident rated the pain as moderate on a scale of 1 to 10 (10 being the worse pain) was a 5. R134 indicated pain management was effective on the current schedule. The narcotic sign out book was reviewed with registered nurse (RN)-A on 3/19/14, at 9:45 a.m. R134 had received a Fentanyl patch on 3/12/14, at 10:00 a.m. 3/15/14, at 9:20 a.m. and 3/18/14, at 9:47 a.m. In addition, according to the narcotic book records, the Fentanyl patch count was correct. However, a nursing progress note dated 3/12/14, at 10:57 a.m. was reviewed and indicated: "Late	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245619	A. BUILDING _____ B. WING _____	R 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	**5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443**

(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 425	Continued From page 2 Entry. Writer and Clinical coordinator destroyed Fentanyl patch in a.m. on 3/12/14." The licensed staff had not documented the appropriate information to indicate they had both witnessed the destruction of the Fentanyl patch which had been removed prior to applying the new patch. A nursing progress note dated 3/15/14, at 10:30 p.m. included: "Fentanyl patch removed and flushed down sewer with [RN-B and RN-C]". The licensed staff involved had not both documented the necessary verification of having witnessed the destruction of the Fentanyl patch which had been removed prior to applying the new patch. In addition, although the Fentanyl patch had been applied at 9:20 a.m., a progress note entry had not been documented until 10:30 p.m., 11 hours and 10 minutes later. A nursing progress note in R134's record, dated 3/18/14 at 4:00 p.m., included: "Fentanyl patch wasted this a.m., new patch applied at 9:45." The documentation was written six hours and 13 minutes after the Fentanyl patch had been applied to the resident. In addition, the licensed staff witnessing the destruction of the Fentanyl path had not both signed to indicate verification of the destruction. RN-A was interviewed on 3/19/14, at 9:45 a.m. and confirmed the three nursing progress notes dated 3/12/14, 3/15/14, and 3/18/14, failed to include documentation to verify the witnessing of the Fentanyl patch destruction, and RN-A confirmed the documentation had not been immediately documented. The director of nursing (DON) was interviewed on 3/19/14, at 4:45 p.m. and confirmed the identified	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245619	A. BUILDING _____ B. WING _____	R 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	**5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443**

(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 425	Continued From page 3 licensed staff had not followed the facility's policy for destruction of narcotic patches to minimize or prevent diversion or accidental exposure. The DON confirmed the late entries and failure of both witnesses to verify destruction, went against the facility policy. The facility did not ensure the Fentanyl patches were wasted which involved a secure and safe method, so diversion and/or accidental exposure are minimized.	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27752	A. BUILDING: _____ B. WING _____	R 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	**5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	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: A follow up was completed to verify correction of licensing orders issued at the time of the January 10, 2014 survey. The following licensing orders were reissued:	{2 000}		
{21630}	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction	{21630}		4/9/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27752	A. BUILDING: _____ B. WING _____	R 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21630}	Continued From page 1 Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure Fentanyl patches (narcotic patch) used to control pain were destroyed in a manner to prevent potential diversion for 1 of 2 residents (R134) who utilized Fentanyl patches. Findings include: On 3/19/14, the facility provided a document for review entitled, Plan of Correction Education Overview/Policy for Licensed staff (no date)	{21630}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27752	A. BUILDING: _____ B. WING _____	R 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21630}	Continued From page 2 indicated "Narcotic pain patches need to be destroyed with two nurses via the sewer system. Each nurse needs to independently place a note in the progress notes that the patch was removed and destroyed via the sewer system and who was present." According to review of the facility's education roster documentation, each of the facility's licensed nurses had received training between 2/10/14 through 2/17/14, related to the appropriate destruction, and required record keeping, related to Fentanyl patches. R134 was admitted to the facility on 3/9/14, after having a total left hip replacement. R134 had a physician's order dated 3/9/14, for a Fentanyl patch 75 micrograms (mcg) per hour which was to be applied transdermally (on the skin) every three days. A progress note dated, 3/14/14, indicated the resident rated the pain as moderate on a scale of 1 to 10 (10 being the worse pain) was a 5. R134 indicated pain management was effective on the current schedule. The narcotic sign out book was reviewed with registered nurse (RN)-A on 3/19/14, at 9:45 a.m. R134 had received a Fentanyl patch on 3/12/14, at 10:00 a.m. 3/15/14, at 9:20 a.m. and 3/18/14, at 9:47 a.m. In addition, according to the narcotic book records, the Fentanyl patch count was correct. However, a nursing progress note dated 3/12/14, at 10:57 a.m. was reviewed and indicated: "Late Entry. Writer and Clinical coordinator destroyed Fentanyl patch in a.m. on 3/12/14." The licensed staff had not documented the appropriate information to indicate they had both witnessed the destruction of the Fentanyl patch which had been removed prior to applying the new patch.	{21630}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27752	A. BUILDING: _____ B. WING _____	R 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443

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{21630}	Continued From page 3 A nursing progress note dated 3/15/14, at 10:30 p.m. included: "Fentanyl patch removed and flushed down sewer with [RN-B and RN-C]". The licensed staff involved had not both documented the necessary verification of having witnessed the destruction of the Fentanyl patch which had been removed prior to applying the new patch. In addition, although the Fentanyl patch had been applied at 9:20 a.m., a progress note entry had not been documented until 10:30 p.m., 11 hours and 10 minutes later. A nursing progress note in R134's record, dated 3/18/14 at 4:00 p.m., included: "Fentanyl patch wasted this a.m., new patch applied at 9:45." The documentation was written six hours and 13 minutes after the Fentanyl patch had been applied to the resident. In addition, the licensed staff witnessing the destruction of the Fentanyl path had not both signed to indicate verification of the destruction. RN-A was interviewed on 3/19/14, at 9:45 a.m. and confirmed the three nursing progress notes dated 3/12/14, 3/15/14, and 3/18/14, failed to include documentation to verify the witnessing of the Fentanyl patch destruction, and RN-A confirmed the documentation had not been immediately documented. The director of nursing (DON) was interviewed on 3/19/14, at 4:45 p.m. and confirmed the identified licensed staff had not followed the facility's policy for destruction of narcotic patches to minimize or prevent diversion or accidental exposure. The DON confirmed the late entries and failure of both witnesses to verify destruction, went against the facility policy. The facility did not ensure the Fentanyl patches	{21630}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27752	A. BUILDING: _____ B. WING _____	R 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	**5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21630}	Continued From page 4 were wasted which involved a secure and safe method, so diversion and/or accidental exposure are minimized.	{21630}		

Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Electronically Delivered: April 9, 2014

Ms. Dinah Martin, Administrator
Saint Therese at Oxbow Lake
5200 Oak Grove Parkway
Brooklyn Park, Minnesota 55443

Re: Project Number: S5619001

Dear Ms. Martin:

On March 19, 2014, 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 January 10, 2014 with orders received by you January 30, 2014.

State licensing orders issued pursuant to the last survey completed on January 10, 2014 and found corrected at the time of this March 19, 2014 revisit, are being submitted to you electronically via the ePOC Web Portal.

State licensing orders issued pursuant to the last survey completed on January 10, 2014 , found not corrected at the time of this March 19, 2014 revisit and subject to penalty assessment are as follows:

- **21630 - MN Rule 4658.1350 Subp. 2 A.B. - Disposition Of Medications; Destruction - $300.00**

The details of the violations noted at the time of this revisit completed on March 19, 2014 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically sign and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of **$300.00** per day beginning on the day you receive this notice.

The fines shall accumulate daily until written notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to , Minnesota Department of Health, Licensing and Certification Program, Division of Compliance Monitoring, Po Box 64900 St Paul Mn

55164-0900.

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Division of Compliance Monitoring, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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.

Sincerely,

Anne Kleppe

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

cc: Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245619	A. BUILDING _____ B. WING _____	R 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	**5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443**

(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 A Post Certification Revisit (PCR) was completed on March 19, 2014. Based on the PCR it was determined the facility was not in substantial compliance with Federal requirements. The following deficiency is issued:	{F 000}		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure Fentanyl patches (narcotic patch) used to control pain were destroyed in a manner to prevent potential diversion for 1 of 2 residents (R134) who utilized Fentanyl patches.	F 425	A. Corrective action for residents involved: Nurse identified as being responsible for not following facility policy for the destruction of fentanyl patches was	4/9/14

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

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245619	A. BUILDING _____ B. WING _____	R 03/19/2014

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F 425	Continued From page 1 Findings include: On 3/19/14, the facility provided a document for review entitled, Plan of Correction Education Overview/Policy for Licensed staff (no date) indicated "Narcotic pain patches need to be destroyed with two nurses via the sewer system. Each nurse needs to independently place a note in the progress notes that the patch was removed and destroyed via the sewer system and who was present." According to review of the facility's education roster documentation, each of the facility's licensed nurses had received training between 2/10/14 through 2/17/14, related to the appropriate destruction, and required record keeping, related to Fentanyl patches. R134 was admitted to the facility on 3/9/14, after having a total left hip replacement. R134 had a physician's order dated 3/9/14, for a Fentanyl patch 75 micrograms (mcg) per hour which was to be applied transdermally (on the skin) every three days. A progress note dated, 3/14/14, indicated the resident rated the pain as moderate on a scale of 1 to 10 (10 being the worse pain) was a 5. R134 indicated pain management was effective on the current schedule. The narcotic sign out book was reviewed with registered nurse (RN)-A on 3/19/14, at 9:45 a.m. R134 had received a Fentanyl patch on 3/12/14, at 10:00 a.m. 3/15/14, at 9:20 a.m. and 3/18/14, at 9:47 a.m. In addition, according to the narcotic book records, the Fentanyl patch count was correct. However, a nursing progress note dated 3/12/14, at 10:57 a.m. was reviewed and indicated: "Late	F 425	disciplined. B. How to identify other residents potentially affected: All nurses and clinical coordinators were notified to alert Director of Clinical Services when any orders were received for fentanyl patches. C. Measure/Systemic changes to ensure deficient practice will not reoccur: All narcotic pain patches will be removed, destroyed by two licensed nurses via the sewer system, and both nurses will document as soon as possible in the electronic health record the destruction of the patch. All licensed staff will be reeducated on the procedure for disposal of narcotic pain patches during the week of April 7, 2014. D. How to monitor: All residents with narcotic pain patches will be audited weekly for the next two months, then monthly for three months, then quarterly for appropriate disposal and documentation of disposal of narcotic pain patches. Audits will be received by the Director of Clinical Services and reviewed by clinical coordinators. Trends and audit results will be reviewed at facility quality improvement committee meetings. Director of Clinical Services is responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245619	A. BUILDING _____ B. WING _____	R 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	**5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443**

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F 425	Continued From page 2 Entry. Writer and Clinical coordinator destroyed Fentanyl patch in a.m. on 3/12/14." The licensed staff had not documented the appropriate information to indicate they had both witnessed the destruction of the Fentanyl patch which had been removed prior to applying the new patch. A nursing progress note dated 3/15/14, at 10:30 p.m. included: "Fentanyl patch removed and flushed down sewer with [RN-B and RN-C]". The licensed staff involved had not both documented the necessary verification of having witnessed the destruction of the Fentanyl patch which had been removed prior to applying the new patch. In addition, although the Fentanyl patch had been applied at 9:20 a.m., a progress note entry had not been documented until 10:30 p.m., 11 hours and 10 minutes later. A nursing progress note in R134's record, dated 3/18/14 at 4:00 p.m., included: "Fentanyl patch wasted this a.m., new patch applied at 9:45." The documentation was written six hours and 13 minutes after the Fentanyl patch had been applied to the resident. In addition, the licensed staff witnessing the destruction of the Fentanyl path had not both signed to indicate verification of the destruction. RN-A was interviewed on 3/19/14, at 9:45 a.m. and confirmed the three nursing progress notes dated 3/12/14, 3/15/14, and 3/18/14, failed to include documentation to verify the witnessing of the Fentanyl patch destruction, and RN-A confirmed the documentation had not been immediately documented. The director of nursing (DON) was interviewed on 3/19/14, at 4:45 p.m. and confirmed the identified	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 425	Continued From page 3 licensed staff had not followed the facility's policy for destruction of narcotic patches to minimize or prevent diversion or accidental exposure. The DON confirmed the late entries and failure of both witnesses to verify destruction, went against the facility policy. The facility did not ensure the Fentanyl patches were wasted which involved a secure and safe method, so diversion and/or accidental exposure are minimized.	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27752	A. BUILDING: _____ B. WING _____	R 03/19/2014

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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: A follow up was completed to verify correction of licensing orders issued at the time of the January 10, 2014 survey. The following licensing orders were reissued:	{2 000}		
{21630}	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction	{21630}		4/9/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{21630}	Continued From page 1 Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure Fentanyl patches (narcotic patch) used to control pain were destroyed in a manner to prevent potential diversion for 1 of 2 residents (R134) who utilized Fentanyl patches. Findings include: On 3/19/14, the facility provided a document for review entitled, Plan of Correction Education Overview/Policy for Licensed staff (no date)	{21630}	A. Corrective action for residents involved: Nurse identified as being responsible for not following facility policy for the destruction of fentanyl patches was disciplined. B. How to identify other residents potentially affected: All nurses and clinical coordinators were notified to alert Director of Clinical Services when any orders were received	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{21630}	Continued From page 2 indicated "Narcotic pain patches need to be destroyed with two nurses via the sewer system. Each nurse needs to independently place a note in the progress notes that the patch was removed and destroyed via the sewer system and who was present." According to review of the facility's education roster documentation, each of the facility's licensed nurses had received training between 2/10/14 through 2/17/14, related to the appropriate destruction, and required record keeping, related to Fentanyl patches. R134 was admitted to the facility on 3/9/14, after having a total left hip replacement. R134 had a physician's order dated 3/9/14, for a Fentanyl patch 75 micrograms (mcg) per hour which was to be applied transdermally (on the skin) every three days. A progress note dated, 3/14/14, indicated the resident rated the pain as moderate on a scale of 1 to 10 (10 being the worse pain) was a 5. R134 indicated pain management was effective on the current schedule. The narcotic sign out book was reviewed with registered nurse (RN)-A on 3/19/14, at 9:45 a.m. R134 had received a Fentanyl patch on 3/12/14, at 10:00 a.m. 3/15/14, at 9:20 a.m. and 3/18/14, at 9:47 a.m. In addition, according to the narcotic book records, the Fentanyl patch count was correct. However, a nursing progress note dated 3/12/14, at 10:57 a.m. was reviewed and indicated: "Late Entry. Writer and Clinical coordinator destroyed Fentanyl patch in a.m. on 3/12/14." The licensed staff had not documented the appropriate information to indicate they had both witnessed the destruction of the Fentanyl patch which had been removed prior to applying the new patch.	{21630}	for fentanyl patches. C. Measure/Systemic changes to ensure deficient practice will not reoccur: All narcotic pain patches will be removed, destroyed by two licensed nurses via the sewer system, and both nurses will document as soon as possible in the electronic health record the destruction of the patch. All licensed staff will be reeducated on the procedure for disposal of narcotic pain patches during the week of April 7, 2014. D. How to monitor: All residents with narcotic pain patches will be audited weekly for the next two months, then monthly for three months, then quarterly for appropriate disposal and documentation of disposal of narcotic pain patches. Audits will be received by the Director of Clinical Services and reviewed by clinical coordinators. Trends and audit results will be reviewed at facility quality improvement committee meetings. Director of Clinical Services is responsible for compliance.	

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{21630}	Continued From page 3 A nursing progress note dated 3/15/14, at 10:30 p.m. included: "Fentanyl patch removed and flushed down sewer with [RN-B and RN-C]". The licensed staff involved had not both documented the necessary verification of having witnessed the destruction of the Fentanyl patch which had been removed prior to applying the new patch. In addition, although the Fentanyl patch had been applied at 9:20 a.m., a progress note entry had not been documented until 10:30 p.m., 11 hours and 10 minutes later. A nursing progress note in R134's record, dated 3/18/14 at 4:00 p.m., included: "Fentanyl patch wasted this a.m., new patch applied at 9:45." The documentation was written six hours and 13 minutes after the Fentanyl patch had been applied to the resident. In addition, the licensed staff witnessing the destruction of the Fentanyl path had not both signed to indicate verification of the destruction. RN-A was interviewed on 3/19/14, at 9:45 a.m. and confirmed the three nursing progress notes dated 3/12/14, 3/15/14, and 3/18/14, failed to include documentation to verify the witnessing of the Fentanyl patch destruction, and RN-A confirmed the documentation had not been immediately documented. The director of nursing (DON) was interviewed on 3/19/14, at 4:45 p.m. and confirmed the identified licensed staff had not followed the facility's policy for destruction of narcotic patches to minimize or prevent diversion or accidental exposure. The DON confirmed the late entries and failure of both witnesses to verify destruction, went against the facility policy. The facility did not ensure the Fentanyl patches	{21630}		

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{21630}	Continued From page 4 were wasted which involved a secure and safe method, so diversion and/or accidental exposure are minimized.	{21630}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: RNX6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 27752

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245619**
2.STATE VENDOR OR MEDICAID NO.
(L2) **753490000**

3. NAME AND ADDRESS OF FACILITY
(L3) **SAINT THERESE AT OXBOW LAKE**
(L4) **5200 OAK GROVE PARKWAY**
(L5) **BROOKLYN PARK, MN** (L6) **55443**

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 **01/10/2014** (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)
06/13

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

12.Total Facility Beds **64** (L18)

13.Total Certified Beds **64** (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
	64			
(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 02/19/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 02/25/2014 (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
07/16/2013
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN#: 24-5619

At the time of the standard survey completed January 15, 2014, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8279

January 28, 2014

Ms. Dinah Martin, Administrator
Saint Therese At Oxbow Lake
5200 Oak Grove Parkway
Brooklyn Park, Minnesota 55443

RE: Project Number S5619001

Dear Ms. Martin:

On January 15, 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:

<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, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55108-2970
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 February 19, 2014, 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 19, 2014 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 April 10, 2014 (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 July 10, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245619	A. BUILDING _____ B. WING _____	01/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443

(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 verifcation 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	Corrective action for residents involved: The nurse practitioner for R35 was updated on 11/4/13 and an order was received for an Xray of hand. No acute fracture was noted in Xray. Resident remained comfortable with the use of as needed pain medication and ice to hand. A report was filed with the appropriate state agency and injury to hand was investigated. R35 remains at stable and has not had a change in condition. How identify other residents potentially affected: All residents could potentially be affected. Measure/Systemic changes to ensure deficient practice will not reoccur: All licensed staff will receive education the week of February 10, 2014 in regards to when the physician needs to be updated. Facility policy titled MD/NP notification regarding change of resident's condition was reviewed and updated. Licensed staff were reeducated on policy during education sessions.	2/19/14
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157		

accepted 2-12-14 Jennifer Dunn

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

Executive Director 2/7/14

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

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F 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician in a timely manner for 1 of 3 residents (R35) who sustained a skin tear, bruising and swelling injury to the right hand. Findings include: R35's diagnoses included osteoporosis and history of a close fracture unspecified part upper end humerus obtained from the quarterly Minimum Data Set (MDS) dated 10/3/13. The MDS indicated R35's Brief Interview of Mental Status (BIMS-tool used to measure cognitive status) score was 15 (which indicated intact cognitive status). R35's Progress Notes revealed the following: -On 10/19/13, a skin tear to the right wrist measuring 2 centimeter (cm) x 1.5 cm was and R35 had reported she bumped her hand over her walker was noted. Steri-strips were applied and the note indicated staff would continue to monitor. -On 10/20/13, R35's right hand was noted to be red, swollen, warm to touch and the Steri-strips remained intact. R35 denied pain and the note indicated staff would continue to monitor. -On 11/2/13, the top of R35's right hand was	F 157	How to monitor: A random sample of progress notes will be audited and reviewed monthly for three months then quarterly. Progress noted will be reviewed to assure physicians were updated timely and appropriately. Audit results will be reviewed with Director of Clinical services and clinical coordinators. Director of Clinical Services is responsible for compliance RECEIVED FEB - 7 2014 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	2/19/14

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F 157	Continued From page 2 observed to have one Steri-strip from a previous skin tear and the hand was bruised, swollen and tender to touch. R35 was not able to explain exactly what happened when asked and stated she was constantly bumping the hand on something. Ice was applied to R35's hand two times during the shift, with decreased swelling noted. The note indicated staff would continue to monitor R35's needs. -On 11/3/13, two notes indicated R35's right hand remained swollen/puffy, bruised, warm, and tender to touch and R35 reported pain. Scheduled pain medication and ice were administered and R35 reported relief. -On 11/4/13, an earlier note indicated the top of R35's right hand was bruised, reddened and swollen. Later that same day, the bruise was noted to be dark red, measured 35 cm x 15 cm, and was swollen all the way down to the fingers. R35 reported pain with range of motion and with pressure. The nurse practitioner (NP) was updated and an x-ray was ordered. R35's medical record lacked documented evidence the physician (MD) or NP was notified of the right hand injury until 16 days after the skin tear occurred and/or two days after the right hand bruising and swelling was noted. On 1/10/14, at 11:11 a.m. the director of clinical services (DCS) was asked why the physician was not updated when the skin tear was first noted on 10/19/13, and on 11/2/13. DCS stated, "I'd have to go back and review the incident." She further stated she expected the physician to be notified, "If injury with pain, increased swelling, tenderness ...anything out of the ordinary." DCS further explained when the bruising was first noted on 11/2/13, she would have liked both herself and	F 157		

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F 157	Continued From page 3 the administrator to have been notified of the right hand injury. On 1/10/14, at 12:15 p.m. the NP stated the facility was supposed to update her of any change in condition, new complaint, or change off baseline immediately. NP stated if she was not working, or if it was during the weekend, the facility was to call the on-call provider for treatment. Additionally, the NP stated she expected the nurses to leave a voice message for issues that would not need immediate attention. NP stated she would follow up on her next working day. NP further stated she recalled being updated regarding R35's bruised right hand on 11/4/13, and stated she had ordered an x-ray to rule out a possible fracture due to the swelling and pain. The licensed practical nurse (LPN)-C who had worked with R35 on 11/2/13, was interviewed on 1/10/14, at 12:33 p.m. via telephone. LPN-C was able to re-call the bruising incident and Progress Note dated 11/2/13. LPN-C also added there was more swelling than bruising at the time and had updated the next shift to continue to monitor. LPN-C confirmed neither the physician, NP nor the supervisor were notified about the condition of the right hand. The MD/NP and/or Resident/Family Notification Regarding a change of Resident's Condition policy dated February 2013, indicated the MD/NP were to be kept informed of change in current health status so that a medical decision can be made.	F 157		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE	F 167		

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F 167	Continued From page 4 A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post prior survey results in an area easily accessible to residents and visitors. This had the potential to affect all 60 of 60 residents in the facility and visitors. Findings include: During the initial facility tour on 1/7/14, at 10:15 a.m. a sign posted at the receptionist desk indicated the survey results were available behind the desk. A red three ring binder was observed in a corner behind the desk which included the previous survey results. On 1/9/14, at 9:10 a.m. the resident counsel president (R10) accompanied the surveyor to the receptionist desk. R10 was shown the sign which indicated where the survey results were kept. R10 stated she would not be able to reach the survey results from her wheelchair and would have to ask staff to see the survey results. In addition, R10 stated she would not want to have to ask staff to see the survey results.	F 167	Corrective action for residents involved: The red binder containing the most recent survey results will be placed on top of the reception desk at the entrance of the facility, clearly visible and accessible to all residents and visitors. The sign posted on the reception desk noting the location of the red binder has been updated to announce this correction. How identify other residents potentially affected: All residents could potentially be affected. Measure/Systemic changes to ensure deficient practice will not reoccur: All staff will be educated of this change through staff meetings and Plan of Correction education held on the week of February 10, 2014. Education will also be provided at the resident council held on February 4, 2014 and the family meeting on February 11, 2014.	2/19/14

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F 167	Continued From page 5 On 1/9/14, at 10:08 a.m. the red binder with the survey results was observed on top of the receptionist desk. The administrator verified the survey results were not posted anywhere else, could not be reached behind the desk and stated they would now be kept on top of the receptionist desk instead of behind the desk. On 1/9/14, at 3:15 p.m. the administrator stated the facility did not have a policy and procedure for posting the survey results and used the regulation as a guide.	F 167	How to monitor: This change is now part of the receptionist's daily tasks to ensure proper location and will be monitored through facility QA process. Findings of monthly audit will be reported at facility quality improvement committee meeting. Administrator is responsible for compliance.	2/19/14
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		

Don't type past here.

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F 225	Continued From page 6 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to immediately report injuries of unknown origin (bruises and skin tears) to the administrator and the designated State agency (SA); in addition, the facility failed to ensure a resident was protected during investigation of alleged verbal abuse for 3 of 4 residents (R75, R35, R30) reviewed for abuse prohibition. Findings include: INJURIES OF UNKNOWN ORIGIN R75's bruises of unknown origin to both forearms were not immediately reported to the administrator, immediately reported to the SA or thoroughly investigated. On 1/7/14, at 1:44 p.m. R75 was observed to have several dark purple bruises to both forearms at different stages of healing. R75 was unable to explain how she got the bruises.	F 225	Corrective action for residents involved: Bruises noted on R75 were brought to the attention of the Director of Clinical Services and were immediately reported to the administrator on January 9, 2014. Upon review with the administrator the bruises were reported to the state agency on 1/9/14 due to the bruises were of unknown origin. Bruises were documented, investigated, care plan was updated, and interventions were put in place to reduce further injury. R75 was noted by staff to ambulate independently and at times bump into things being unaware of surroundings. Family and physician were updated immediately of bruises. Investigative report was filed with the state agency. Injury to R35's hand had previously been reported. Care plan was reviewed for R35 to assure current and up to date. Resident has had no changes in ADLs or condition related to bruise and swelling to hand.	2/19/14

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F 225	Continued From page 7 - At 5:22 p.m. R75 was observed sitting at the dining room table eating independently. A nursing assistant (NA)-B was sitting between R75 and other resident cuing her to eat. NA-B was not observed to acknowledge or asked R75 about the bruises. On 1/8/14, at 2:27 p.m. NA-B stated if she noticed any resident with bruises, she would report to the nurse immediately to ensure the nurse assessed the bruising. Although NA-B stated she would report bruises immediately, the clinical record lacked evidence the observed bruises were reported. On 1/9/14, at 7:30 a.m. R75 was observed to be sitting on the couch in the middle lounge with her eyes closed. The administrator was observed to be reading the paper outloud to R75 and four other residents. The administrator sat next to R75; R75's forearms and the bruises were clearly visible during the activity. Although the administrator was present and the bruises were clearly visible, the clinical record lacked documented evidence the bruises were identified. R75's significant change Minimum Data Set (MDS) dated 9/20/13, indicated R75's diagnoses included Alzheimer's disease and macular degeneration of the retina. The MDS indicated R75 had severe cognitive impairment and require extensive assistance for all activities of daily living. The Pressure Ulcer Care Area Assessment (CAA) dated 10/3/13, indicated R75 was at risk for pressure ulcers related to dementia, not always being able to verbalize needs. The CAA lacked R75's risk for bruising due to being a wanderer.	F 225	Incident with R30 had previously been reported. R30 remains safe and no further incidents have been reported. Nursing assistant involved in incident had been disciplined and education was provided to prevent further incidents How identify other residents potentially affected:All residents could potentially be affected. Measure/Systemic changes to ensure deficient practice will not reoccur: Reminders and education was provided to staff addressing the facility Vulnerable Adult policy to report immediately all allegations involving mistreatment, neglect or abuse, including injuries of unknown source. Survey results were reviewed with Clinical and Household Coordinator and reminded about immediate reporting. All staff were educated on vulnerable adult reporting during education sessions the week of February 10, 2014.	2/19/14

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F 225	Continued From page 8 R75's care plan dated 11/20/12, identified for skin integrity, "[R75 was] At risk for impaired skin integrity due to always being incontinent of bladder and occasionally incontinent of bowel, fall risk and self-care deficit related to dementia." The care plan did not identify R75's risk for bruising, but directed to "monitor for skin changes during baths/showers, during am/pm cares and notify the nurse." Although the vision focus identified R75 had potential for change in vision related to macular degeneration; the behavior focus identified R75 wandered around the unit and into other resident rooms, neither focus included how R75 was at risk for injury or bruising. Review of R75's Progress Notes revealed on 11/25/13, 12/2/13, and 12/16/13, old bruising had been noted on both of R75's forearms. A nursing Progress Note dated 1/9/14 (after concern had been brought to the attention of facility staff by the surveyor), indicated R75 had eight bruises to both arms. The note indicated the measurements of the bruises were as follows: - right upper forearm 6 centimeter (cm) x 8 cm; - right mid forearm 3 cm 1 cm; - right wrist 2 cm x 2.5 cm; - below right index finger 4 cm x 2.5 cm; - at base of right thumb 3 cm x 1 cm; - left upper forearm 5 cm x 5.5 cm; - left mid forearm 5 cm x 3 cm; - area to left wrist/top of hand 5 cm x 3 cm. Although the condition of bruising was documented on the above dates, the medical record lacked evidence R75's current bruises were assessed and measures were put in place to prevent further bruising. On 1/9/14, at 8:40 a.m. the registered nurse clinical coordinator (RN)-D stated, "I am	F 225	How to monitor: A sample of weekly skin check progress notes will be audited monthly to assure bruises are investigated and addressed per policy. Also on a monthly basis a visual assessment of resident's skin will be conducted. Vulnerable adult reports and trending will be reviewed at the facility quality improvement committee meetings every three months and also reviewed monthly at facility staff meetings to assure appropriate steps have been taken with each investigation. Director of Clinical Services is responsible for compliance.	2/19/14

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	245619	A. BUILDING _____ B. WING _____	01/10/2014

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F 225	Continued From page 9 supposed to be notified and my boss [director of clinical services- DCS], of any bruises or falls immediately. For the bruises of unknown origin, the nurses are supposed to measure, document and start the investigation." She further stated all residents skin was supposed to be checked weekly with bath/shower and the nurses were supposed to document the resident skin condition with cares. RN-D stated if anything was noted it needed to be addressed immediately. The RN-D confirmed both of R75's forearms had dark purple bruises and verified after looking at both forearms and stated the bruises were at different stages of healing. On 1/9/14, at 9:42 a.m. DSC stated all bruises were supposed to be documented by the nurses and if the bruise was of unknown origin, the DSC stated she was supposed to be notified immediately or as soon as possible. DSC stated she was to be notified even when she was on call. DSC further stated the nurses were supposed to let the clinical coordinator know to update the care plan and monitor the skin issue every shift until resolved. On 1/9/14, at 2:10 p.m. clinical coordinator (RN)-D stated she was not aware R75 had the bruises. RN-D stated R75 "was a wanderer" and may have bumped or "ran into something" causing the bruising. On 1/9/14, at 3:03 p.m. DSC stated R75's bruises were not brought to her attention and she was not aware of the bruises. DSC stated if she had been aware of the bruises, she would have started an investigation immediately, reported it immediately to the administrator and immediately to SA. DSC further stated an investigation had been started	F 225		

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F 225	Continued From page 10 and the bruising was reported to SA. R35 sustained a skin tear to the right wrist on 10/19/13, redness and swelling to the right hand on 10/20/13, and bruising to the right hand of unknown origin on 11/2/13; none of the injuries were immediately reported to the administrator and the SA. The quarterly MDS dated 10/3/13, indicated R35's diagnoses included osteoporosis and history of a close fracture unspecified part upper end humerus. The MDS indicated R35's Brief Interview of Mental Status (BIMS-tool used to measure cognitive status) score was 15 (which indicated intact cognitive status). The MDS in addition indicated R35 required limited to extensive physical assist of one staff with activities of daily living (ADL's), R35 was identified as being unsteady with balance with transitions, was able to walk with without assist and used a walker and/or wheelchair. R35's nursing Progress Notes revealed the following: -On 10/19/13, a skin tear to the right wrist measuring 2 centimeter (cm) x 1.5cm was noted and R35 had reported she had bumped her hand over her walker. Steri-strips were applied and the note indicated staff would continue to monitor. -On 10/20/13, R35's right hand was noted to be red, swollen, warm to touch and the Steri-strips remained intact. R35 denied pain and the note indicated staff would continue to monitor. -On 11/2/13, R35's top of right hand was observed to have one Steri-strip from previous skin tear and hand was bruised, swollen and tender to touch. R35 was not able to explain	F 225		

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F 225	Continued From page 11 exactly what happened when asked and stated she was constantly bumping the hand on something. Ice was applied to hand two times during the shift with decreased swelling. The note revealed staff would continue to monitor R35's needs. -On 11/3/13, two notes indicated R35's right hand remained swollen/puffy, bruised, warm, and tender to touch and R35 reported pain. Scheduled pain medication and ice were administered and R35 reported relief. -On 11/4/13, an earlier note indicated top of right hand was bruised, reddened and swollen. Later that same day the bruise was noted to be dark red, measured 35 cm x 15 cm, was swollen all the way down to the fingers. R35 reported pain with range of motion and with pressure. The nurse practitioner (NP) was updated and an x-ray was ordered. The x-ray results dated 11/4/13, indicated there was no evidence of acute bony injury. On 1/10/14, at 11:11 a.m. DCS stated she would have liked both herself and the administrator to have been notified of the right hand injury. The DCS verified the administrator should have been notified immediately. On 1/10/14, at 12:33 p.m. the licensed practical nurse (LPN)-C was interviewed via telephone. LPN-C confirmed he worked with R35 on 11/2/13, verified he recalled the bruising incident and was able to recall the nursing Progress note from that day. LPN-C stated there was more swelling, than bruising at the time and stated he had updated the next shift to continue to monitor the right hand. LPN-C confirmed he did not update the supervisor about the condition of R35's right hand. LPN-C stated he asked the NA assigned to	F 225		

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F 225	Continued From page 12 R35 regarding the skin issue. LPN-C stated he and the NA both thought the bruise was caused "by the vanity." LPN-C stated R35 had told him she went to the toilet "back and forth" and probably had bumped herself "on something." VERBAL ABUSE ALLEGATION R30 was not protected during an investigation of alleged verbal abuse. A vulnerable adult (VA) report dated 6/27/13, indicated R30 had reported a nursing assistant (NA) who had worked with R30 the evening before (on 6/26/13) was abusive. The report indicated R30 reported the NA screamed and yelled at R30 that her (R30's) eyes were okay and R30 was "not blind." An email dated 6/27/13, at 3:45 p.m. from the household coordinator to DSC indicated R30's "reported to me just now" a [NA staff] "who helped her get to bed last night was 'abusive.'" The email discribed the abusive behaviors of "yelling and screaming at her [R30]and telling her that her eyes are okay and that she [R30] is not blind." Although the email indicated the allegation was reported to the DSC, the clinical record lacked evidence the allegation was reported to the administrator immediately, reported to the SA, and lacked evidence the incident was documented in the medical record. The quarterly MDS dated 10/24/13, indicated R30's diagnoses included dementia and chronic kidney disease. R30's Brief Interview of Mental Status (BIMS-tool used to measure cognitive status) score was 15 (which indicated intact cognitive status).	F 225		

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F 225	Continued From page 13 The vision care plan dated 5/17/13, identified R30 had decreased vision due to macular degeneration and was legally blind. The visual function CAA dated 2/5/13, also identified R30 with an impairment with risk factors including blindness and dementia. On 1/10/14, at 10:58 a.m. DCS stated the incident was called in by telephone to the SA (versus online reporting) as the facility did not have a Medicare provider number at the time (and could not complete online reports to SA). After the DCS reviewed the VA log, DCS stated the administrator had been notified the same day on 6/27/13, at 4:50 p.m. DCS recalled the incident and stated she would need to "go back" and review the incident. DCS stated during the investigation, "That NA was asked not to take care of her [R30]." DCS further stated during the investigation the NA "went back and apologized to her [R30] too" and the NA continued to work on the unit. When asked how the facility ensured R30 was safe from the alleged perpetrator while they continued worked on the same unit as R30 during the investigation, DCS was unclear how R30 was protected. DCS confirmed the household coordinator should have documented the complaint in the clinical record including the actual report, what the follow up at the time was and that he had reported the incident to his immediate supervisor and herself. Review of the VA log confirmed the administrator had been notified on 6/27/13, at 4:50 p.m. as indicated earlier by DSC during interview. On 1/10/14, at 11:56 a.m. when interviewed about the procedure handling the allegation of abuse,	F 225		

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F 225	Continued From page 14 the administrator stated she expected R30 to have been interviewed. The administrator stated this had been done by the clinical coordinator. The administrator added she would have expected the employee in question not to work with R30 providing direct care until education was provided. The administrator verified she would not know if a resident was protected during the investigation if the staff continued to work in the unit unless she was "sitting right there." She further stated the facility had suspended staff during an investigation in the past and verified R30 was not protected during the investigation. The administrator verified R30's incident should have been documented in the clinical record and should have included: the initial complaint, notification, details of the incident and what had been done. On 1/10/14, at 12:16 p.m. the household coordinator stated usually he would document the basics on the incident/report, who he spoke with, send an email and immediately report to "my supervisors" who were the DCS and administrator. The household coordinator verified the allegation and incident, including reporting to the DSC, was not documented in the medical record. The household coordinator verified he should have documented the incident. The Incident Report/Falls Scene Investigation policy dated August 2012, indicated the report was completed whenever a resident is involved in an unusual situation, such as a fall, roll onto a matt, (unless it is on care plan that resident intentionally places self on matt), lowered to floor, bruises greater than a quarter, bruises in vulnerable areas ie:groin, breast, face, fingerprint appearing, elopement, resident to resident	F 225		

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F 225	Continued From page 15 altercation or unaccounted injuries.	F 225	Corrective action for residents involved:	2/19/14
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to implement their abuse prohibition policy regarding immediately reporting bruise and skin tear injuries of unknown origin to the administrator, immediately report to the State agency (SA) and to thoroughly investigate the injury to rule out potential abuse (R75, R35); in addition, the facility failed to protect a resident (R30) during investigation of alleged verbal abuse for 3 of 4 residents (R75, R35, R30) reviewed for abuse prohibition. Findings include: The facility Vulnerable Adult, Reporting of Maltreatment of policy dated 8/28/2013, defined abuse as, "An act against a vulnerable adult that constitutes a violation or, an attempt to violate, or aiding, and abetting a violation ..." and further defined unexplained injuries (injuries of unknown source) as, "An injury, which is not associated with an explainable current medical condition." The policy identified bruises, skin tears and fractures as reportable injuries. The procedure directed to report abuse/neglect allegations orally	F 226	Bruises noted on R75 were brought to the attention of the Director of Clinical Services and were immediately reported to the administrator on 1/9/14. Upon review with the administrator the bruises were reported to the state agency on 1/9/14 due to the bruises were of unknown origin. Bruises were documented, investigated, care plan was updated, and interventions were put in place to reduce further injury. R75 was noted by staff to ambulate independently and at times bump into things being unaware of surroundings. Family and physician were updated immediately of bruises. Investigative report was filed with the state agency. Injury to R35's hand had previously been reported. Care plan was reviewed for R35 to assure current and up to date. Resident has had no changes in ADLs or condition related to bruise and swelling to hand.	

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F 226	Continued From page 16 to the appropriate department head and the administrator immediately. The procedure also directed upon receiving an oral or written report of abuse/neglect the director of clinical services (DCS) would review it and determine if to report it externally to the SA immediately. The policy further directed, "e. If staff to resident abuse/neglect is suspected, determine with the involved supervisor and/or appropriate department head if the named employee(s) should be placed on investigative suspension based on the potential of further resident abuse/neglect and/or disruption of the work environment. The employee(s) will be given a notice of investigative leave... pending investigation by the supervisor." INJURIES OF UNKNOWN SOURCE R75's bruises of unknown origin to both forearms were not investigated and reported to the administrator and SA. On 1/7/14 and 1/9/14, R75 was observed to have eight clearly visible dark purple bruises at different stages of healing to both forearms. R75 was unable to explain how she got the bruises and a facility staff was present during the observations. The clinical record lacked evidence the bruises were identified and/or reported immediately to the administrator and SA; the clinical record lacked evidence the bruises were thoroughly investigated. Review of R75's Progress Notes dated 11/25/13, 12/2/13, and 12/16/13, indicated R75 had old bruises noted on both forearms. On 1/9/14, at 3:03 p.m. DSC stated R75's bruises were not brought to her attention and she was not	F 226	Incident with R30 had previously been reported. R30 remains safe and no further incidents have been reported. Nursing assistant involved in incident had been disciplined and education was provided to prevent further incidents. How identify other residents potentially affected: All residents could potentially be affected. Measure/Systemic changes to ensure deficient practice will not reoccur: Reminders and education was provided to staff addressing the facility Vulnerable Adult policy to report immediately all allegations involving mistreatment, neglect or abuse, including injuries of unknown source. Survey results were reviewed with Clinical and Household Coordinator and reminded about immediate reporting. All staff were educated on vulnerable adult reporting during education sessions the week of February 10, 2014.	2/19/14

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F 226	Continued From page 17 aware of the bruises. DSC stated if she had been aware of the bruises, she would have started an investigation immediately, reported it immediately to the administrator and immediately to SA. DSC further stated an investigation had been started and the bruising was reported to SA. R35 skin tear to right wrist and bruise to right hand of unknown origin were not reported to the facility administrator and SA. R35's nursing Progress Notes indicated on 10/19/13, 10/20/13, 11/2/13, and 11/3/13 a skin tear to the right wrist and the right hand redness, bruising, swelling and warm to touch had been noted. The medical record lacked documented evidence the skin tear and bruising of unknown origin had been reported to the administrator and SA for 16 days since the first time the issue had been identified on 10/19/13. The nursing Progress Note dated 11/4/13, indicated top of the right hand was bruised, reddened and swollen. Later that same day the bruise was noted to be dark red, measured 35 cm x 15 cm and was swollen all the way down to the fingers. R35 reported pain with range of motion and with pressure. The nurse practitioner had been updated and an x-ray was ordered. The x-ray results dated 11/4/13, indicated there was no evidence of acute bony injury. On 1/10/14, at 11:11 a.m. DCS stated she would have liked both herself and the administrator to have been notified of the right hand injury. The DCS verified the administrator should have been notified immediately. On 1/10/14, at 11:41 a.m. the administrator stated she was supposed to be notified "Right away" of	F 226	How to monitor: A sample of weekly skin check progress notes will be audited monthly to assure bruises are investigated and addressed per policy. Also on a monthly basis a visual assessment of resident's skin will be conducted. Vulnerable adult reports and trending will be reviewed at the facility quality improvement committee meetings every three months and also reviewed monthly at facility staff meetings to assure appropriate steps have been taken with each investigation. Director of Clinical Services is responsible for compliance.	2/19/14

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F 226	Continued From page 18 anything including building, resident or staff issues. She added the staff are to notify her of any VA issues such as any suspicion of abuse, neglect, bruising, anything they report to the State immediately. She further stated the DCS should have been notified on 11/2/13, and DCS should have contacted her which had not been done. The administrator verified skin tears of unknown origin should have been investigated to determine the root cause analysis and verified investigation would not be started until after reporting has been completed. ALLEGATION OF VERBAL ABUSE R30 was not protected during an investigation of alleged verbal abuse. A Vulnerable Adult (VA) report dated on 6/27/13, indicated R30 had reported to staff a nursing assistant (NA) who had worked with her evening before 6/26/13, was abusive. R30 reported the NA was screaming and yelling at her that her eyes were okay and that she was not blind. During further document review, it was revealed R30 had reported to the household coordinator on 6/27/13, at 3:45 p.m. through e-mail correspondence to the DSC. The household coordinator never documented R30's complaint in the clinical resident record. On 1/10/14, at 10:58 a.m. DCS was interviewed stated during the investigation "That nursing assistant was asked not to take care of her (resident)." DCS further stated during the investigation the staff "went back and apologized to her (R30) too" and the staff continued to work on the unit. DCS was unclear how she ensured the resident was protected with the staff person still working on the unit during the investigation.	F 226		

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F 226	Continued From page 19 DCS confirmed the household coordinator should have documented the complaint in the clinical record including the actual report, what the follow up at the time was and that he had reported the incident to his immediate supervisor and herself. On 1/10/14, at 11:56 a.m. the administrator was interviewed verified she would not know R30 was protected during the investigation if the staff continued to work in the unit unless she was sitting right there. She further stated facility had suspended pending investigation in the past and verified the R30 was not protected during the investigation. The administrator verified the incident should have been documented in the clinical record, including initial complaint, notification, details of the incident and what had been done which was lacking.	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279	Corrective action for residents involved: Care plan and care guide for R27 were reviewed to assure they addressed resident's sleep problems, sleep monitoring, and the use of sleep aids. R27's care plan has been updated to reflect the use of Trazodone for sleep in the focus, a sleep related goal, non-pharmacological interventions for sleep, side effects to monitor with Trazodone use, and intervention for monitoring and evaluating sleep patterns and medication use.	2/19/14

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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 279	Continued From page 20 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a care plan to address sleep problems, sleep monitoring and/or the use of Trazodone for 1 of 5 residents (R27) reviewed for un-necessary medications. Findings include: R27 received scheduled Trazodone for sleep without development of a care plan to address the use of the medication, risk factors associated with the medication and non-pharmacological interventions, such as for sleep. Physician's orders dated 11/7/13, indicated R27 received Trazodone HCL 25 milligrams (mg) by mouth (PO) twice daily and 50 mg PO every hour of sleep (HS). The orders identified R27's diagnoses to include unspecified psychosis, dementia without behavioral disturbance, and Alzheimer's disease. The care plan dated 12/13/13, did not identify the use of Trazodone for sleep, lacked a focus for sleep and non-pharmacological interventions to promote sleep. In addition, the care plan lacked direction for monitoring and evaluation of R27's sleep patterns and potential side effects of the medication. On 1/9/14, at 2:01 p.m. the clinical coordinator (RN)-B verified the care plan did not address	F 279	How identify other residents potentially affected: All other resident care plan and care guides who are receiving a sleep aid were reviewed and updated to reflect usage of sleep aid, non-pharmacological interventions for sleep, side effects of sleep aid, and intervention for monitoring sleep patterns and medication use. Facility policy for psychotropic medication and monitoring was reviewed and updated. Measure/Systemic changes to ensure deficient practice will not reoccur: Education provided to all licensed staff in regards to policy and procedure for care planning and development of comprehensive care plans was provided during plan of correction education sessions during the week on February 10,2014. Care plans and care guides are to be updated every two weeks per set schedule and as needed to reflect changes in resident's abilities or needs. Licensed staff to update Clinical Coordinator if care plan does not accurately reflect the resident's needs, abilities, medication usage, and/or behaviors.	2/19/14

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	245619	A. BUILDING _____ B. WING _____	01/10/2014

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F 279	Continued From page 21 sleep or the use of Trazodone. At 2:31 p.m. the consultant pharmacist (CP)-F was interviewed via telephone and verified the facility should have care planned the use of Trazodone. On 1/10/14, at 9:04 a.m. the director of clinical services (DCS) verified the Trazodone and R27's sleep problems should have been care planned. The facility's Psychotropic Medications and Monitoring policy and procedure dated 8/2012, identified pertinent direction for psychoactive medications, including antidepressants. Although the policy directed appropriate indications for use of psychotropic medications, evaluation, monitoring and assessment of psychotropic medications; the policy lacked direction for care planning psychotropic medications.	F 279	How to monitor: A sample of residents care guides and care plans that receive psychotropic medication or sleep aides, will be audited monthly for three months, than quarterly for one year. A summary of the audit will be given to the Director of Clinical Services. Trending and audit reports will be reviewed every three months at the Quality Improvement committee meeting. Director of Clinical Services is responsible for compliance.	2/19/14
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280	Corrective action for residents involved: Daughter present during R63's scheduled bath time and reported R63 had extreme anxiety when brought to the tub room. R63 brought to room and given a complete bed bath, according to daughter R63 showed decreased anxiety with complete bed bath and even thanked the CLS staff. Conversed with daughter and received okay to give R63 bed baths only. Care plan and care guide updated to reflect R63 receives bed baths only on weekly bath days. Educated staff on new plan of care for R63 relating to weekly bath.	2/19/14

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F 280	Continued From page 22 each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was revised regarding bathing preferences for 1 of 5 residents (R63) reviewed for unnecessary medications. In addition the facility failed to revise a plan of care for 1 of 3 residents (R75) with bruises on unknown origin and risk for bruising reviewed for non-pressure skin conditions. Findings include: The Admission Record for R63 dated 12/4/13, included diagnoses of dementia, aphasia, and depression. The Order Summary Report dated 1/9/14, revealed R63 was prescribed Seroquel 25mg every bedtime and 25mg every Friday for anxiety to be given before bath/shower on Friday mornings. The every Friday Seroquel orders dated 8/13/13, included directions of may try bed bath/sponge bath instead. The bathing care plan dated 11/6/13, indicated R63 had a history of refusing showers, becoming very agitated and upset during the shower activity and identified R63 did not like water on her head. The care plan directed staff to administer a psychotropic medication prior to shower, directed not to wash R63's hair with the bath, directed to provide a calm approach and offer reassurance during the shower. The care plan directed to	F 280	Care plan for R75 was updated to identify bruises noted on arms. Care plan was also updated with risk factors and interventions to prevent further injury. How identify other residents potentially affected: Care plans were reviewed for those residents with identified bruises and residents receiving psychotropic medication. Measure/Systemic changes to ensure deficient practice will not reoccur: Education provided to all licensed staff the week of February 10,2014 in regards to the policy; Charting: Documentation/updating and reviewing care plans. Care plans will be updated as needed and every two weeks per set schedule. Licensed staff to update clinical coordinator if changes are needed and possibility of significant change in status. Care plans will be reviewed and updated by Clinical and Household coordinators every three months with RAI review.	2/19/14

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F 280	Continued From page 23 re-approach at a later time if R63 became agitated or upset. The care plan did not include direction to offer a bed bath to R63. When interviewed on 1/8/14, at 9:03 a.m. family member (FM)-A reported R63 had problems with bathing and did not like to take baths or showers. FM-A stated R63 would become very upset during and after bathing. FM-A further stated R63 used to take showers regularly without problems and did not know what had caused the change. On 1/9/14, at 9:24 a.m. nursing assistant (NA)-A stated R63 did not like water and would scream, kick, yell and call angry names with showers. NA-A reported noting no difference in R63's behaviors since Seroquel was started and stated R63 now needed two staff members to assist with a shower. NA-A further stated when she gave R63 a bed bath, R63 was "happy." At 9:34 a.m. registered nurse (RN)-A stated R63 would get very upset, verbally and physically abusive during baths, and verified the behavior had not improved since the Seroquel was started on 8/13/13. RN-A stated R63 was much calmer with a bed bath. On 1/9/14, at 9:57 a.m. the clinical coordinator (RN)-B stated R63's family had requested Ativan (an anti-anxiety medication), but the staff wanted to use Seroquel. RN-B stated she had not seen any notes about behaviors with baths and if staff "doesn't tell" her, she "doesn't know." RN-B reported R63 got a shower weekly versus a bed bath per her family's request. On 1/9/14, at 12:27 p.m. FM-A was interviewed again and stated it was not a family request R63 got a shower every week and stated she did not know a bed bath was an option. FM-A reported	F 280	How to monitor: A sample of resident's care plans and care guides will be audited monthly for three months then quarterly for one year. Findings will be reviewed with the licensed staff. A summary of the findings will be given to the Director of Clinical Services. Director of Clinical Services is responsible for compliance.	2/19/14

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F 280	Continued From page 24 she noted R63 was still very upset when she visited the day after her showers. On 1/9/14, at 12:39 p.m. the director of clinical services (DCS) stated weekly residents do not need to have a shower and if a bed bath was more comfortable for them that was "their choice." The DCS stated she would expect alternatives to be used prior to using an antipsychotic for bathing. On 1/9/14, at 1:44 p.m. R63's physician (MD)-A stated he ordered Seroquel for R63 because he did not like the side effects of benzodiazepines. MD-A further stated he used Seroquel because that was what he usually used in nursing homes. MD-A stated he would expect facility staff to explain things to residents to increase their comfort before starting any medications for behavior. R75's care plan was not revised for risk of bruising and the bruises on both forearms. On 1/7/14, at 1:44 p.m. R75 was observed to have several dark purple bruises to both forearms at different stages of healing. On 1/9/14, at 7:30 a.m. R75 was observed sitting on a couch in the middle lounge with her eyes closed. The administrator was reading the newspaper to R75 and four other residents; R75's forearms and bruises were visible at the time. The significant change Minimum Data Set (MDS) dated 9/20/13, indicated R75's diagnoses included Alzheimer's disease and macular degeneration of retina. The MDS indicated R75 had severe cognitive impairment and required	F 280		

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F 280	Continued From page 25 extensive assistance for all activities of daily living. R75's care plan dated 11/20/12, identified for skin integrity, "[R75 was] At risk for impaired skin integrity due to always being incontinent of bladder and occasionally incontinent of bowel, fall risk and self-care deficit related to dementia." The care plan did not identify R75's risk for bruising, but directed to "monitor for skin changes during baths/showers, during am/pm cares and notify the nurse." Although the vision focus identified R75 had potential for change in vision related to macular degeneration; the behavior focus identified R75 wandered around the unit and into other resident rooms, neither focus included how R75 was at risk for injury or bruising with the risk factors. Review of R75's Progress Notes revealed on 11/25/13, 12/2/13, and 12/16/13, old bruising had been noted on both of R75's forearms. Although the bruising was documented occassionally in the medical record, R75's care plan did not address bruising risk, idenify the new bruising, such as risk factors and interventions in place to prevent new bruising. On 1/9/14, at 8:40 a.m. the clinical coordinator registered nurse (RN)-D after looking at R75's both forearms verified R75's had dark purple bruises and stated the bruises were at different stages of healing. On 1/9/14, at 9:42 a.m. DCS stated the nurses were supposed to let the clinical coordinator know to update the care plan. On 1/9/14, at 2:10 p.m. RN-D stated she was not	F 280		

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F 280	Continued From page 26 aware R75 had the bruising and stated if she was aware she would have updated the care plan. The Skin Care Protocol dated May 2013, directed if bruises are noted during daily cares or during weekly skin check the clinical or DON (director of nursing) will be updated immediately. In addition, the policy indicated resident care interventions will be provided based on nursing assessment and application of the nursing process for the resident identified as being at risk for altered skin integrity. The policy lacked who was responsible to revise the care plan when any resident's skin had been assessed and noted to have an issue. The Resident Assessment and Care Planning policy dated September 2012, indicated the purpose was to provide a means for the interdisciplinary team to assess residents, plan and implement an individualized care plan, and evaluate the effectiveness of their care and treatment on an ongoing basis. The policy indicated this process was used to assist each resident to achieve/maintain an optimal functional level. The policy lacked information on revising a plan of care on going when any resident was identified with new issues or risk factors between the MDS's.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	Corrective action for residents involved: R75 care plan and care guide was reviewed on 1/9/14 to reflect current level of care. Physician and Family were notified of skin alteration. Care plan and care guide updated with current risk factors and interventions were put in place including Geri sleeves to bilateral arms.	2/19/14

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F 309	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to identify, assess for root cause and provide preventative measures to prevent bruising for 1 of 3 residents (R75) reviewed for non- pressure related skin issues Findings include: On 1/7/14, at 1:44 p.m. R75 was observed to have several dark purple bruises to both forearms at different stages of healing but was not able to explain how she got the bruises. - At 5:22 p.m. R75 was observed sitting at the dining room table eating independently. A nursing assistant (NA)-B sat between R75 and other resident cuing her to eat. On 1/8/14, at 2:27 p.m. the nursing assistant (NA)-B stated if she noticed any resident with bruises she would report to the nurse immediately to ensure the nurse assessed the bruising. Although NA-B stated they would report bruises to the nurse immediately, the clinical record lacked evidence R75's bruises were reported and assessed. On 1/9/14, at 7:30 a.m. observed R75 sitting on couch in the middle lounge eyes closed, R75's forearms and bruises were visible at the time. R75's diagnoses included dementia, personal history of falls, Alzheimer's disease, and macular degeneration of retina obtained from the significant Minimum Data Set dated 9/20/13. The MDS indicated R75 to had severe cognitive	F 309	How identify other residents potentially affected: Current incident reports involving bruises were reviewed to assure bruises were identified on plan of care, assessed for root cause, and preventative measures were put in place. Measure/Systemic changes to ensure deficient practice will not reoccur: Education provided to staff during the week of February 10, 2014 in regards to skin alteration policy. Care plans will be updated as needed and every two weeks per schedule to assure accurate reflection of current needs, risks, and interventions. Licensed staff was reeducated to update clinical coordinator if changes are needed and possibility of significant change in status.	2/19/14

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F 309	Continued From page 28 impairment and require extensive assistance for all activities of daily living. The Care Area Assessment (CAA) dated 10/4/13, indicated R75 was at potential risk for pressure ulcers related to needing extensive assist with bed mobility at times. The CAA indicated R75 had a diagnosis of dementia and was not always able to make her needs known. The Pressure Ulcer CAA lacked R75's risk for bruising due to being a wanderer. The skin integrity care plan dated 11/20/12, identified R75 was at risk for impaired skin integrity due to always being incontinent of bladder and occasionally incontinent of bowel. The care plan identified R75 was a fall risk and had self care deficits related to dementia. The goal indicated, "Skin will remain intact" and directed to "monitor for skin changes during baths/showers, during am/pm cares and notify the nurse." Review of R75's Progress Notes revealed on 11/25/13, 12/2/13, and 12/16/13, old bruising had been noted on both of R75's forearms. A nursing Progress Note dated 1/9/14 (after concern had been brought to the attention of facility staff by the surveyor), indicated R75 had eight bruises to both arms. The note indicated the measurements of the bruises were as follows: - right upper forearm 6 centimeter (cm) x 8 cm; - right mid forearm 3 cm 1 cm; - right wrist 2 cm x 2.5 cm; - below right index finger 4 cm x 2.5 cm; - at base of right thumb 3 cm x 1 cm; - left upper forearm 5 cm x 5.5 cm; - left mid forearm 5 cm x 3 cm; - area to left wrist/top of hand 5 cm x 3 cm. Although the condition of bruising was documented on the above dates, the medical	F 309	How to monitor: A sample of weekly skin check progress notes will be audited monthly to assure bruises are assessed for root cause, plan of care is updated, and preventative measures were put in place. A sample of incident reports will also be reviewed monthly to assure appropriate follow up and investigation has occurred. Audit results will be reviewed by Director of Clinical Services. Reports and trending will be reviewed at the facility quality improvement committee meetings every three months. Director of Clinical Services is responsible for compliance.	2/19/14

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F 309	Continued From page 29 record lacked evidence R75's current bruises were assessed and measures were put in place to prevent further bruising. On 1/9/14, at 8:40 a.m. the registered nurse clinical coordinator (RN)-D stated, "I am supposed to be notified and my boss [director of clinical services, DCS], of any bruises or falls immediately. For the bruises of unknown origin, the nurses are supposed to measure, document and start the investigation." She further stated all residents skin was supposed to be checked weekly with bath/shower and the nurses were supposed to document the resident skin condition with cares. RN-D stated if anything was noted it needed to be addressed immediately. The RN-D confirmed both of R75's forearms had dark purple bruises and verified the bruises were at different stages of healing. On 1/9/14, at 9:42 a.m. DCS stated all bruises are supposed to be documented by the nurses. She further stated the nurses are supposed to let the clinical coordinator know to update the care plan and monitor the skin issue every shift until resolved. On 1/9/14, at 2:10 p.m. the RN-D stated she was not aware R75 had the bruising and one thing for sure R75 was a wanderer and may have bumped or ran into something causing the bruising but stated if she was aware she would have updated the care plan. On 1/9/14, at 3:03 p.m. DCS was interviewed stated she was not aware of R75's bruises and as soon as the bruising had been brought to her attention, resident bruises were assessed and interventions have been put in place.	F 309		

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F 309	Continued From page 30 The Skin Care Protocol dated May 2013, directed if bruises are noted during daily cares or during weekly skin check the clinical or DON will be updated immediately. In addition, the policy indicated a resident care interventions will be provided based on nursing assessment and application of the nursing process for the resident identified as being at risk for altered skin integrity.	F 309		2/19/14
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement a new diet order for 1 of 3 residents (R99) reviewed for nutrition. Findings include: R99's diet order was changed from a limited high sodium, fat and cholesterol diet to a regular diet on 1/7/14, but was observed to not be implemented on 1/9/14.	F 325	Corrective action for residents involved: R99's diet was changed in the electronic medical record per physician order. A new report was printed on 1/9/14 to assure all staff aware of change to diet. How identify other residents potentially affected: All resident's could potentially be affected. A new diet report was posted for all neighborhoods to assure all staff had most accurate information. Measure/Systemic changes to ensure deficient practice will not reoccur: Training was provided to dining supervisors to access diet reports in electronic medical record and to check email frequently to obtain new resident diet orders and updates in diet orders, training was completed on 1/31/14. All clinical staff were reeducated on diet order process during plan of education the week of 2/10/14.	

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F 325	Continued From page 31 R99 was assessed to be at nutritional risk by the facility due to weight loss and a low body mass index (BMI, a number calculated from a person's weight and height used as a screening tool to identify possible weight problems for adults). R99's weight was 88 pounds and the BMI was 16.8 on 1/8/14. According to the Centers for Disease Control (CDC) website, date of reference 1/10/14, a BMI of below 18.5 indicates a person to be underweight. A Physician's Order dated 1/7/14, directed to give R99 a nutritional supplement and, ...ok for regular diet. On 1/9/14, at 12:25 p.m. R99 was observed in the dining room at a large table eating lunch and socializing. R99 had milk and water. The meal served was tomato soup with crackers, fresh fruit and a cookie. R99 was observed to eat 100% of the tomato soup, 100% of the milk and cookie and 25% of the fresh fruit. On 1/9/14, at 12:30 p.m. the dietary aide (DA)-A was asked how they ensured residents received the correct diet, DA-A showed the surveyor a chart, taped to the wall in the kitchen, which listed each residents name and prescribed diet. R99 was listed as requiring a limited high sodium/fat/cholesterol diet with texture of regular. DA-A confirmed R99 did not receive the regular diet. On 1/9/14, at 12:44 p.m. licensed practical nurse (LPN)-A checked the diet orders in the electronic medical record and noted R99 had been on a limited diet with regular texture. LPN-A then found the regular diet order from 1/7/14 and	F 325	How to monitor: Director of dining will complete a monthly audit of a sample of diet orders for a period of three months then quarterly. Diet orders in clinical record will be audited for accuracy with diet posting. A summary of diet order audit will be reviewed at facility Quality Improvement Committee. A summary will also be forwarded to the Director of Clinical Services. Director of Dining responsible for compliance.	2/19/14

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F 325	Continued From page 32 stated she would have to clarify the order. At 12:57 p.m. LPN-A confirmed R99 should have been receiving a regular diet with regular texture starting on 1/7/14. At 1:01 p.m. R99's physician (MD)-A clarified and confirmed the diet order was regular starting on 1/7/14. A nutritional assessment dated 1/6/14, noted R99's low BMI as a concern and identified their ideal body weight range as 95-115. The assessment also noted R99 was independent with intake and documented intakes at meals were fair (50%). The assessment included "will provide diet as ordered." On 1/9/14, at 1:50 p.m. the director of clinical services (DCS) was made aware R99's diet order was changed to a regular diet on 1/7/14, and the kitchen still had R99 listed as needing a limited diet. DCS stated she would investigate why the order was not yet implemented. When asked about the process of getting new orders implemented the DCS stated new orders go into the electronic medical record. DCS stated new diet orders also were communicated via emails to a "diet order group" which included the dietary director. On 1/9/14, at 1:55 p.m. the dietary director (DD) was asked about R99's diet order not being changed to a regular diet and not being implemented on 1/7/14, DD stated, "To be honest with you, I didn't check the email." The facility Diet Changes policy dated December 2013, indicated it was the facility policy the dining and nursing departments would communicate to keep all diet orders current, whether initial or a change. The policy indicated all diet changes	F 325		

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F 325	Continued From page 33 must be communicated to the dining services department in a timely manner. The staff responsible for transcribing the new order would send an email to facility diet order group. The policy indicated when a diet order changed, a new diet report was printed by dietary for the kitchen and staff for the neighborhood kitchens.	F 325	Corrective action for residents involved:	2/19/14
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:	F 329	Physician was contacted R27's psychotropic medications. Haldol was discontinued and Seroquel was decreased. Physician note dated 1/10/2014 states "as patient stable will decrease dose of Seroquel advise to watch behavior closely. May need to consider stopping Trazodone in future especially the PRN dose." Nursing order written to monitor behavior and update MD as needed. Physician to address diagnoses for psychotropic use and provide appropriate diagnoses. R27's Target Behavior monitoring form and care plan reviewed and updated to reflect R27 specific behaviors. Care plan for R27 reviewed and updated with Trazodone in focus statement, sleep related goal, sleep related interventions, and intervention for monitoring sleep patterns and medication use. R63's daughter involved in interventions to decrease anxiety during weekly bath.	

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F 329	Continued From page 34 Based on observation, interview and document review, the facility failed to ensure appropriate clinical indications for the ongoing use of Seroquel (Quetiapine Fumarate, an antipsychotic) and as needed (PRN) Haldol (haloperidol, an antipsychotic), failed to monitor for efficacy and failed to assess for a potential gradual dosage reduction (GDR) of the antipsychotic medications; the facility failed to evaluate sleep for the ongoing use of Trazodone (an antidepressant medication used to treat sleep problems) (R27); the facility failed to assess and monitor the ongoing use of scheduled Seroquel (R63); for 2 of 5 residents (R27, R63) in the sample reviewed for un-necessary medications. Findings include: R27 received scheduled Seroquel and PRN Haldol without appropriate clinical indications for ongoing use, lacked appropriate target behavior monitoring and lacked evaluation to determine if a potential GDR for the use of the antipsychotics was warranted; although the facility monitored R27's sleep, the facility did not evaluate the sleep to determine the efficacy of ongoing scheduled Trazodone use. Physician's orders dated 11/7/13, indicated R27 received quetiapine fumarate (Seroquel) 50 milligrams (mg) by mouth (PO) daily at the hour of sleep (HS); Haldol 0.25 milliliters (ml) PO for "Agitation/restlessness/abusive behaviors" sublingual (under the tongue) every four hours PRN; Trazodone HCl 25 mg PO twice daily and 50 mg PO every HS. The Physician's Orders identified R27's diagnoses to include unspecified psychosis, dementia without behavioral disturbance, Alzheimer's disease, and	F 329	Daughter present during R63's scheduled bath time and reported R63 had extreme anxiety when brought to the tub room. R63 brought to room and given a complete bed bath, according to daughter R63 showed decreased anxiety with complete bed bath and even thanked the CLS staff. Conversed with daughter and received okay to give R63 bed baths only. Care plan and care guide updated to reflect R63 receives bed baths only on weekly bath days. Educated staff on new plan of care for R63 relating to weekly bath. Physician contacted regarding ineffective psychotropic before bath and bed bath is tolerated well. Order obtained to discontinue scheduled Seroquel prior to weekly bath. R63 no longer exhibits behaviors related to bathing, it does not need to be addressed on the target behavior form at this time. How identify other residents potentially affected: Target behavior forms and care plans reviewed and updated for all resident receiving a psychotropic medication that requires Target monitoring forms to be completed, to reflect resident specific behaviors.	2/19/14

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F 329	Continued From page 35 encephalopathy. The significant change Minimum Data Set (MDS) dated 6/6/13, identified R27 had moderate cognitive impairment, no mood or behavior problems and indicated R27 was independent with all activities of daily living (ADLs). - The Care Area Assessment (CAA) for psychotropic drug use dated 6/11/13, indicated, "Resident receives an antipsychotic medication for a diagnosis of psychosis and an antidepressant for a diagnosis of Alzheimer's Dementia and psychosis. Per previous facility resident has had agitation, restlessness and abusive behaviors, which none have been exhibited since admission here. Will monitor medication side effects and look at gradual dose reduction [GDR] as indicated." Although the CAA indicated the diagnosis of psychosis was used for Seroquel, the CAA did not address resident specific behaviors associated with the diagnosis, such as paranoia or hallucinations. The diagnoses for the use of Trazodone did not include sleep/insomnia and inappropriately identified Alzheimer's (not a psychiatric condition) and psychosis as the diagnoses for the antidepressant. The CAA did not identify factors which warranted a potential GDR, such as lack of indications to warrant the use of the medication. The clinical record lacked further evidence a GDR was considered. - The CAA for ADL functional/rehabilitation Potential dated 6/11/13, indicated R27's cognition had declined, she remained independent with ADLs and R27 had been recently discharged from Hospice. - The CAA for falls dated 6/11/13, indicated R27 had sustained no falls since admission, but remained at risk for falls. The CAA further	F 329	Measure/Systemic changes to ensure deficient practice will not reoccur: Education provided to all licensed staff in regards to psychotropic medication monitoring, target behavior forms, documenting on behaviors, and gradual dose reduction. Educated all staff to monitor and observe residents for behaviors and update Clinical Coordinator if new or worsening behaviors are noted. Clinical Coordinator will continue to evaluate psychotropic medications quarterly and as needed and approach the MD if gradual dose reduction is indicated. How to monitor: All resident's medication will be reviewed for irregularities by the Consultant Pharmacist monthly. A sample of Target Behavior monitoring forms and care plans will be audited monthly for three months and then quarterly for one year to ensure Target behaviors are resident specific and care plan is in congruence with Target Behavior monitoring forms. A sample of target behavior monitoring forms and assessments will be audited monthly for three months and then quarterly for one year to ensure gradual dose reduction is addressed when indicated.	2/19/14

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F 329	Continued From page 36 indicated, "Resident also takes scheduled Trazodone throughout the day which could contribute to falls for resident. Staff is monitoring for side effects." - The CAA for cognitive loss/dementia dated 6/19/13, identified R27's decline in cognition and indicated, "Resident does have a diagnosis of dementia and cognition fluctuates." R27's physician's Progress Notes indicated: - On 9/5/13, the nurse practitioner (NP) had seen R27 and, "Patient offers no concerns or complaints." The note indicated, "Psychiatric: Mood, memory, affect and judgement normal." The note further indicated, "Currently on haldol [sic] PRN and Quetiapine. Uses trazaDCSe [sic] for sleep...Since last visit, patient has been removed from hospice [sic]." - On 10/11/13, the medical doctor (MD) had seen R27 and identified, "Psychiatric: Her behavior is normal. Dementia: Stable no behavioural [sic] isses [sic] noted. Pt [patient] does not to [sic] have haldol [sic]" Although the Progress Note from 9/5/13, identified R27 was no longer on Hospice, the MD Progress Note contradicted, "Pt on hospice no new concerns." - On 11/22/13, the NP indicated R27 offered no new complaints, R27 felt "'discouraged sometimes that things are so slow around here [the facility].'" The note indicated, "Dementia - No behaviors reported from staff. Pt unable to recall any previous visits from MD or NP, however. 'Have people been meeting behind my back?'" Although the physician's progress notes appropriately reviewed R27's mood, behavior and psychiatric data, the documentation reflected lack of indication for the ongoing use of antipsychotic medication. The notes lacked review of R27 sleep and Trazodone use.	F 329	A summary of these audits will be given to the Director of Clinical Services. Audits and trends will be reviewed at Quality Improvement committee meeting. Director of Clinical Services is responsible for compliance.	2/19/14

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F 329	Continued From page 37 The quarterly MDS dated 11/26/13, indicated no changes in R27's cognition, R27 had mood problem of "feeling tired or having little energy;" had the behavior of "rejecting cares" occur 1-3 days during the assessment period; R27 remained independent with all ADLs. The Psychotropic Medication Review dated 11/26/13, identified R27's current psychotropic medications were Seroquel and Haldol. The behaviors and occurrences listed for both medications were, "Refusal of cares: One occurrence on day shift, no occurrences on evening shift, and no occurrences on night shift." The indications for use for both medications were, "Agitation/Restlessness: No occurrences on day shift, one occurrence on evening shift, and no occurrences on night shift." The assessment indicated R27 had no involuntary movement side effects when last assessed on 10/22/13. Although the review indicated a review of the behaviors, the behaviors were not appropriate for antipsychotic use and did not reflect appropriate indications for use. In addition, although the review identified low numbers of the target behaviors, the review did not address a potential GDR of the antipsychotic medications. Review of the Chemical Restraint assessment dated 11/26/13, indicated the following: - The assessment identified the medication being reviewed was "TrazaDCSe," with the therapeutic goal of, "Diagnosis is sleep/agitation. Goal is to decrease agitation and increase ability to fall asleep, stay asleep, and increase the number of restful sleep hours." - Indications for the use of Trazodone were "Sleeplessness, agitation, verbal aggression,	F 329		

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F 329	Continued From page 38 inability to redirect." - The non-pharmacological interventions to address the indications for the use of the medication were "1:1, reassurance, validation of feelings, redirection, provide quiet, dark environment for sleep." - The efficacy section of the assessment indicated, "No nursing documentation noted that describes agitation or sleeplessness." - The GDR section of the assessment indicated, "Will address with the physician this quarter." - The resident input/education section indicated, "Resident offers no c/o [complaints of] inability to sleep or feeling tired/not rested in the morning." The assessment indicated R27 required no care plan updates "at this time." Although the assessment referred to address the GDR with the physician, the clinical record lacked evidence the physician was consulted regarding a potential GDR for Trazodone. The clinical record lacked evidence the use of Seroquel and PRN Haldol were assessed as potential chemical restraints or if a GDR for the use the antipsychotic medications was attempted. The clinical record lacked documented evidence why a GDR was clinically contraindicated for R27. In addition, the assessment inappropriately included antipsychotic indications such as "agitation, verbal aggression, inability to redirect" for the use of Trazodone (an antidepressant medication). The care plan dated 12/13/13, identified R27 was at risk for behaviors of "(paranoia, restlessness, insomnia, and agitation) r/t [related to] Alzheimer's dementia." The care plan identified, " I [R27] currently receive Seroquel every HS to manage these behaviors. I have a strong personality and try to become involved in other residents personal business at times. I do not	F 329		

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always understand that I cannot receive information regarding other residents health and/or care." The care plan directed, "Monitor/Observe for restlessness, agitation, insomnia, and suspiciousness/fearfulness r/t paranoia and notify nurse and MD/NP [medical doctor/nurse practitioner] as needed. Notify Nurse if I resist ADL care or I refuse to eat. Notify MD/NP as needed if I resist taking medications, which could lead to medical decline. Redirect me as needed when I ask questions about other residents. Remind me that I cannot receive information about other residents." Although the Chemical Restraint assessment indicated no care plan update was warranted on 11/26/13, R27's care plan did not identify the use of Trazodone for sleep, lacked a focus for sleep and non-pharmacological interventions to promote sleep. In addition, the care plan lacked direction for monitoring and evaluation of R27's sleep patterns. Although the care plan identified a "risk for behaviors" of paranoia, restlessness, insomnia, and agitation diagnoses; the care plan did not identify current behaviors warranting the use of antipsychotic medication or resident specific behaviors to reflect the above listed diagnoses.

During all dates of the survey 1/7/14, through 1/10/14, R27 was observed to have no behavioral concerns, was pleasant and interacted appropriately with staff and other residents.

Review of the Medication Administration Records (MARs) from January 2014 through September 2013 indicated the following:
- The September, October, November and December 2013 MARs indicated Seroquel was offered for the diagnoses of "Alzheimer's

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F 329	Continued From page 40 Dementia" and Trazodone was offered for "Sleep/Agitation." The MARs indicated both medications were administered as ordered. No PRN Haldol doses were administered. - The January 2014 MAR indicated scheduled Seroquel and Trazodone medications were both administered as ordered. MAR indicated on 1/1/14, at 5:00 a.m. R27 had PRN Haldol administered. The MAR did not indicate why the PRN antipsychotic was administered to R27. Review of the Treatment Administration Records (TARs) from January 2014 through September 2013 indicated beginning on 5/28/13, "Hours of Sleep" was monitored. The documentation included the number of hours slept by 6:45 a.m., 2:45 p.m. and 10:45 p.m. The TARs indicated R27 occasionally slept 0.5 -1 hour 6:45 p.m., rarely slept by 2:45 p.m. and usually had eight hours of sleep documented at 10:45 p.m. The clinical record lacked evaluation of R27s sleep patterns, such as efficacy of Trazodone and R27 usually sleeping for eight hours during the night. R27's nursing Progress Notes were reviewed from 9/4/13, through 1/8/14 and revealed the following: - On 9/4/13, at 4:59 a.m. a note indicated, "Hours of Sleep, Did not sleep very well tonight. Up x2 [twice] to void, and incontinent at 0430 [4:30 a.m.]. Offers no complaints of pain, discomfort, states 'one of those nights that cannot fall sleep [sic] well..'" At 7:27 p.m. a note indicated, "Resident was easily agitated today..." and identified R27 asked for "bath soap" from the facility and R27 stating she "pays the bills." The note indicated the clinical coordinator was updated and the house supervisor "came to talk to" R27. R27 refused supper after being	F 329		

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F 329	Continued From page 41 re-approached twice, R27 grew "agitated and said she was not hungry." The note indicated R27 accepted her shower and had no further behaviors. - On 9/5/13, at 1:46 p.m. R27 refused to have her weight taken. - On 9/18/13, at 4:55 p.m. a note indicated, "Resident refused shower tonight. Said she will have it tomorrow. VSS [vital signs stable]." The clinical record did not indicate if the shower was received the next day. - On 10/23/13, at 10:48 p.m. a note indicated R27 refused the shower. - On 11/20/13, at 10:53 p.m. a note indicated R27 refused the shower. - On 12/4/13, at 10:06 p.m. a note indicated R27 refused the shower. - On 1/1/14, at 5:01 a.m. an "eMAR [electronic medication administration record]-Medication Administration Note indicated, "PRN Administration was: Effective." The note did not identify the PRN medication administered, why the medication was administered and how the medication was effective. The clinical record lacked documented evidence of clinical indications for the ongoing use of the antipsychotic medications. On 1/9/14, at 1:13 p.m. the licensed practical nurse (LPN)-B stated target behavior monitoring was documented in a light blue binder labeled "LH Nursing Documentation." The Behaviors tab of the binder included Target Behavior Forms for documentation of target behaviors. The forms for R27 indicated the resident was monitored for the target behaviors related to "Seroquel/Haldol" use. The target behaviors information included direction to "Document freq [frequency] per shift.": - In September 2013, on 9/4/13, the	F 329		

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F 329	Continued From page 42 documentation indicated a "+ [plus sign]" was documented for "Agitation/restlessness" on the evening shift; a "+" was documented for "Refusal of care" on the day shift of 9/5/13. Although the "+" indicated the behavior occurred, the documentation did not include the number of times the behavior occurred (frequency). The documentation for the rest of the month indicated R27 had no further behaviors for the month of September. - In both October and November 2013, the documentation indicated all hash marks for both target behaviors of "Refusal of cares" and "Agitation/Restlessness." R27 had no target behaviors identified in the months of October and November. - In December 2013, the documentation indicated all hash marks for both target behaviors the entire month. Although only "Refusal of cares" and "Agitation/Restlessness" were identified as the target behaviors being monitored, the documentation indicated staff documented hash marks and initialed for target behaviors not specified for R27. Spaces for both target behaviors were blank. No target behaviors were identified in the month of December. - In January 2014, R27 was monitored for refusal of cares and agitation/restlessness. The form indicated no documentation for any shift from 1/1/4 thru 1/3/14. A "-" (hash mark) was documented sporadically the rest of the month; No target behaviors were identified in early January 2014. The target behavior monitoring indicated R27 had little to no behavioral problems since September 2013 through January 2014 (for approximately four months) and did not support the ongoing use of antipsychotic medications.	F 329		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443

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F 329	Continued From page 43 On 1/9/14, at 2:01 p.m. LPN-B and the clinical coordinator (RN)-B, were interviewed together. - When asked if R27 had received PRN Haldol, both staff verified PRN Haldol was administered to R27 on 1/1/14. - When LPN-B was asked what target behaviors were monitored in relation to the use of the antipsychotic medications, LPN-B stated staff would "look for agitation, restlessness," and described these as, "If she's [R27's] getting antsy." LPN-B further gave examples for restlessness as "pacing, rummaging, getting into all sorts of things;" for agitation LPN-B described R27 as being "upset" and staff would observe for "non-verbal communication" such as "doing something with your hands." - When asked what the indication for administering PRN Haldol was, LPN-B verified there was a note in the clinical record identifying the medication was "effective," LPN-B verified the clinical record did not include a behavior warranting the use of the drug. - When asked the meaning of the hash marks in the documentation, LPN-B stated the hash mark was a "negative" and a "plus sign [+]" indicated a behavior occurred and we "put a progress note on it." - RN-B verified the indications for use and target behavior monitoring were not resident specific, verified the indications for the use of PRN Haldol were not resident specific. RN-B stated R27 was admitted to the facility enrolled in Hospice and had an order for Haldol which was "not discontinued." - RN-B verified she was unclear when R27 was assessed for GDR with the use of antipsychotics. RN-B stated GDRs were addressed either on the "Chemical Restraint or Psychotropic Assessments." RN-B confirmed the assessments	F 329		

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F 329	Continued From page 44 did not indicate a GDR was attempted, did not indicate if the physician was notified of a potential GDR and verified the clinical record lacked clinical rational why a GDR was clinically contraindicated. - RN-B verified R27's sleep was tracked, but was unclear which facility staff were supposed to monitor and evaluate the sleep data to determine efficacy of the Trazodone. RN-B verified the clinical record lacked documented evidence R27's sleep or the use of Trazodone had ever been evaluated. On 1/9/14, at 2:31 p.m. the consultant pharmacist (CP)-F was contacted via telephone and verified the indications for the use of PRN Haldol and Seroquel should be "expanded on." CP-F stated she had alerted the facility Target Behavior monitoring needed to be "expanded on." CP-F verified restlessness and agitation was not enough of a clinical indication for use and stated the reasons should have been noted on review. CP-F stated indications for use, target behavior monitoring and determining GDR was audited by the pharmacy, but was unclear if R27 was included in the audit. CP-F verified the sleep monitoring should have been evaluated to determine the ongoing efficacy of Trazodone. On 1/10/14, at 9:04 a.m. the director of clinical services (DCS) stated when determining indications for use of a psychotropic medication, she would "look at the behaviors" and determine "what she [R27] was doing" and "how it [behavior] affected her or others" and determine resident specific target behaviors for monitoring. DCS verified restlessness and agitation were not resident specific indications for the ongoing use of Seroquel and PRN Haldol. DCS confirmed	F 329		

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F 329	Continued From page 45 indications for the administration of the PRN Haldol on 1/1/14, should have been documented; target behavior monitoring should be reviewed by the clinical coordinator quarterly during the MDS assessments and between the MDS assessment periods, target behavior monitoring should be reviewed by the nurses. DCS verified R27 had no behaviors documented to warrant the ongoing use of the antipsychotics. DCS verified Trazodone sleep logs should be evaluated quarterly to determine efficacy of the medication and verified the clinical record lacked evaluation for R27. The facility's Psychotropic Medications and Monitoring policy and procedure dated 8/2012, identified all residents receiving a medication "to alter behavior" were to have an "approved diagnosis" and "reason for use" of the medication. The policy indicated there should be a "therapeutic goal, and symptoms monitored." - The policy further indicated, "The drug chosen should be administered in the lowest dose possible only after non pharmaceutical interventions to control/alter the behavior have been attempted." The procedure identified appropriate non pharmaceutical interventions to attempt, directed to obtain "an approved therapeutic goal" and diagnosis from MD/NP "as related to the behavior altering medication." - The procedure directed to determine target behaviors to monitor and "B. Behaviors must be specific and appropriate to the drug ordered. Agitation, anxiety, abusive, etc. need further explicit behaviors identified." In addition, the procedure directed, "C. Behaviors for use of antipsychotic medication must potentially be distressful or harmful to self or others" and listed examples such as physical aggression "(hitting,	F 329		

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F 329	Continued From page 46 kicking, hurting self or others, destroying property, physical sexual advances)," physical non-aggression behaviors "(pacing, disrobing, trying to leave without authorization)," verbally agitated behaviors "(screaming, cursing, verbal sexual advances, etc.)" The procedure directed to document on the "target behavior form" each shift and identified the "Clinical Coordinator" would be responsible to evaluate the target behavior forms and the Psychotropic Medication Quarterly Review would be utilized to assess the effect of psychotropic medications. - The policy indicated, "F. Symptom(s) for antidepressant use must be identified and addressed on the CPL (care plan); antidepressants should be evaluated with each RAI (Resident Assessment Instrument, MDS and CAAs) and documented in the residents' chart. - The policy indicated dosage reductions of psychoactive medications would be attempted per "regulation;" could be initiated by MD/NP, pharmacy review, case manager, the resident and/or the family. The policy indicated if MD/NP "does not agree to dosage reduction, the rationale will be documented by the MD/NP." R63 received Seroquel 25 mg every Friday and the facility failed to identify, assess and monitor for ongoing use of the medication. The Admission Record for R63 dated 12/4/13, included diagnoses of dementia, aphasia, and depression. The Order Summary Report dated 1/9/14, revealed R63 was prescribed Seroquel 25mg every bedtime and 25mg every Friday for anxiety to be given before bath/shower on Friday	F 329		

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F 329	Continued From page 47 mornings. The every Friday Seroquel orders dated 8/13/13, included directions of may try bed bath/sponge bath instead. R63 also had a physician ' s order for Ativan (an anti-anxiety medication) 0.25mg for anxiety 30 minutes prior to dental procedure. R63's annual MDS dated 11/5/13, established R63 had severely impaired cognitive skills for daily decision making, responded to simple direct communication only, required physical help of one person for transfer only with bathing. The MDS indicated rejection of care did not occur. The Care Area Assessment (CAA) for behaviors dated 11/5/13, indicated R63 had a diagnosis of dementia with agitation, R63 had some behaviors with daily cares and behaviors that required Seroquel use. The CAA noted R63 would make statements of staff trying to kill her or wanting her dead when staff attempted to give her medications and noted some anxiety in regards to bathing. The psychotropic medication CAA dated 11/5/13, identified R63 was receiving Seroquel for dementia with agitation. The CAA did not address any non-pharmacological interventions being used for R63. The communication CAA dated 11/5/13, indicated R63 was not always able to make her needs known. The bathing care plan dated 11/6/13, indicated R63 had a history of refusing showers, becoming very agitated and upset during the shower activity and identified R63 did not like water on her head. The care plan directed staff to administer a psychotropic medication prior to shower, directed not to wash R63's hair with the bath, directed to provide a calm approach and offer reassurance during the shower. The care plan directed to re-approach at a later time if R63 became	F 329		

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F 329	Continued From page 48 agitated or upset. The care plan did not include direction to offer a bed bath to R63. Review of R63's Progress Notes indicated the following: - On 7/26/13, the note indicated R63 continued to get very agitated during the shower and seemed very distressed at the mention of shower. - On 8/2/13, the note indicated R63 was very agitated during the shower, verbally very aggressive to staff assisting with shower. - On 8/3/13, the note indicated R63 seemed upset all shift, the writer gathered from listening to resident she "felt staff hated her" since receiving shower "on evening shift last night." " Will update nurse practitioner [NP] to see if a small dose of Ativan would be appropriate before showers to reduce agitation and anxiety." - On 8/9/13, the note indicated R63 did not receive shower, became anxious and agitated at mention of shower, pleaded with writer to let her go to bed after supper. Noted anxiety for shower getting worse each week. - On 8/16/13, noted R63 to be verbally and physically aggressive with staff during shower. The note indicated the shower was upsetting for R63 every week. - On 8/23/13, the note indicated R63's shower was given; resident was very upset after shower, swearing and striking out at staff. - On 9/13/13, the note indicated an extra dose of Seroquel was given to R63. The shower was not given, R63 was "very agitated and verbally aggressive at mention of shower," and indicated R63 refused to enter spa room and told staff "you got me last time, not today." - On 9/20/13, the note indicated Seroquel was given prior to R63's shower. The note indicated R63 was still physically and verbally aggressive	F 329		

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F 329	Continued From page 49 during the shower. - On 9/27/13, the note indicated Seroquel was given at 5:00 p.m., R63 was still physically and verbally aggressive. - On 10/4/13, the note indicated Seroquel was given prior to the shower. At mention of shower R63 became "very anxious," restless and verbally and physically aggressive. The note described R63 as very upset after the shower and crying to the point she started having emesis (vomited). The note indicated attempts to calm R63 agitated her further. The note indicated R63 calmed down when staff left her alone. - On 10/25/13, the note indicated R63 was given a shower and verbal aggression was still noted. A physician Progress Note dated 9/6/13, indicated a nursing concern of non-cooperative behavior with cares, was getting aggressive at times and noted R63 had been on Seroquel with no changes. A nurse practitioner Progress Note dated 10/8/13, noted staff reported behavioral issues with bathing and noted R63 received Seroquel 25 mg every bedtime, 12.5mg as needed for agitation and 25mg prior to weekly bath. The Target Behavior Forms from August 2013 - January 2014, indicated R63 had target behaviors of increased rambling speech, verbally agitated, and yelling out. Behaviors with bathing were not included for monitoring. When interviewed on 1/8/14, at 9:03 a.m. family member (FM)-A reported R63 had problems with bathing and did not like to take baths or showers. FM-A stated R63 would become very upset	F 329		

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F 329	Continued From page 50 during and after bathing. FM-A further stated R63 used to take showers regularly without problems and did not know what had caused the change. On 1/9/14, at 9:24 a.m. nursing assistant (NA)-A stated R63 did not like water and would scream, kick, yell and call angry names with showers. NA-A reported noting no difference in R63's behaviors since Seroquel was started and stated R63 now needed two staff members to assist with a shower. NA-A further stated when she gave R63 a bed bath, R63 was "happy." At 9:34 a.m. registered nurse (RN)-A stated R63 would get very upset, verbally and physically abusive during baths, and verified the behavior had not improved since the Seroquel was started on 8/13/13. RN-A stated R63 was much calmer with a bed bath. On 1/9/14, at 9:57 a.m. the clinical coordinator (RN)-B stated R63's family had requested Ativan (an anti-anxiety medication), but the staff wanted to use Seroquel. RN-B stated she had not seen any notes about behaviors with baths and if staff "doesn't tell" her, she "doesn't know." RN-B reported R63 got a shower weekly versus a bed bath per her family's request. On 1/9/14, at 12:27 p.m. FM-A was interviewed again and stated it was not a family request R63 got a shower every week and stated she did not know a bed bath was an option. FM-A reported she noted R63 was still very upset when she visited the day after her showers. On 1/9/14, at 12:39 p.m. the director of clinical services (DCS) stated weekly residents do not need to have a shower and if a bed bath was more comfortable for them that was "their choice." The DCS stated she would expect	F 329		

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F 329	Continued From page 51 alternatives to be used prior to using an antipsychotic for bathing. On 1/9/14, at 1:44 p.m. R63's physician (MD)-A stated he ordered Seroquel for R63 because he did not like the side effects of benzodiazepines. MD-A further stated he used Seroquel because that was what he usually used in nursing homes. MD-A stated he would expect facility staff to explain things to residents to increase their comfort before starting any medications for behavior.	F 329		2/19/14
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 interview and document review, the facility's consultant pharmacist failed to identify irregularities with the use of Seroquel and PRN Haldol (both antipsychotic medications) for 1 of 5 residents (R27) in the sample reviewed for un-necessary medications. Findings include:	F 428	Corrective action for residents involved: Consultant pharmacist reviewed R27 medications for irregularities. Haldol PRN was discontinued and Seroquel was decreased. Care plan and target behaviors were updated to accurately reflect need for medication. Diagnosis for medication was reviewed by physician and updated. Will continue to monitor effectiveness of medication. How to identify other residents potentially affected: All residents receiving psychotropic medications will be reviewed for approved diagnosis, appropriate target behaviors, care plan up to date and include non-pharmacy interventions.	

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F 428	Continued From page 52 Physician's orders dated 11/7/13, indicated R27 received quetiapine fumarate (Seroquel) 50 milligrams (mg) by mouth (PO) daily at the hour of sleep (HS); Haldol 0.25 milliliters (ml) PO for "Agitation/restlessness/abusive behaviors" sublingual (under the tongue) every four hours PRN. The Physician's Orders identified R27's diagnoses to include unspecified psychosis, dementia without behavioral disturbance, Alzheimer's disease, and encephalopathy. The Psychotropic Medication Review dated 11/26/13, identified R27's current psychotropic medications were Seroquel and Haldol. The behaviors and occurrences listed for both medications were, "Refusal of cares: One occurrence on day shift, no occurrences on evening shift, and no occurrences on night shift." The indications for use for both medications were, "Agitation/Restlessness: No occurrences on day shift, one occurrence on evening shift, and no occurrences on night shift." The assessment indicated R27 had no involuntary movement side effects when last assessed on 10/22/13. Review of the Chemical Restraint assessment dated 11/26/13, indicated the following: - The assessment identified the medication reviewed was "Trazadone [sic]," with the therapeutic goal of, "Diagnosis is sleep/agitation. Goal is to decrease agitation and increase ability to fall asleep, stay asleep, and increase the number of restful sleep hours." - Indications for the use of Trazodone were "Sleeplessness, agitation, verbal aggression, inability to redirect." - The non-pharmacological interventions to address the indications for the use of the medication were "1:1, reassurance, validation of	F 428	Measure/Systemic changes to ensure deficient practice will not reoccur: All resident's medication will be reviewed for irregularities by the Consultant Pharmacist monthly. Education provided to nurses during plan of correction education sessions the week of February 10, 2014 in regards to monitoring for behaviors, approved diagnosis for medication and assuring interventions are in place and documented. How to monitor: All resident's medications will be reviewed for irregularities by the Consultant Pharmacist monthly. Recommendations will be given to the attending physician and the Director of Nursing for review. Consultant pharmacist's quarterly reports will be reviewed at the facility quality improvement committee meetings every three months and also reviewed by the clinical coordinators. Director of Clinical Services is responsible for compliance.	2/19/14

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F 428	Continued From page 53 feelings, redirection, provide quiet, dark environment for sleep." - The efficacy section of the assessment indicated, "No nursing documentation noted that describes agitation or sleeplessness." - The GDR section of the assessment indicated, "Will address with the physician this quarter." - The resident input/education section indicated, "Resident offers no c/o [complaints of] inability to sleep or feeling tired/not rested in the morning." The assessment indicated R27 required no care plan updates "at this time." Although the assessment referred to address the GDR with the physician, the clinical record lacked evidence the physician was consulted regarding a potential GDR. The clinical record lacked evidence a GDR for the use of Seroquel or Haldol was attempted or a reduction was clinically contraindicated. The care plan dated 12/13/13, identified R27 was at risk for behaviors of "(paranoia, restlessness, insomnia, and agitation) r/t [related to] Alzheimer's dementia." The care plan identified, " I [R27] currently receive Seroquel every HS to manage these behaviors. I have a strong personality and try to become involved in other residents personal business at times. I do not always understand that I cannot receive information regarding other resident ' s health and/or care." The care plan directed, "Monitor/Observe for restlessness, agitation, insomnia, and suspiciousness/fearfulness r/t paranoia and notify nurse and MD/NP [medical doctor/nurse practitioner] as needed. Notify Nurse if I resist ADL care or I refuse to eat. Notify MD/NP as needed if I resist taking medications, which could lead to medical decline. Redirect me as needed when I ask questions about other	F 428		

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F 428	Continued From page 54 residents. Remind me that I cannot receive information about other residents." The care plan did not identify the use of Trazodone for sleep, lacked a focus for sleep and non-pharmacological interventions to promote sleep. In addition, the care plan lacked direction for monitoring and evaluation of R27's sleep patterns. Review of the Medication Administration Records (MARs) from January 2014 through September 2013 indicated the following: - The September, October, November and December 2013 MARs indicated Seroquel was offered for the diagnoses of "Alzheimer's Dementia" and Trazodone was offered for "Sleep/Agitation." The MARs indicated both medications were administered as ordered. No PRN Haldol doses were administered. - The January 2014 MAR indicated scheduled Seroquel and Trazodone medications were both administered as ordered. MAR indicated on 1/1/14, at 5:00 a.m. R27 had PRN Haldol administered. Review of the Treatment Administration Records (TARs) from January 2014 through September 2013 indicated beginning on 5/28/13, "Hours of Sleep" was monitored. The documentation included the number of hours slept by 6:45 a.m., 2:45 p.m. and 10:45 p.m. The TARs indicated R27 occasionally slept 0.5-1 hour 6:45 p.m., rarely slept 2:45 p.m. and usually had eight hours of sleep documented at 10:45 p.m. The clinical record lacked evaluation of R27s sleep patterns, such as efficacy of Trazodone and R27 usually sleeping for eight hours during the night. R27's nursing Progress Notes were reviewed from 9/4/13, through 1/8/14 and revealed the	F 428		

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	245619	A. BUILDING _____ B. WING _____	01/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428	Continued From page 55 following: - On 9/4/13, at 4:59 a.m. a note indicated, "Hours of Sleep Did not sleep very well tonight. Up x2 [twice] to void, and incontinent at 0430 [4:30 a.m.]. Offers no complaints of pain, discomfort, states 'one of those nights that cannot fall sleep [sic] well.... ' " At 7:27 p.m. a note indicated, "Resident was easily agitated today..." and identified R27 asked for "bath soap" from the facility and R27 stating she "pays the bills." The note indicated the clinical coordinator was updated and the house supervisor "came to talk to" R27. R27 refused supper after being re-approached twice, R27 grew "agitated and said she was not hungry." The note indicated R27 accepted her shower and had no further behaviors. - On 9/5/13, at 1:46 p.m. R27 refused to have her weight taken. - On 9/18/13, at 4:55 p.m. a note indicated, "Resident refused shower tonight. Said she will have it tomorrow. VSS [vital signs stable]." The clinical record did not indicate if the shower was received the next day. - On 10/23/13, at 10:48 p.m. a note indicated R27 refused the shower. - On 11/20/13, at 10:53 p.m. a note indicated R27 refused the shower. - On 12/4/13, at 10:06 p.m. a note indicated R27 refused the shower. - On 1/1/14, at 5:01 a.m. an "eMAR [electronic medication administration record]-Medication Administration Note indicated, "PRN Administration was: Effective." The note did not identify the PRN medication administered, why the medication was administered and how the medication was effective. The clinical record lacked documented evidence of clinical indications for the ongoing use of the	F 428		

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F 428	Continued From page 56 antipsychotic medications. The Monthly Medication Regimen Review indicated from 4/23/13, to 12/18/13, the consultant pharmacist reviewed R27's medication regiment. On 4/23/13, the use of Quetiapine (Seroquel) and Trazodone were identified. On 11/20/13, the consultant pharmacist identified no PRN Haldol was administered from 11/1/13 - 11/19/13, and to check the psychotropic documentation in one to two months. The consultant pharmacist documentation did not identify irregularities with R27's medication regimen. On 1/9/14, at 2:31 p.m. the consultant pharmacist (CP)-F was contacted via telephone and verified the indications for the use of PRN Haldol and Seroquel should be "expanded on." CP-F stated she had alerted the facility the Target Behavior monitoring needed to be "expanded on." CP-F verified restlessness and agitation was not enough of a clinical indication for use and stated the reasons should have been noted on review. Stated indications for use, target behavior monitoring and determining GDR was audited by the pharmacy, but was unclear if R27 was included in the audit. CP-F verified the sleep monitoring should have been evaluated to determine efficacy of Trazodone. On 1/10/14, at 9:04 a.m. the director of clinical services (DCS) verified CP-F was responsible to review target behaviors and identify irregularities "they've [consultant pharmacists] done that in the past." DCS verified the CP-F was not an active member of the Quality Assessment and Assurance committee. "After this, she will be."	F 428		

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F 428	Continued From page 57 The facility's Psychotropic Medications and Monitoring policy and procedure dated 8/2012, identified all residents receiving a medication "to alter behavior" were to have an "approved diagnosis" and "reason for use" of the medication. The policy indicated there should be a "therapeutic goal, and symptoms monitored." - The policy further indicated, "The drug chosen should be administered in the lowest dose possible only after non pharmaceutical interventions to control/alter the behavior have been attempted." The procedure identified appropriate non pharmaceutical interventions to attempt, directed to obtain "an approved therapeutic goal" and diagnosis from MD/NP "as related to the behavior altering medication." - The procedure directed to determine target behaviors to monitor and "B. Behaviors must be specific and appropriate to the drug ordered. Agitation, anxiety, abusive, etc. need further explicit behaviors identified." In addition, the procedure directed, "C. Behaviors for use of antipsychotic medication must potentially be distressful or harmful to self or others" and listed examples such as physical aggression "(hitting, kicking, hurting self or others, destroying property, physical sexual advances)," physical non-aggression behaviors "(pacing, disrobing, trying to leave without authorization)," verbally agitated behaviors "(screaming, cursing, verbal sexual advances, etc.)" The procedure directed to document on the "target behavior form" each shift and identified the "Clinical Coordinator" would be responsible to evaluate the target behavior forms and the Psychotropic Medication Quarterly Review would be utilized to assess the effect of psychotropic medications. - The policy indicated, "F. Symptom(s) for antidepressant use must be identified and	F 428		

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F 428	Continued From page 58 addressed on the CPL (care plan); antidepressants should be evaluated with each RAI (Resident Assessment Instrument, MDS and CAAs) and documented in the residents' chart. - The policy indicated dosage reductions of psychoactive medications would be attempted per "regulation;" could be initiated by MD/NP, pharmacy review, case manager, the resident and/or the family. The policy indicated if MD/NP "does not agree to dosage reduction, the rationale will be documented by the MD/NP."	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	F 431	Corrective action for residents involved: Narcotic pain patches for R27 will be removed and destroyed by two nurses in sewer system. How to identify other residents potentially affected: Currently no other residents in facility with narcotic pain patch. Measure/Systemic changes to ensure deficient practice will not reoccur: Medication: controlled substance policy was updated on narcotic pain patches. All narcotic pain patches will be removed and destroyed by two licensed nurses. All licensed staff were educated on new procedure for disposal during plan of correction education session during the week of February 10, 2014.	2/19/14

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F 431	Continued From page 59 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure Fentanyl patches (a narcotic(s) used to control pain) were destroyed in a manner to prevent potential diversion for 1 of 1 resident (R27). Findings include: During the medication pass observation, the following was randomly observed: On 1/9/14, at 7:28 a.m. the licensed practical nurse (LPN)-B stated she had to apply a Fentanyl patch and offer an oral Percocet (a narcotic(s) used to control pain) to R27. LPN-B was observed to remove one sealed Fentanyl patch from a box, two sealed patches were observed to remain in the box. LPN-B counted the patches and recorded the number of Fentanyl patches and Percocet in the Individual Narcotic Record. - At 7:33 a.m. LPN-B opened the patch, wrote date and initials on the patch. - At 7:39 a.m. LPN-B entered R27's room and explained the medications to R27. LPN-B handed the Percocet, a full glass of water to R27, who took the medication and drank the water. LPN-B then retrieved gloves, removed the old Fentanyl patch from R27's left shoulder/back area and	F 431	How to monitor: All residents with narcotic pain patches will be audited monthly for the next three months then quarterly for appropriate disposal and documentation of disposal of narcotic pain patches. Audits will be received by the Director of Clinical Services and reviewed by clinical coordinators. Trends and audit results will be reviewed at facility quality improvement committee meetings. Director of Clinical Services is responsible for compliance.	2/19/14

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F 431	Continued From page 60 applied the new patch to the right shoulder/back area. LPN-B was observed to place the spent patch in the empty package. LPN-B left the room and returned to the nurse ' s station, opened the cupboard under the sink and bent to place the spent patch and Fentanyl patch package in a Sharps container (a plastic container used to dispose of sharp hazardous equipment such as used medication needles). LPN-B stated the container was "full" and stated she would use the Sharps container at the other second floor nursing station. LPN-B carried the spent patch over to neighboring unit nursing station and placed the spent Fentanyl patch in the Sharps container under the sink. LPN-B was observed to be alone and did not seek out another nurse to witness the disposal of the narcotic patch. - At 8:30 a.m. LPN-B stated she was trained to dispose of the Fentanyl patch in the Sharps container and stated she was aware of other facility policies to dispose of the patches differently, "I was told there could be fines for putting anything other than Sharps in the container." LPN-B was unclear on the actual policy and stated she was going to ask the clinical coordinator (RN)-B "right now." - At approximately 8:35 a.m. RN-B was asked by LPN-B (with surveyor present) regarding Fentanyl patch disposal. RN-B stated she believed LPN-B could dispose of the patch in the Sharps container alone. On 1/9/14, at 9:05 a.m. RN-B provided a copy of the Medications: Controlled Substances policy and procedure dated 5/2005. Review of the policy indicated, "D. Narcotic pain patches that are removed from residents should be disposed of in sharps container or flushed in sewer system." RN-B confirmed the policy directed to dispose the	F 431		

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F 431	Continued From page 61 patches in Sharps, but verified the policy directed to dispose of or destroy "narcotics" with two staff. The policy directed to "request another nurse to verify the amount of drug being wasted" and disposal of "medication in the sewer system with nurse/nurse or nurse/TMA [trained medication aide] present to witness the disposal." On 1/9/14, at 12:27 p.m. the consultant pharmacist (CP)-F was contacted via telephone. CP-F stated "it was not regulation," but her "recommendation" to have the Fentanyl patches "flushed" and "witnessed" when disposed of. The surveyor explained the facility Medications: Controlled Substances policy to CP-F, CP-F stated she was not familiar with the policy and she had not seen the policy. "That [policy] does not go through me, I'm not part of QA [quality assurance], and it ' s not a requirement." CP-F verified she was not consulted regarding disposal of Fentanyl patches, verified it should be the same as any narcotic and verified there was a high risk for diversion as "there is enough medication left in the patch to cause harm or to give affect/relief." On 1/9/14, at 12:42 p.m. the director of clinical services (DCS) verified Fentanyl patches should be disposed of either in a Sharps container or to "flush them." DCS stated a pharmacist was consulted when the policy was developed, but CP-F was not the same pharmacist. DCS verified the policy identified "narcotics" and the Fentanyl patches should be treated the same. DCS verified the facility had not required a second nurse to witness the destruction of the narcotic patches and verified there was a high risk for diversion of the medication.	F 431		

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

PRINTED: 01/28/2014
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, Saint Therese at Oxbow Lake was found not in substantial compliance with the requirements for participation in Medicare/Medicaid, 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101 , Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	POC ok JB 2-7-14 RECEIVED FEB - 7 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dc: 2-19-14

EXIT: 1-10-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sarah Mark Smith	Executive Director	2/7/14

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 Marlan.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Oxbow Lake Care Center is a 2-story building with a basement. The building was constructed in 2012 and was determined to be of Type II (111) construction. It is automatic fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitor for fire department notification. The facility has a capacity of 64 beds with a census of 60 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	K-050 Fire Drill Schedule. The facility fire drill schedule was updated to include fire drills on all shifts for each quarter. A night shift fire drill is to be conducted on February 11th, 2014. The schedule was updated on 1/15/14 and the missing night shift fire drill will be conducted on 2/11/14. Roy Krueger, Plant Operations Director is responsible to ensure completion and ongoing monitoring. The facility Safety Committee is overseen by Roy Krueger. The Safety Committee met on 1/28/14 to implement an audit practice to ensure ongoing compliance with the fire drill schedule that will be monitored by the Safety Committee in their quarterly meetings. Education has been provided to the staff at Safety Committee meetings to ensure ongoing awareness.	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded	K 050		

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K 050	Continued From page 2 announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and interview, it was determined that the facility failed to vary the times and dates of numerous fire drills in the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all residents. Findings include: On facility tour between between 9:30 AM and 12:30 PM on 01/15/2014, record review revealed that there was no night shift fire drill for the third quarter of 2013. This deficient practice was verified by the administrator at the time of the inspection.	K 050	K 052 Fire Alarm System Test Ban-Koe, contracted Fire Panel operator, ran a smoke detector sensitivity test per requirements on 1/20/14. Sensitivity test is attached to this document. Mayer Electric, the contracted company for the facilities low voltage smoke detector system and the UL device counts was contacted on 1/15/14 and provided a new, updated UL Certificate for 1/23/14. The annual fire alarm test will be completed going forward within 365 days. Mayer electric provided a computer generated report for the annual Fire Alarm Inspection report.	
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 This STANDARD is not met as evidenced by: Based on observation, interview and record	K 052		

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K 052	Continued From page 3 review, the facility failed to maintain the fire alarm system in accordance with NFPA 72. This deficient practice could effect all residents. Findings include: During facility tour between 9:30 AM and 12:30 PM on 01/15/2014, record review revealed that: 1. There is no documentation of the smoke detector sensitivity test 2. The device counts between the UL Certificate, the fire alarm acceptance report dated 08/14/2012 and the annual inspection report dated 09/04/2013 reflect different number(s) of smoke detectors, duct detectors and supervisory devices. There is no supporting documentation identifying why there is a difference in device counts 3. The annual fire alarm inspection was not completed within the required 365 days 4. The "Initiating and Supervisory Device Test and Inspection" checkboxes located on Page 3 of the NFPA 72 Fire Alarm Inspection Report dated 09/04/2013 are marked with a blue ball point pen which is inconsistent with the rest of the computer generated form and associated signatures on Page 4 of the report. These deficient practices were verified by the administrator at the time of the inspection.	K 052	K 052 Fire Alarm System Test The dates for completion are listed above: sensitivity test complete on 1/20/14, UL Device counts on 1/23/14 and next scheduled Fire Alarm Inspection is scheduled for 365 days from initial install of system, August of 2014. Roy Krueger, Plan Operations Director is responsible for follow up and ongoing compliance of reports and inspections. Facility will require all reports to be computer generated by contractor	
K 071 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive	K 071		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245619	A. BUILDING 01 - MAIN BLDG B. WING _____	01/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443

(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 071	Continued From page 4 construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4. (4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 8.4, 9.5, 18.5.4, NFPA 82 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has trash chutes that do not meet the requirements of LSC Sections 18.5.4, 9.5 and 8.4 and NFPA 82. This deficient practice could affect all residents. Findings include: During facility tour between 9;30 AM and 12;30 PM on 01/15/2014, observation revealed that 1. There are no fire rating on the trash chute doors 2. The first floor trash chute door does not fully close and latch 3. In the basement trash collection room, the	K 071	K 071 Rubbish Chutes All trash chute doors have proper fire rating markings installed to show compliance. The first floor trash chute closes and latches properly. Trash is removed from below the trash chute on a consistent basis throughout the day to ensure trash does not overflow and block the chute. The fusible link on the trash chute door was connected to be in compliance. Trash chute doors had proper fire rating markings installed on 2/5/14. The first floor trash chute was fixed on 1/15/14. Trash removal of overflow happened on 1/15/14 and new check system by maintenance was implemented on 1/15/14. The fusible link on the trash chute was repaired on 1/15/14. Roy Krueger, Plant Operations Director is responsible for ongoing monitoring of these practices and has made the trash removal part of facility QM Process to be audited monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245619	A. BUILDING 01 - MAIN BLDG B. WING _____	01/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443

(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 071	Continued From page 5 trash was overflowing the dumpster preventing the trash chute door from closing 4. The fusible link for the basement trash collection room trash chute door was disconnected. These deficient practices were verified by the administrator at the time of the inspection.	K 071		
K 140 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Master alarm panels are in two separate locations and have audible and visible signals. There are high/low alarms for +/- 20% operating pressure. NFPA 99, 4.3.1.2.2 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain the piped medical gas system in accordance with NFPA 99. This deficient practice could effect all resident who used the piped medical gases. Findings include: During facility tour between 9:30 AM and 12:30 PM on 01/15/2014, record review revealed that there has not been any monthly or annual testing of the Level II piped medical gas system serving the TCU. This deficient practice was verified by the administrator at the time of the inspection.	K 140	K 140 Med Gas monthly and annual inspections A-1 Med Gas, contracted vendor, completed required annual inspection on 2/4/14. Inspection report is attached to this document. Monthly testing of the system commenced on 1/21/14. Inspection completed on 2/4/14. Roy Krueger, Plant Operations Director is responsible for ongoing compliance with annual inspections and monthly inspections.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245619	A. BUILDING 01 - MAIN BLDG B. WING _____	01/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443

(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 144	Continued From page 6 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 observation and interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110-1999 edition, Section 6-4. This deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 12:30 PM on 01/15/2014, record review revealed that 1. The monthly generator test for May was conducted in June and the September test was conducted in October 2. The emergency generator has not been inspected on a weekly basis. These deficient practices were verified by the administrator at the time of the inspection.	K 144	K 144 Generator testing Monthly generator test schedule was updated to reflect a monthly test within the exact month. Dates of test will occur mid-month to comply with this requirement. This practice will be reviewed by facility Safety Committee quarterly. Weekly generator tests began on 1/21/14 and followed weekly. Generator monthly test schedule was updated on 1/15/14 and weekly inspections began on 1/21/14 and followed weekly. Roy Krueger, Plant Operations Director is responsible to oversee the ongoing compliance of required inspections of the generator. The Safety Committee will run audits of this practice to ensure ongoing compliance quarterly.	

MAYER ELECTRIC SYSTEM SERVICES
Energy Management - Fire Protection - Voice - Data - Security

INSPECTION AND TESTING FORM

DATE: 1-23-2014 (9-4-2013)
TIME: 7AM

SERVICE ORGANIZATION

Name: MAYER ELECTRIC CORPORATION
Address: 7224 WINNETKA AVE N.
BROOKLYN PARK, MN 55428
Representative: JIM MORRIS
License No.: CA01205
Telephone: (763) 537-9357

PROPERTY NAME (USER)

Name: ST. THERESE AT OXBOW LAKE
Address: 9751 REGENT AVE N.
BROOKLYN PARK, MN 55443
Owner Contact: ROY KRUEGER
Telephone: (763) 493-7070

MONITORING ENTITY

Contact: W-H INTERNATIONAL RESPONSE CENTER
Telephone: (800) 858-7811
Monitoring Account Ref. No.: SS9312

APROVING AGENCY

Contact: BROOKLYN PARK FIRE INSPECTOR
Telephone: (763) 493-8020

TYPE TRANSMISSION

- ☐ McCulloh
- ☐ Multiplex
- ☒ Digital
- ☐ Reverse Polarity
- ☐ RF
- ☐ Other (Specify)

SERVICE

- ☐ Weekly
- ☐ Monthly
- ☐ Quarterly
- ☐ Semiannually
- ☒ Annually
- ☐ Other (Specify)

Control Unit Manufacturer: EST
Model No.: lo 500
Circuit Class - Styles: B - 4
Software Rev.: 3-3
Number of Circuits: 1 SLC CIRCUIT
Firmware Rev.: 3-3
Last Date System Had Any Service Performed: 8-16-2013
Last Date that Any Software or Configuration Was Revised: 8-16-2013

ALARM-INITIATING DEVICES AND CIRCUIT INFORMATION

Quantity	Circuit Class - Style	
9	B - 4	Manual Fire Alarm Boxes (Pull Stations)
0	B - 4	Ion Detectors
90	B - 4	Photo Detectors
2	B - 4	Duct Detectors
4	B - 4	Heat Detectors
1	B - 4	Waterflow Switches
4	B - 4	Supervisory Switches (3) SPRINKLER TAMPER, (1) PIV
2	B - 4	Other (Specify) (1) ANSUL -- FLOOR 1 KITCHEN
		(1) ANSUL -- FLOOR 2 KITCHEN

Alarm verification feature is disabled ☒ enabled ☐

Chapter 10.6.2.3 Inspection and Testing

NFPA 72 (2002), 1 of 4

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ALARM NOTIFICATION APPLIANCE AND CIRCUIT INFORMATION

Quantity	Circuit Class - Style	
49	B - Y	Horn/Strobes
29	B - Y	Strobes
0	B - Y	Horns
0	B - Y	Chimes
0	B - Y	Bells
0	B - Y	Speaker/Strobes
4	B - Y	Other (Specify) FAAP: 2 @ F-1 NUR STAT, 2 @ F-2 NUR STAT

No. of alarm notification appliance circuits: 4

Are circuits monitored for integrity: ☒ Yes ☐ No

SUPERVISORY SIGNAL-INITIATING DEVICES AND CIRCUIT INFORMATION

Quantity	Circuit Class - Style	
0	B - 4	Building Temp.
0	B - 4	Site Water Temp.
0	B - 4	Site Water Level
0	B - 4	Fire Pump Power
0	B - 4	Fire Pump Running
0	B - 4	Fire Pump Auto Position
0	B - 4	Fire Pump or Pump Controller Trouble
0	B - 4	Fire Pump Running
0	B - 4	Generator In Auto Position
0	B - 4	Generator or Controller Trouble
0	B - 4	Switch Transfer
0	B - 4	Generator Engine Running
2	B - 4	Other (Specify) ELEVATOR SHUNT TRIP

SIGNALING LINE CIRCUITS

Quantity and style of signaling line circuits connected to system (*see* NFPA 72, Table 6.6.1):

Quantity: 1 Class - Styles: B - 4

SYSTEM POWER SUPPLIES

(a) Primary – Main: Nominal Voltage 120VAC Amps 2.0A

Overcurrent Protection: Type CIRCUIT BREAKER Amps 20A

Location (of Primary Supply Panelboard): MEMORY CARE STORAGE

Disconnecting Means Location: ELECTRIC PANEL (LP-11), BREAKER (57)

(b) Secondary (Standby):

12V x 2 Storage Battery: Amp-Hr. Rating 18 AH

Calculated capacity to operate system, in hours: 24

Engine-driven generator dedicated to fire alarm system:

Location of fuel storage:

TYPE BATTERY

☐ Dry Cell ☐ Nickel-Cadmium ☒ Sealed Lead-Acid

☐ Lead-Acid ☐ Other (Specify):

(c) Emergency or standby system used as a backup to primary power supply, instead of using a secondary power supply:

N/A Emergency system described in NFPA 70, Article 700

N/A Legally required standby described in NFPA 70, Article 701

N/A Optional standby system described in NFPA 70, Article 702, which also meets the performance requirements of Article 700 or 701.

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PRIOR TO ANY TESTING

NOTIFICATIONS ARE MADE	Yes	No	Who	Time
Monitoring Entity	☒	☐	WHIRC	
Building Occupants	☒	☐	ST. THERESE	
Building Management	☒	☐	ST. THERESE	
Other (Specify)	☐	☐		
AHJ Notified of Any Impairments	☒	☐	BROOK PARK	

SYSTEM TESTS AND INSPECTIONS

TYPE	Visual	Functional	Comments
Control Unit	☒	☒	
Interface Equipment	☒	☒	
Lamps/LEDS	☒	☒	
Fuses	☐	☐	
Primary Power Supply	☒	☒	
Trouble Signals	☒	☒	
Disconnect Switches	☐	☐	
Ground-Fault Monitoring	☒	☒	

SECONDARY POWER

TYPE	Visual	Functional	Comments
Battery Condition	☒	☐	
Load Voltage		☒	
Discharge Test		☒	
Charge Test		☐	
Specific Gravity		☐	
TRANSIENT SUPPRESSORS	☐		
REMOTE ANNUNCIATORS	☒	☒	
NOTIFICATION APPLIANCES			
Audible	☒	☒	
Visible	☒	☒	
Speakers	☐	☐	N/A
Voice Clarity		☐	N/A

INITIATING AND SUPERVISORY DEVICE TESTS AND INSPECTIONS

Type	Device Type	Visual Check	Functional Test	Factory Setting	Measured Setting	Pass	Fail
INITIATING	PULLS	☒	☒			☒	☐
INITIATING	SMOKES	☒	☒			☒	☐
INITIATING	HEATS	☒	☒			☒	☐
INITIATING	WATERFLOW	☒	☒			☒	☐
SUPERVISORY	TAMPERS	☒	☒			☒	☐
SUPERVISORY	LOW AIR PRESS.	☐	☐	N/A		☐	☐
SUPERVISORY	HIGH AIR PRESS.	☐	☐	N/A		☐	☐

Comments: SMOKES (GROUP OF 10) ON FLOOR-1 NEED PROGRAMMING CORRECTION.
ONE OR MORE OF OF SMOKES 150 - 162 CURRENTLY INITIATES ELEVATOR RECALL.
REPAIR: FAS PROGRAMMING CORRECT; RESIDENT EVENT TRIPPED SMOKE DURING FAS TEST.

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INSPECTION, TESTING, AND MAINTENANCE

EMERGENCY COMMUNICATIONS EQUIPMENT	Visual	Functional	Comments
Phone Set	☐	☐	N/A
Phone Jacks	☐	☐	N/A
Off-Hook Indicator	☐	☐	N/A
Amplifier(s)	☐	☐	N/A
Tone Generator(s)	☐	☐	N/A
Call-In Signal	☐	☐	N/A
System Performance	☐	☐	N/A

INTERFACE EQUIPMENT	Visual	Device Operation	Simulated Operation
(Specify) N/A	☐	☐	☐
(Specify) N/A	☐	☐	☐
(Specify) N/A	☐	☐	☐

SPECIAL HAZARD SYSTEMS			
(Specify) N/A	☐	☐	☐
(Specify) N/A	☐	☐	☐
(Specify) N/A	☐	☐	☐

Special Procedure: N/A

Comments: VISIBLE/AUDIBLE NAC DEVICES AUTOMATICALLY STOP FUNCTIONING AFTER 60 SECONDS.
FACP REMAINS IN ALARM.
REPAIR: FAS PROGRAMMING CHANGE MADE.

SUPERVISING STATION MONITORING	Yes	No	Time	Comments
Alarm Signal	☒	☐		
Alarm Restoration	☒	☐		
Trouble Signal	☒	☐		
Supervisory Signal	☒	☐		
Supervisory Restoration	☒	☐		

NOTIFICATIONS THAT TESTING IS COMPLETE	Yes	No	Who	Time
Building Management	☒	☐	ST. THERESE	
Monitoring Agency	☒	☐	WHIRC	
Building Occupants	☒	☐	ST. THERESE	
Other (Specify)	☐	☐		

The following did not operate correctly:

System restored to normal operation: Date: 1-23-2014 (9-4-2013) Time: 1PM

THIS TESTING WAS PERFORMED IN ACCORDANCE WITH APPLICABLE NFPA STANDARDS

Name of Inspector: JORDAN KORAN Date: 1-23-2014 (9-4-2013) Time: 1PM

Signature:

Name of Owner or Representative:

Date: 1-23-2014 (9-4-2013) Time: 1PM

Signature: Nancy Holton

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Panel Device Maintenance/Sensitivity Report

Project: sttherese
Date: 1/20/2014 8:54:33 AM
Page: 1
Panel Name: PANEL1.SEN
Panel Version: 2.10.0
Report Filter: All Devices

Loop	Address	% Dirty	Sensitivity	CO Life Left Months	Message
1	1	0%	Least	N/A	SMOKE 1ST FL DINING ROOM BY 171 WEST
1	2	0%	Least	N/A	HEAT SOUTH ELEVATOR MACHINE ROOM
1	3	8%	Least	N/A	SMOKE SOUTH ELEVATORMACHINE ROOM
1	4	16%	Least	N/A	SMOKE SOUTH ELEVATORBASEMENT LOBBY
1	5	68%	Least	N/A	SMOKE SOUTH ELEVATOR1ST FLOOR LOBBY
1	6	0%	Least	N/A	SMOKE 1ST FLOOR COFFEE SHOP
1	7	0%	Least	N/A	SMOKE 1ST FLOOR NORTH ELEV LOBBY FRT
1	8	0%	Least	N/A	SMOKE BASEMENT NORTHELEV LOBBY
1	9	0%	Least	N/A	HEAT BASEMENT ELEC ROOM NORTH ELEV.
1	10	0%	Least	N/A	SMOKE BASEMENT ELEC ROOM NORTH ELEV.
1	11	0%	Least	N/A	SMOKE 2ND FLOOR N. ELEV KITCHEN LOBBY
1	12	0%	Least	N/A	SMOKE 2ND FL NORTH ELEV HALL LOBBY
1	13	0%	Least	N/A	SMOKE 1ST FL SOUTH ELEV KITCHEN LOBBY
1	14	0%	Least	N/A	SMOKE -1 LEVEL STORAGE NEXT TO DATA
1	15	0%	Least	N/A	SMOKE -1 LEVEL DATA ROOM
1	16	0%	Least	N/A	SMOKE -1 LEVEL EDUCATION ROOM
1	17	0%	Least	N/A	SMOKE -1 LEVEL POOL EQUIPMENT ROOM
1	18	0%	Least	N/A	SMOKE -1 LEVEL MAIN ELECT RM SERVIC
1	19	0%	Least	N/A	SMOKE -1 LEVEL LAUNDRY ROOM
1	20	0%	Least	N/A	SMOKE -1 LEVEL WALK IN COOLER
1	21	0%	Least	N/A	SMOKE -1 LEVEL MECH. RM PUMP RM
1	22	0%	Least	N/A	SMOKE 1ST FL HALL BY BATHER
1	23	0%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 150
1	24	0%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 152
1	25	4%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 154
1	26	0%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 157
1	27	0%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 158
1	28	0%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 160
1	29	0%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 162
1	30	0%	Least	N/A	SMOKE 1ST FL ELECT RM BY ROOM 162
1	31	0%	Least	N/A	SMOKE 1ST FL ENTRY WAY LOBBY
1	32	0%	Least	N/A	SMOKE 1ST FL LOBBY HALL BY STAIRS
1	33	0%	Least	N/A	SMOKE 1ST FL LOBBY HALL BY CONF
1	34	8%	Least	N/A	SMOKE -1 LEVEL GARBAGE ROOM
1	35	16%	Least	N/A	SMOKE 1ST FL HALL BY WELLNESS CENTER
1	36	0%	Least	N/A	SMOKE 1ST FL WELLNESCENTER BY DOOR A-150
1	37	0%	Least	N/A	SMOKE 1ST FL HALL BY STUDIO
1	38	0%	Least	N/A	SMOKE 1ST FL HALL BY DOOR B161A
1	39	0%	Least	N/A	SMOKE 1ST FL HALL WOMANS LOCKER
1	40	0%	Least	N/A	SMOKE 1ST FL LOBBY BY FACP
1	41	0%	Least	N/A	SMOKE 1ST FL HALLWAYWELLNESS CENTER
1	42	0%	Least	N/A	SMOKE 1ST FL BY POOLDOOR IN POOL LOBBY

Panel Device Maintenance/Sensitivity Report

Project: sttherese
Date: 1/20/2014 8:54:33 AM

Panel Name: PANEL1.SEN
Panel Version: 2.10.0
Report Filter: All Devices

Loop	Address	% Dirty	Sensitivity	CO Life Left Months	Message
1	43	0%	Least	N/A	1ST FL LOBBY BY DOOR B166E
1	44	0%	Least	N/A	SMOKE 1ST FL INSIDE LINK BY DOOR B166B
1	45	0%	Least	N/A	SMOKE 2ND FL HALL BY ROOM 279
1	46	0%	Least	N/A	SMOKE 2ND FL HALL BY ROOM 277
1	47	0%	Least	N/A	SMOKE 2ND FL HALL BY ROOM 282
1	48	0%	Least	N/A	SMOKE 2ND FL HALL BY ROOM 284
1	49	0%	Least	N/A	SMOKE 2ND FL HALL BY ROOM 285
1	50	0%	Least	N/A	SMOKE 2ND FL BY NURSE STATION
1	51	0%	Least	N/A	SMOKE 2ND FL ELECTRICAL ROOM
1	52	0%	Least	N/A	SMOKE 2ND FL HALL BY ROOM 275
1	53	0%	Least	N/A	SMOKE 2ND FL DINE ROOM
1	54	0%	Least	N/A	SMOKE 2ND FL HALL BY ROOM 270
1	55	0%	Least	N/A	SMOKE 2ND FL LIVING ROOM FIRE DR
1	56	0%	Least	N/A	SMOKE 2ND FL HALL BY ROOM 253
1	57	0%	Least	N/A	SMOKE 2ND FL HALL BY ROOM 205
1	58	0%	Least	N/A	SMOKE 2ND FL HALL BY ROOM 257
1	59	0%	Least	N/A	SMOKE 2ND FL HALL BY ROOM 259
1	60	0%	Least	N/A	SMOKE 2ND FL HALL BY ROOM 260
1	61	0%	Least	N/A	SMOKE 2ND FL HALL BY ROOM 262
1	62	0%	Least	N/A	SMOKE 2ND FL HALL BY ROOM 264
1	63	0%	Least	N/A	SMOKE 2ND FL HALL BY ROOM 265
1	64	0%	Least	N/A	SMOKE 2ND FL HALL BY ROOM 254
1	65	0%	Least	N/A	SMOKE 2ND FL ELECTRICAL ROOM 220
1	66	0%	Least	N/A	SMOKE 2ND FL HALL BY DOOR B276
1	67	12%	Least	N/A	SMOKE 2ND FL HALL BY DOOR B276
1	68	0%	Least	N/A	SMOKE 2ND FL HALL BY ROOM 272
1	69	0%	Least	N/A	SMOKE 2ND FL TRASH ROOM
1	70	0%	Least	N/A	SMOKE 2ND FL LIV ROOM 2 BY TRASH
1	71	0%	Least	N/A	SMOKE 2ND FL HALL BY ROOM 251
1	72	0%	Least	N/A	HEAT 2ND FL KITCHEN
1	73	0%	Least	N/A	SMOKE 1ST FL DINE ROOM BY FIRE DR
1	74	0%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 178
1	75	0%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 180
1	76	0%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 182
1	77	0%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 184
1	78	0%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 185
1	79	0%	Least	N/A	SMOKE 1ST FL BY NURSE STATION
1	80	0%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 175
1	81	0%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 177
1	82	0%	Least	N/A	SMOKE 1ST FL LIVING RM BY RM 173
1	83	0%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 172
1	84	0%	Least	N/A	SMOKE 1ST FL DINING RM BY RM 171

Panel Device Maintenance/Sensitivity Report

Project: sttherese
Date: 1/20/2014 8:54:33 AM

Panel Name: PANEL1.SEN
Panel Version: 2.10.0
Report Filter: All Devices

Loop	Address	% Dirty	Sensitivity	CO Life Left Months	Message
1	85	0%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 170
1	86	0%	Least	N/A	SMOKE 1ST FL HALL BY CLINICAL SER
1	87	0%	Least	N/A	SMOKE 1ST FL HALL BY DISH WASHING
1	88	0%	Least	N/A	SMOKE 1ST FL DINING RM BY ENTRY
1	89	0%	Least	N/A	HEAT 1ST FL KITCHEN
1	90	0%	Least	N/A	SMOKE 1ST FL HALLWAYWELLNESS CENTER
1	91	0%	Least	N/A	SMOKE 1ST FL EAST LINK HALL 153
1	92	0%	Least	N/A	SMOKE 1ST FL MEM CARE KITCHEN
1	93	0%	Least	N/A	SMOKE 1ST FL MEM CARE LOUNGE
1	94	0%	Least	N/A	SMOKE 2ND FL EAST LOUNGE

Mayer Electric Corp
7224 Winnetka Ave N
Brooklyn Park, MN 55428
Phone: (763) 537-9357
Fax: (763) 537-2309

INVOICE

copy

INVOICE NO
16916

CUST Saint Therese at Oxbow Lake
9751 Regent Ave N
Brooklyn Park, MN 55443

SITE Saint Therese at Oxbow Lake
9751 Regent Ave N
Brooklyn Park, MN 55443

ACCOUNT NO	INVOICE DATE	TERMS	DUE DATE			PAGE
SAITHE	01/23/2014	Net 30	02/22/2014			1

ORDER 7082, PO

ORDERED BY Roy Krueger

DESCRIPTION 2013 UL fire alarm test follow up.

RESOLUTION Followed up to check device locations.

ITEM NO	QUANTITY	DESCRIPTION	UNIT PRICE	EXTENDED
JKORAN	3.50	Jordan Koran	125.00	437.50*
TRUCK	1	Truck Charge	30.00	30.00*
	1	FAS SERVICE "FAS RUNNER SOW: DOWNLOAD SENSITIVITY REPORT FROM FACP.	177.00	177.00*

* means item is non-taxable

Fac	Dept	Account	Amt
Signature			Date

TOTAL AMOUNT **644.50**

File No: **S24368**	CCN: **UUFX**
Service Center No: **1**	
Expires: **01/23/2019**	
Issued: **01/23/2014**	
Entry No: **5298954**	Version: **7**

CENTRAL STATION - FIRE
FIRE ALARM SYSTEM CERTIFICATE DESCRIPTION
FOR Certificate Serial No: FC46391268

Protected Property:
ST. THERESE AT OXBOW LAKE
9751 REGENT AVE N
BROOKLYN PARK, MN 55443

Alarm Service Company:
MAYER ELECTRIC CORPORATION
7224 WINNETKA AVE N
MINNEAPOLIS MN 55428-1622

System Description:
Area Covered: ENTIRE PREMISE
Authority Having Jurisdiction: BROOKLYN PARK FIRE MARSHAL 763-493-8020
Responding Fire Department: BROOKLYN PARK
Testing and Maintenance Contract date: 08/08/2012

SYSTEM DEVIATIONS FROM REFERENCED NFPA STANDARDS
ANNUAL TESTING PER AHJ

Automatic Fire Detection and Alarm Service
Coverage is Selected Area
90 - Smoke Detectors : 0 - Ionization 90 - Photoelectric
2 - Duct Smoke Detectors : 0 - Ionization 2 - Photoelectric
4 - Heat Detectors : 0 - ROR (Rate of temperature rise) 0 - Fixed Temperature 4 - Combination

Sprinkler System Waterflow Alarm and Supervisory Service
Sprinkler System Type: Wet Pipe
1 - Waterflow Switch
4 - Sprinkler Valve Supervisory Services
4 - Other Devices : 2 ANSUL, 2 ELEV SHUNT TRIP

Manual Fire Alarm and Guard's Tour Supervisory Service
9 - Manual Fire Alarm Boxes

Alarm Notification and Annunciation Devices
29 - Visual Signals : Type - Strobe
49 - Audible/Visual Signals : Type - Strobe

Control and Transmitter Unit
EST IO500/SA-DACT

Remote Monitoring
UL Listed Central Station
File: S7050, Service Center Number: 0
WH INTERNATIONAL RESPONSE CENTER
6800 ELECTRIC DR
PO BOX 330
ROCKFORD MN 55373-0330

File No: **S24368** CCN: **UUFX**
Service Center No: **1**
Expires: **01/23/2019**
Issued: **01/23/2014**

CENTRAL STATION - FIRE
FIRE ALARM SYSTEM CERTIFICATE
(NFPA 72)

THIS CERTIFIES that the *Alarm Service Company* is included by UL LLC in its Directory as qualified to use the *UL Listing Mark* in connection with the certificated *Alarm System*. This Certificate is the *Alarm Service Company*'s representation that the *Alarm System* including all connecting wiring and equipment has been installed and will be maintained in compliance with requirements established by UL. This Certificate does not apply in any way to the installation of any additional signaling systems, such as; fire, smoke, waterflow, burglary, holdup, medical emergency, or otherwise, that may be connected to or installed along with the Certificated *Alarm System*. This Certificate does not apply in any way to the communication channel between the protected property and any facility that monitors signals from the protected property unless the use of a UL listed or Classified Alarm Transport Company is specified on the Certificate.

LIMITATION OF LIABILITY: UL LLC makes no representations or warranties, express or implied, that the Alarm System will in all cases prevent any loss by fire, smoke, water damage, burglary, hold-up or otherwise, or that the Alarm System will in all cases provide the protection for which it is installed or intended. By the Alarm Service Company providing this Certificate and the Protected Property acceptance of this Certificate, the Alarm Service Company and the Protected Property acknowledge and agree that UL does not assume or undertake to discharge any liability of the Alarm Service Company or any other party. UL is not an insurer and assumes no liability which may result directly or indirectly from inspection of the equipment, failure of the equipment, failure to conduct inspections, incorrect certification, nonconformity with requirements, failure to discover nonconformity with requirements, cancellation of the Certificate or withdrawal of the Alarm Service Company from inclusion in ULs Directory prior to the expiration date appearing on this Certificate.

OPERATIONAL REQUIREMENTS: The *Alarm Service Company* bears the responsibility for the correctness of the installation; maintenance of the system documentation; periodic system inspection and testing; maintaining and providing any necessary repairs. All operations and maintenance shall be conducted in the manner prescribed by the NFPA standard referenced. All required service is to be provided for in an appropriate contract. System documentation is defined to include any "As Built Drawings"; the records of any "Acceptance Testing"; and the records of all periodic system testing and maintenance.

SYSTEM DESCRIPTION: This system is installed and operated in accordance with standard NFPA 72,2002 edition.

Area Covered: ENTIRE PREMISE
Authority Having Jurisdiction: BROOKLYN PARK FIRE MARSHAL 763-493-8020
Responding Fire Department: BROOKLYN PARK

SYSTEM DEVIATIONS FROM REFERENCED NFPA STANDARDS

ANNUAL TESTING PER AHJ

Protected Property:

ST. THERESE AT OXBOW LAKE
9751 REGENT AVE N
BROOKLYN PARK, MN 55443

Alarm Service Company:

MAYER ELECTRIC CORPORATION
7224 WINNETKA AVE N
MINNEAPOLIS MN 55428-1622

SN: FC46391268

File No: **S24368**	CCN: **UUFX**
Service Center No: **1**	
Expires: **01/23/2019**	
Issued: **01/23/2014**	
Entry No: **5298954**	Version: **7**

CENTRAL STATION - FIRE
FIRE ALARM SYSTEM CERTIFICATE DESCRIPTION
FOR Certificate Serial No: FC46391268

Alarm Retransmission to Fire Department
Public Telephone Network and Public Telephone Network
Alarm Transmission Method: Digital Alarm Communicator

A1 MED GAS

Annual Medical Gas Inspection-2014

Saint Therese at Oxbow Lake
5200 Oak Grove Pkwy
Brooklyn Park, MN

Date Inspected: February 4th, 2014
Inspected by: David Alsop | ASSE 6030 Medical Gas Verifier

Medical Gas Inventory Summary

Medical Gas Terminal Count	
Oxygen	17
Medical Air	0
Medical Vacuum	0
Waste Anesthetic Gas Disposal	0
Nitrous Oxide	0
Carbon Dioxide	0
Nitrogen	0
Helium	0
Total Gas Terminals	17

Total Zone Valves	Total Area Alarms	Master Panels
1	0	Location 1: 1st Floor Nurses Desk

A1 MED GAS

A1 Medical Gas, Inc
Phone: 919-247-4728
Email: A1medgas@gmail.com

Medical Gas Contaminants Evaluation

Contaminants Evaluation

Location	Sample ID	Gas	% Gas	CO	CO2	Gaseous Hydrocarbons	Halogenated Hydrocarbons	White Rag Test	Odor	Total Particulate
Room 177	13-68	O2	99.99% O2	<1 ppm	<5 ppm	<.7 ppm	<.1 ppm	Pass	N/D	<1 mg

LEGEND KEY

TBD=To be Determined, data analysis not yet performed.	N/D = None Detected

NFPA 2005 Gas Concentration Requirements (minimum)		NFPA 2005 Contaminant Requirements (minimum) -Medical Air Only
Gas	Concentration Requirement	CO 10ppm (maximum allowable)
Oxygen	>99% O2	CO2 500ppm (maximum allowable)
Medical Air	19.5-23.5% O2	Gaseous Hydrocarbons as Methane 25ppm (max allowed)
Nitrous Oxide	>99% N2O	Halogenated Hydrocarbons 2ppm (maximum allowable)
Carbon Dioxide	>99% CO2	Dew Point 39 ° F (4°C) @ 50 psig
Nitrogen	>99% N2 or <1% O2	Odor-Shall show no signs of non-standard odor

NFPA 2005 Contaminant Requirements-Positive Pressure Gases, excluding Medical Air
Dew Point 41 ° F (5°C) @ 50 psig
CO 10ppm (maximum allowable)
Total Hydrocarbons as Methane 1ppm (maximum allowable)
Halogenated Hydrocarbons 2ppm (maximum allowable)

A1 Medical Gas, Inc
Phone: 919-247-4728
Email: david@a1medicalgas.com

Master Alarm Summary

Master Alarm Signal Summary		
Master Alarm 1	Location	
	1st Floor Nurse's Desk	
Gas/Vac:	Oxygen	
Type:	Manifold without Reserve	
Signals	Oxygen	
LINE PRESSURE LOW	40	■
LINE PRESSURE HIGH		■ 60
RESERVE IN USE		■
EMERGENCY RESERVE IN USE		☐
RESERVE PRESSURE LOW		☐
MAIN LIQUID LEVEL LOW		☐
RESERVE LIQUID LEVEL LOW		☐

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Email: A1medgas@gmail.com

Alarm Field Data

Area Alarms							
Area Alarm Location	Gas Type	Pressure Psig/In	Set Point High	Set Point Low	Condition	Manuf/Model	Notes
Near Nurses Desk; Controls Rooms: 170-186	1					Amico Alert	Combo Master / Area
	O2	52 psig	60 psig	40 psig	Good		

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Email: A1medgas@gmail.com

Alarm Deficiencies Information

There are no recommendations at this time.

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Email: A1medgas@gmail.com

Zone Valve Field Data

Zone Valve Boxes				
Zone Valve Location	Gas Type	Pressure Psig/In	Condition	Notes
Near Nurses Desk; Serves Rooms: 170-186	1			
	O2	52 psig	Good	

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Phone: 919-247-4728
Email: A1medgas@gmail.com

Zone Valve Box Deficiencies Information

There are no recommendations at this time.

A1 Medical Gas, Inc
Phone: 919-247-4728
Email: A1medgas@gmail.com

Medical Gas Outlet and Inlet Field Data

Medical Gas Inlets and Outlets

Location	Gas Type	Flow Rate/SCFM	Standing Pressure	Flowing Pressure	Leaks Y/N?	Pass/Fail	Notes
170	O2	>3.5	54 psig	52 psig	N	Pass	
171	O2	>3.5	54 psig	52 psig	N	Pass	
172	O2	>3.5	54 psig	52 psig	N	Pass	
173	O2	>3.5	54 psig	52 psig	N	Pass	
174	O2	>3.5	54 psig	52 psig	N	Pass	
175	O2	>3.5	54 psig	52 psig	N	Pass	
176	O2	>3.5	54 psig	52 psig	N	Pass	
177	O2	>3.5	54 psig	52 psig	N	Pass	
178	O2	>3.5	54 psig	52 psig	N	Pass	
179	O2	>3.5	54 psig	52 psig	N	Pass	
180	O2	>3.5	54 psig	52 psig	N	Pass	
181	O2	>3.5	54 psig	52 psig	N	Pass	
182	O2	>3.5	54 psig	52 psig	N	Pass	
183	O2	>3.5	54 psig	52 psig	N	Pass	
184	O2	>3.5	54 psig	52 psig	N	Pass	
185	O2	>3.5	54 psig	52 psig	N	Pass	
186	O2	>3.5	54 psig	52 psig	N	Pass	

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Medical Gas Inlets and Outlets Deficiencies Information

There are no recommendations at this time.

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Oxygen Emergency Supply Manifold

Oxygen Emergency Supply Manifold Inspection Check List

General Data

1.	Inspection Date:	2/4/2014
2.	Gas System:	Oxygen
3.	Gas or Liquid Source:	Gas
4.	Location of Manifold:	Manifold Room Floor Level -1
5.	Facility Area(s) served :	Entire Facility
6.	Manifold Manufacturer:	Amico
7.	Model Number:	UDHD-HH-U-OXY
8.	Serial Number:	201213-D-A
9.	Cylinders per bank:	4 x 4

10. Is there automatic alternation?
    Yes
11. Are cylinder check valves installed?
    Yes
12. Are there shut off valves for each side of manifold?
    Yes
13. Pressure at which left to right bank changeover occurs (kPa/psig).
    125 psig
14. Pressure at which right to left bank changeover occurs (kPa/psig).
    125 psig
15. Is manifold equipped with status/warning lights?
    Yes
16. Is manifold on emergency electrical power?
    Yes

    Verified by whom? Engineering

A1 Medical Gas, Inc
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Email: david@a1medicalgas.com

Oxygen Emergency Supply Manifold

Oxygen Emergency Supply Manifold Inspection Check List

Components

17. **Dual Line Pressure Regulators**
    Yes
    a. What is the regulator pressure setting (psig)?
       53 psig
    b. Can regulators be isolated from system by ball valves or check valves?
       Yes

18. Is there a line pressure relief valve installed?
    Yes

19. **Relief valve discharge lines**
    a. Is relief valve vented outdoors?
       Yes
    b. Are vent lines ASTM B819 copper with brazed joints?
       Yes
    c. Are relief valves individually vented outdoors?
       Yes
    d. Are multiple relief valves connected to a common vent to outdoors?
       NA
    e. Are vent lines sized properly?
       Yes
    f. Are outdoor vent terminals properly located?
       Yes
    g. Are they turned down?
       Yes
    h. Are they screened?
       Yes

20. Is system piped with brazed copper downstream of the manifold?
    Yes
21. Are Pipelines labeled properly?
    Yes

A1 Medical Gas, Inc
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Oxygen Emergency Supply Manifold

Oxygen Emergency Supply Manifold Inspection Check List

Components (Continued)

22. Source Valve

a. Is there a source valve installed?
Yes

b. Is it properly located in the system?
Yes

c. Is it labeled for gas?
No

d. Is it labeled for area(s) served?
No

e. Is it labeled "DO NOT CLOSE EXCEPT IN EMERGENCY"?
No

23. Where there leaks detected in manifold piping?
No

24. Is manifold area posted "No Smoking"?
Yes

25. Is area enclosed with lockable entry?
Yes

26. Interior locations with mechanical ventilation, where required?
Yes

27. Interior locations with natural ventilation where permitted?
NA

28. Is are free from flammable liquids and gases?
Yes

29. Are all electrical switches and outlets above 5 feet in elevation?
Yes

30. Are cylinders individually chained or secured?
Yes

31. Is area not exposed to temperatures in excess of 130° F (54° C) or less than 20° F (-7° C)?
Yes

A1 Medical Gas, Inc
Phone: 919-247-4728
Email: david@a1medicalgas.com

Oxygen Emergency Supply Manifold
Oxygen Emergency Supply Manifold Inspection Check List
Comments
Source Valve Tags being sent to facility.

A1 Medical Gas, Inc
Phone: 919-247-4728
Email: david@a1medicalgas.com

Oxygen Emergency Supply Manifold
Deficiencies / Recommendations

There are no recommendations at this time.

A1 Medical Gas, Inc
Phone: 919-247-4728
Email: david@a1medicalgas.com

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8279

January 28, 2014

Ms. Dinah Martin, Administrator
Saint Therese At Oxbow Lake
5200 Oak Grove Parkway
Brooklyn Park, Minnesota 55443

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5619001

Dear Ms. Martin:

The above facility was surveyed on January 6, 2014 through January 10, 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health,

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55108-2970
Telephone: (651) 201-3792
Fax: (651) 201-3790

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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27752	A. BUILDING: _____ B. WING _____	01/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/7/14, through 1/10/14, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27752	A. BUILDING: _____ B. WING _____	01/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Certification Programs; 85 East Seventh Place, Suite 220; P.O. Box 64900, St. Paul, Minnesota 55164-0900.	2 000	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 which 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.	
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27752	A. BUILDING: _____ B. WING _____	01/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 2 attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician in a timely manner for 1 of 3 residents (R35) who sustained a skin tear, bruising and swelling injury to the right hand. Findings include: R35's diagnoses included osteoporosis and history of a close fracture unspecified part upper end humerus obtained from the quarterly Minimum Data Set (MDS) dated 10/3/13. The	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27752	A. BUILDING: _____ B. WING _____	01/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 265	Continued From page 3 MDS indicated R35's Brief Interview of Mental Status (BIMS-tool used to measure cognitive status) score was 15 (which indicated intact cognitive status). R35's Progress Notes revealed the following: -On 10/19/13, a skin tear to the right wrist measuring 2 centimeter (cm) x 1.5 cm was and R35 had reported she bumped her hand over her walker was noted. Steri-strips were applied and the note indicated staff would continue to monitor. -On 10/20/13, R35's right hand was noted to be red, swollen, warm to touch and the Steri-strips remained intact. R35 denied pain and the note indicated staff would continue to monitor. -On 11/2/13, the top of R35's right hand was observed to have one Steri-strip from a previous skin tear and the hand was bruised, swollen and tender to touch. R35 was not able to explain exactly what happened when asked and stated she was constantly bumping the hand on something. Ice was applied to R35's hand two times during the shift, with decreased swelling noted. The note indicated staff would continue to monitor R35's needs. -On 11/3/13, two notes indicated R35's right hand remained swollen/puffy, bruised, warm, and tender to touch and R35 reported pain. Scheduled pain medication and ice were administered and R35 reported relief. -On 11/4/13, an earlier note indicated the top of R35's right hand was bruised, reddened and swollen. Later that same day, the bruise was noted to be dark red, measured 35 cm x 15 cm, and was swollen all the way down to the fingers. R35 reported pain with range of motion and with pressure. The nurse practitioner (NP) was updated and an x-ray was ordered. R35's medical record lacked documented	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27752	A. BUILDING: _____ B. WING _____	01/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 265	Continued From page 4	2 265		

evidence the physician (MD) or NP was notified of the right hand injury until 16 days after the skin tear occurred and/or two days after the right hand bruising and swelling was noted.

On 1/10/14, at 11:11 a.m. the director of clinical services (DCS) was asked why the physician was not updated when the skin tear was first noted on 10/19/13, and on 11/2/13. DCS stated, "I'd have to go back and review the incident." She further stated she expected the physician to be notified, "If injury with pain, increased swelling, tenderness ...anything out of the ordinary." DCS further explained when the bruising was first noted on 11/2/13, she would have liked both herself and the administrator to have been notified of the right hand injury.

On 1/10/14, at 12:15 p.m. the NP stated the facility was supposed to update her of any change in condition, new complaint, or change off baseline immediately. NP stated if she was not working, or if it was during the weekend, the facility was to call the on-call provider for treatment. Additionally, the NP stated she expected the nurses to leave a voice message for issues that would not need immediate attention. NP stated she would follow up on her next working day. NP further stated she recalled being updated regarding R35's bruised right hand on 11/4/13, and stated she had ordered an x-ray to rule out a possible fracture due to the swelling and pain.

The licensed practical nurse (LPN)-C who had worked with R35 on 11/2/13, was interviewed on 1/10/14, at 12:33 p.m. via telephone. LPN-C was able to re-call the bruising incident and Progress Note dated 11/2/13. LPN-C also added there was more swelling than bruising at the time and had

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 5 updated the next shift to continue to monitor. LPN-C confirmed neither the physician, NP nor the supervisor were notified about the condition of the right hand. The MD/NP and/or Resident/Family Notification Regarding a change of Resident's Condition policy dated February 2013, indicated the MD/NP were to be kept informed of change in current health status so that a medical decision can be made. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure compliance. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 265		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by	2 555		

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2 555	Continued From page 6 the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a care plan to address sleep problems, sleep monitoring and/or the use of Trazodone for 1 of 5 residents (R27) reviewed for un-necessary medications. Findings include: R27 received scheduled Trazodone for sleep without development of a care plan to address the use of the medication, risk factors associated with the medication and non-pharmacological interventions, such as for sleep. Physician's orders dated 11/7/13, indicated R27 received Trazodone HCl 25 milligrams (mg) by mouth (PO) twice daily and 50 mg PO every hour of sleep (HS). The orders identified R27's diagnoses to include unspecified psychosis, dementia without behavioral disturbance, and Alzheimer's disease. The care plan dated 12/13/13, did not identify the use of Trazodone for sleep, lacked a focus for sleep and non-pharmacological interventions to promote sleep. In addition, the care plan lacked direction for monitoring and evaluation of R27's sleep patterns and potential side effects of the medication. On 1/9/14, at 2:01 p.m. the clinical coordinator (RN)-B verified the care plan did not address sleep or the use of Trazodone. At 2:31 p.m. the	2 555		

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2 555	Continued From page 7 consultant pharmacist (CP)-F was interviewed via telephone and verified the facility should have care planned the use of Trazodone. On 1/10/14, at 9:04 a.m. the director of clincal services (DCS) verified the Trazodone and R27's sleep problems should have been care planned. The facility's Psychotropic Medications and Monitoring policy and procedure dated 8/2012, identified pertinenent direction for psychoactive medications, including antidepressants. Although the policy directed appropriate indications for use of psychotropic medications, evaluation, monitoring and assessment of psychotropic medications; the policy lacked direction for care planning psychotropic medications. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure compliance. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 555		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility	2 570		

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2 570	Continued From page 8 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was revised regarding bathing preferences for 1 of 5 residents (R63) reviewed for unnecessary medications. In addition the facility failed to revise a plan of care for 1 of 3 residents (R75) with bruises on unknown origin and risk for bruising reviewed for non-pressure skin conditions. Findings include: The Admission Record for R63 dated 12/4/13, included diagnoses of dementia, aphasia, and depression. The Order Summary Report dated 1/9/14, revealed R63 was prescribed Seroquel 25mg every bedtime and 25mg every Friday for anxiety to be given before bath/shower on Friday mornings. The every Friday Seroquel orders dated 8/13/13, included directions of may try bed bath/sponge bath instead. The bathing care plan dated 11/6/13, indicated R63 had a history of refusing showers, becoming very agitated and upset during the shower activity and identified R63 did not like water on her head. The care plan directed staff to administer a	2 570		

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2 570	Continued From page 9 psychotropic medication prior to shower, directed not to wash R63's hair with the bath, directed to provide a calm approach and offer reassurance during the shower. The care plan directed to re-approach at a later time if R63 became agitated or upset. The care plan did not include direction to offer a bed bath to R63. When interviewed on 1/8/14, at 9:03 a.m. family member (FM)-A reported R63 had problems with bathing and did not like to take baths or showers. FM-A stated R63 would become very upset during and after bathing. FM-A further stated R63 used to take showers regularly without problems and did not know what had caused the change. On 1/9/14, at 9:24 a.m. nursing assistant (NA)-A stated R63 did not like water and would scream, kick, yell and call angry names with showers. NA-A reported noting no difference in R63's behaviors since Seroquel was started and stated R63 now needed two staff members to assist with a shower. NA-A further stated when she gave R63 a bed bath, R63 was "happy." At 9:34 a.m. registered nurse (RN)-A stated R63 would get very upset, verbally and physically abusive during baths, and verified the behavior had not improved since the Seroquel was started on 8/13/13. RN-A stated R63 was much calmer with a bed bath. On 1/9/14, at 9:57 a.m. the clinical coordinator (RN)-B stated R63's family had requested Ativan (an anti-anxiety medication), but the staff wanted to use Seroquel. RN-B stated she had not seen any notes about behaviors with baths and if staff "doesn't tell" her, she "doesn't know." RN-B reported R63 got a shower weekly versus a bed bath per her family's request. On 1/9/14, at 12:27 p.m. FM-A was interviewed again and stated it was not a family request R63 got a shower every week and stated she did not know a bed bath was an option. FM-A reported she noted R63 was still very upset when she	2 570		

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2 570	Continued From page 10 visited the day after her showers. On 1/9/14, at 12:39 p.m. the director of clinical services (DCS) stated weekly residents do not need to have a shower and if a bed bath was more comfortable for them, that was "their choice." The DCS stated she would expect alternatives to be used prior to using an antipsychotic for bathing. On 1/9/14, at 1:44 p.m. R63's physician (MD)-A stated he ordered Seroquel for R63 because he did not like the side effects of benzodiazepines. MD-A further stated he used Seroquel because that was what he usually used in nursing homes. MD-A stated he would expect facility staff to explain things to residents to increase their comfort before starting any medications for behavior. R75 care plan was not revised for risk of bruising and the bruises on both forearms. On 01/07/14, at 1:44 p.m. R75 was observed to have several dark purple bruises to both forearms at different stages of healing. On 1/9/14, at 7:30 a.m. R75 was observed sitting on a couch in the middle lounge with her eyes closed. The administrator was reading the newspaper to R75 and four other residents; R75's forearms and bruises were visible at the time. The significant change Minimum Data Set (MDS) dated 9/20/13, indicated R75's diagnoses included Alzheimer's disease and macular degeneration of retina. The MDS indicated R75 had severe cognitive impairment and required extensive assistance for all activities of daily living.	2 570		

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2 570	Continued From page 11 R75's care plan dated 11/20/12, identified for skin integrity, "[R75 was] At risk for impaired skin integrity due to always being incontinent of bladder and occasionally incontinent of bowel, fall risk and self-care deficit related to dementia." The care plan did not identify R75's risk for bruising, but directed to "monitor for skin changes during baths/showers, during am/pm cares and notify the nurse." Although the vision focus identified R75 had potential for change in vision related to macular degeneration; the behavior focus identified R75 wandered around the unit and into other resident rooms, neither focus included how R75 was at risk for injury or bruising with the risk factors. Review of R75's Progress Notes revealed on 11/25/13, 12/2/13, and 12/16/13, old bruising had been noted on both of R75's forearms. Although the bruising was documented occassionally in the medical record, R75's care plan did not address bruising risk, idenify the new bruising, such as risk factors and interventions in place to prevent new bruising. On 1/9/14, at 8:40 a.m. the clinical coordinator registered nurse (RN)-D verified R75's both forearms had dark purple bruises at different stages of healing. On 1/9/14, at 9:42 a.m. DCS stated the nurses were supposed to let the clinical coordinator know to update the care plan. On 1/9/14, at 2:10 p.m. RN-D stated she was not aware R75 had the bruising and stated if she was aware she would have updated the care plan. The Skin Care Protocol dated May 2013, directed if bruises are noted during daily cares or during	2 570		

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2 570	Continued From page 12 weekly skin check the clinical or DON (director of nursing) will be updated immediately. In addition, the policy indicated resident care interventions will be provided based on nursing assessment and application of the nursing process for the resident identified as being at risk for altered skin integrity. The policy lacked who was responsible to revise the care plan when any resident's skin had been assessed and noted to have an issue. The Resident Assessment and Care Planning policy dated September 2012, indicated the purpose was to provide a means for the interdisciplinary team to assess residents, plan and implement an individualized care plan, and evaluate the effectiveness of their care and treatment on an ongoing basis. The policy indicated this process was used to assist each resident to achieve/maintain an optimal functional level. The policy lacked information on revising a plan of care on going when any resident was identified with new issues or risk factors between the MDS's. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure compliance. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 570		

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2 830	Continued From page 13	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to identify, assess for root cause and provide preventative measures to prevent bruising for 1 of 3 residents (R75) reviewed for non- pressure related skin issues Findings include: On 1/7/14, at 1:44 p.m. R75 was observed to have several dark purple bruises to both forearms at different stages of healing but was not able to explain how she got the bruises. - At 5:22 p.m. R75 was observed sitting at the dining room table eating independently. A nursing assistant (NA)-B sat between R75 and other resident cuing her to eat. On 1/8/14, at 2:27 p.m. the nursing assistant (NA)-B stated if she noticed any resident with bruises she would report to the nurse immediately	2 830		

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2 830	Continued From page 14	2 830		

to ensure the nurse assessed the bruising. Although NA-B stated they would report bruises to the nurse immediately, the clinical record lacked evidence R75's bruises were reported and assessed.

On 1/9/14, at 7:30 a.m. observed R75 sitting on couch in the middle lounge eyes closed, R75's forearms and bruises were visible at the time.

R75's diagnoses included dementia, personal history of falls, Alzheimer's disease, and macular degeneration of retina obtained from the significant Minimum Data Set dated 9/20/13. The MDS indicated R75 to had severe cognitive impairment and require extensive assistance for all activities of daily living. The Care Area Assessment (CAA) dated 10/4/13, indicated R75 was at potential risk for pressure ulcers related to needing extensive assist with bed mobility at times. The CAA indicated R75 had a diagnosis of dementia and was not always able to make her needs known. The Pressure Ulcer CAA lacked R75's risk for bruising due to being a wanderer.

The skin integrity care plan dated 11/20/12, identified R75 was at risk for impaired skin integrity due to always being incontinent of bladder and occasionally incontinent of bowel. The care plan identified R75 was a fall risk and had self care deficits related to dementia. The goal indicated, "Skin will remain intact" and directed to "monitor for skin changes during baths/showers, during am/pm cares and notify the nurse."

Review of R75's Progress Notes revealed on 11/25/13, 12/2/13, and 12/16/13, old bruising had been noted on both of R75's forearms. A nursing Progress Note dated 1/9/14 (after concern had

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2 830	Continued From page 15 been brought to the attention of facility staff by the surveyor), indicated R75 had eight bruises to both arms. The note indicated the measurements of the bruises were as follows: - right upper forearm 6 centimeter (cm) x 8 cm; - right mid forearm 3 cm 1 cm; - right wrist 2 cm x 2.5 cm; - below right index finger 4 cm x 2.5 cm; - at base of right thumb 3 cm x 1 cm; - left upper forearm 5 cm x 5.5 cm; - left mid forearm 5 cm x 3 cm; - area to left wrist/top of hand 5 cm x 3 cm. Although the condition of bruising was documented on the above dates, the medical record lacked evidence R75's current bruises were assessed and measures were put in place to prevent further bruising. On 1/9/14, at 8:40 a.m. the registered nurse clinical coordinator (RN)-D stated, "I am supposed to be notified and my boss [director of clinical services, DCS], of any bruises or falls immediately. For the bruises of unknown origin, the nurses are supposed to measure, document and start the investigation." She further stated all residents skin was supposed to be checked weekly with bath/shower and the nurses were supposed to document the resident skin condition with cares. RN-D stated if anything was noted it needed to be addressed immediately. The RN-D confirmed both of R75's forearms had dark purple bruises and verified the bruises were at different stages of healing. On 1/9/14, at 9:42 a.m. DCS stated all bruises are supposed to be documented by the nurses. She further stated the nurses are supposed to let the clinical coordinator know to update the care plan and monitor the skin issue every shift until resolved.	2 830		

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2 830	Continued From page 16 On 1/9/14, at 2:10 p.m. the RN-D stated she was not aware R75 had the bruising and one thing for sure R75 was a wanderer and may have bumped or ran into something causing the bruising but stated if she was aware she would have updated the care plan. On 1/9/14, at 3:03 p.m. DCS was interviewed stated she was not aware of R75's bruises and as soon as the bruising had been brought to her attention, resident bruises were assessed and interventions have been put in place. The Skin Care Protocol dated May 2013, directed if bruises are noted during daily cares or during weekly skin check the clinical or DON will be updated immediately. In addition, the policy indicated a resident care interventions will be provided based on nursing assessment and application of the nursing process for the resident identified as being at risk for altered skin integrity. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure compliance to ensure necessary care and services for residents. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 830		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status	2 965		

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2 965	Continued From page 17 Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement a new diet order for 1 of 3 residents (R99) reviewed for nutrition. Findings include: R99's diet order was changed from a limited high sodium, fat and cholesterol diet to a regular diet on 1/7/14, but was observed to not be implemented on 1/9/14. R99 was assessed to be at nutritional risk by the facility due to weight loss and a low body mass index (BMI, a number calculated from a person's weight and height used as a screening tool to identify possible weight problems for adults). R99's weight was 88 pounds and the BMI was 16.8 on 1/8/14. According to the Centers for Disease Control (CDC) website, date of reference 1/10/14, a BMI of below 18.5 indicates a person to be underweight. A Physician's Order dated 1/7/14, directed to give R99 a nutritional supplement and, ...ok for regular diet.	2 965		

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2 965	Continued From page 18 On 1/9/14, at 12:25 p.m. R99 was observed in the dining room at a large table eating lunch and socializing. R99 had milk and water. The meal served was tomato soup with crackers, fresh fruit and a cookie. R99 was observed to eat 100% of the tomato soup, 100% of the milk and cookie and 25% of the fresh fruit. On 1/9/14, at 12:30 p.m. the dietary aide (DA)-A was asked how they ensured residents received the correct diet, DA-A showed the surveyor a chart, taped to the wall in the kitchen, which listed each residents name and prescribed diet. R99 was listed as requiring a limited high sodium/fat/cholesterol diet with texture of regular. DA-A confirmed R99 did not receive the regular diet. On 1/9/14, at 12:44 p.m. licensed practical nurse (LPN)-A checked the diet orders in the electronic medical record and noted R99 had been on a limited diet with regular texture. LPN-A then found the regular diet order from 1/7/14 and stated she would have to clarify the order. At 12:57 p.m. LPN-A confirmed R99 should have been receiving a regular diet with regular texture starting on 1/7/14. At 1:01 p.m. R99's physician (MD)-A clarified and confirmed the diet order was regular starting on 1/7/14. A nutritional assessment dated 1/6/14, noted R99's low BMI as a concern and identified their ideal body weight range as 95-115. The assessment also noted R99 was independent with intake and documented intakes at meals were fair (50%). The assessment included "will provide diet as ordered." On 1/9/14, at 1:50 p.m. the director of clinical services (DCS) was made aware R99's diet order	2 965		

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2 965	Continued From page 19 was changed to a regular diet on 1/7/14, and the kitchen still had R99 listed as needing a limited diet. DCS stated she would investigate why the order was not yet implemented. When asked about the process of getting new orders implemented the DCS stated new orders go into the electronic medical record. DCS stated new diet orders also were communicated via emails to a "diet order group" which included the dietary director. On 1/9/14, at 1:55 p.m. the dietary director (DD) was asked about R99's diet order not being changed to a regular diet and not being implemented on 1/7/14, DD stated, "To be honest with you, I didn't check the email." The facility Diet Changes policy dated December 2013, indicated it was the facility policy the dining and nursing departments would communicate to keep all diet orders current, whether initial or a change. The policy indicated all diet changes must be communicated to the dining services department in a timely manner. The staff responsible for transcribing the new order would send an email to facility diet order group. The policy indicated when a diet order changed, a new diet report was printed by dietary for the kitchen and staff for the neighborhood kitchens. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure compliance. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance.	2 965		

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2 965	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 965		
21525	MN Rule 4658.1305 A.B.C Pharmacist Service Consultation A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who: A. provides consultation on all aspects of the provision of pharmacy services in the nursing home; B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility's consultant pharmacist failed to identify irregularities with the use of Seroquel and PRN Haldol (both antipsychotic medications) for 1 of 5 residents (R27) in the sample reviewed for un-necessary medications. Findings include: Physician's orders dated 11/7/13, indicated R27 received quetiapine fumarate (Seroquel) 50 milligrams (mg) by mouth (PO) daily at the hour of sleep (HS); Haldol 0.25 milliliters (ml) PO for "Agitation/restlessness/abusive behaviors" sublingual (under the tongue) every four hours PRN. The Physician's Orders identified R27's	21525		

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diagnoses to include unspecified psychosis, dementia without behavioral disturbance, Alzheimer's disease, and encephalopathy.

The Psychotropic Medication Review dated 11/26/13, identified R27's current psychotropic medications were Seroquel and Haldol. The behaviors and occurrences listed for both medications were, "Refusal of cares: One occurrence on day shift, no occurrences on evening shift, and no occurrences on night shift." The indications for use for both medications were, "Agitation/Restlessness: No occurrences on day shift, one occurrence on evening shift, and no occurrences on night shift." The assessment indicated R27 had no involuntary movement side effects when last assessed on 10/22/13.

Review of the Chemical Restraint assessment dated 11/26/13, indicated the following:
- The assessment identified the medication reviewed was "Trazadone [sic]," with the therapeutic goal of, "Diagnosis is sleep/agitation. Goal is to decrease agitation and increase ability to fall asleep, stay asleep, and increase the number of restful sleep hours."
- Indications for the use of Trazodone were "Sleeplessness, agitation, verbal aggression, inability to redirect."
- The non-pharmacological interventions to address the indications for the use of the medication were "1:1, reassurance, validation of feelings, redirection, provide quiet, dark environment for sleep."
- The efficacy section of the assessment indicated, "No nursing documentation noted that describes agitation or sleeplessness."
- The GDR section of the assessment indicated, "Will address with the physician this quarter."
- The resident input/education section indicated,

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21525	Continued From page 22 "Resident offers no c/o [complaints of] inability to sleep or feeling tired/not rested in the morning." The assessment indicated R27 required no care plan updates "at this time." Although the assessment referred to address the GDR with the physician, the clinical record lacked evidence the physician was consulted regarding a potential GDR. The clinical record lacked evidence a GDR for the use of Seroquel or Haldol was attempted or a reduction was clinically contraindicated. The care plan dated 12/13/13, identified R27 was at risk for behaviors of "(paranoia, restlessness, insomnia, and agitation) r/t [related to] Alzheimer's dementia." The care plan identified, " I [R27] currently receive Seroquel every HS to manage these behaviors. I have a strong personality and try to become involved in other residents personal business at times. I do not always understand that I cannot receive information regarding other residents health and/or care." The care plan directed, "Monitor/Observe for restlessness, agitation, insomnia, and suspiciousness/fearfulness r/t paranoia and notify nurse and MD/NP [medical doctor/nurse practitioner] as needed. Notify Nurse if I resist ADL care or I refuse to eat. Notify MD/NP as needed if I resist taking medications, which could lead to medical decline. Redirect me as needed when I ask questions about other residents. Remind me that I cannot receive information about other residents." The care plan did not identify the use of Trazodone for sleep, lacked a focus for sleep and non-pharmacological interventions to promote sleep. In addition, the care plan lacked direction for monitoring and evaluation of R27's sleep patterns. Review of the Medication Administration Records	21525		

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(MARs) from January 2014 through September 2013 indicated the following:
- The September, October, November and December 2013 MARs indicated Seroquel was offered for the diagnoses of "Alzheimer's Dementia" and Trazodone was offered for "Sleep/Agitation." The MARs indicated both medications were administered as ordered. No PRN Haldol doses were administered.
- The January 2014 MAR indicated scheduled Seroquel and Trazodone medications were both administered as ordered. MAR indicated on 1/1/14, at 5:00 a.m. R27 had PRN Haldol administered.

Review of the Treatment Administration Records (TARs) from January 2014 through September 2013 indicated beginning on 5/28/13, "Hours of Sleep" was monitored. The documentation included the number of hours slept by 6:45 a.m., 2:45 p.m. and 10:45 p.m. The TARs indicated R27 occasionally slept 0.5-1 hour 6:45 p.m., rarely slept 2:45 p.m. and usually had eight hours of sleep documented at 10:45 p.m. The clinical record lacked evaluation of R27s sleep patterns, such as efficacy of Trazodone and R27 usually sleeping for eight hours during the night.

R27's nursing Progress Notes were reviewed from 9/4/13, through 1/8/14 and revealed the following:
- On 9/4/13, at 4:59 a.m. a note indicated, "Hours of Sleep, Did not sleep very well tonight. Up x2 [twice] to void, and incontinent at 0430 [4:30 a.m.]. Offers no complaints of pain, discomfort, states 'one of those nights that cannot fall sleep [sic] well..'" At 7:27 p.m. a note indicated, "Resident was easily agitated today..." and identified R27 asked for "bath soap" from the facility and R27 stating she "pays the bills." The

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note indicated the clinical coordinator was updated and the house supervisor "came to talk to" R27. R27 refused supper after being re-approached twice, R27 grew "agitated and said she was not hungry." The note indicated R27 accepted her shower and had no further behaviors.
- On 9/5/13, at 1:46 p.m. R27 refused to have her weight taken.
- On 9/18/13, at 4:55 p.m. a note indicated, "Resident refused shower tonight. Said she will have it tomorrow. VSS [vital signs stable]." The clinical record did not indicate if the shower was received the next day.
- On 10/23/13, at 10:48 p.m. a note indicated R27 refused the shower.
- On 11/20/13, at 10:53 p.m. a note indicated R27 refused the shower.
- On 12/4/13, at 10:06 p.m. a note indicated R27 refused the shower.
- On 1/1/14, at 5:01 a.m. an "eMAR [electronic medication administration record]-Medication Administration Note indicated, "PRN Administration was: Effective." The note did not identify the PRN medication administered, why the medication was administered and how the medication was effective.
The clinical record lacked documented evidence of clinical indications for the ongoing use of the antipsychotic medications.

The Monthly Medication Regimen Review indicated from 4/23/13, to 12/18/13, the consultant pharmacist reviewed R27's medication regiment. On 4/23/13, the use of Quetiapine (Seroquel) and Trazodone were identified. On 11/20/13, the consultant pharmacist identified no PRN Haldol was administered from 11/1/13 - 11/19/13, and to check the psychotropic documentation in one to two months. The

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21525	Continued From page 25 consultant pharmacist documentation did not identify irregularities with R27's medication regimen. On 1/9/14, at 2:31 p.m. the consultant pharmacist (CP)-F was contacted via telephone and verified the indications for the use of PRN Haldol and Seroquel should be "expanded on." CP-F stated she had alerted the facility the Target Behavior monitoring needed to be "expanded on." CP-F verified restlessness and agitation was not enough of a clinical indication for use and stated the reasons should have been noted on review. Stated indications for use, target behavior monitoring and determining GDR was audited by the pharmacy, but was unclear if R27 was included in the audit. CP-F verified the sleep monitoring should have been evaluated to determine efficacy of Trazodone. On 1/10/14, at 9:04 a.m. the director of clinical services (DCS) verified CP-F was responsible to review target behaviors and identify irregularities "they've [consultant pharmacists] done that in the past." DCS verified the CP-F was not an active member of the Quality Assessment and Assurance committee. "After this, she will be." The facility's Psychotropic Medications and Monitoring policy and procedure dated 8/2012, identified all residents receiving a medication "to alter behavior" were to have an "approved diagnosis" and "reason for use" of the medication. The policy indicated there should be a "therapeutic goal, and symptoms monitored." - The policy further indicated, "The drug chosen should be administered in the lowest dose possible only after non pharmaceutical interventions to control/alter the behavior have been attempted." The procedure identified	21525		

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appropriate non pharmaceutical interventions to attempt, directed to obtain "an approved therapeutic goal" and diagnosis from MD/NP "as related to the behavior altering medication."
- The procedure directed to determine target behaviors to monitor and "B. Behaviors must be specific and appropriate to the drug ordered. Agitation, anxiety, abusive, etc. need further explicit behaviors identified." In addition, the procedure directed, "C. Behaviors for use of antipsychotic medication must potentially be distressful or harmful to self or others" and listed examples such as physical aggression "(hitting, kicking, hurting self or others, destroying property, physical sexual advances)," physical non-aggression behaviors "(pacing, disrobing, trying to leave without authorization)," verbally agitated behaviors "(screaming, cursing, verbal sexual advances, etc.)" The procedure directed to document on the "target behavior form" each shift and identified the "Clinical Coordinator" would be responsible to evaluate the target behavior forms and the Psychotropic Medication Quarterly Review would be utilized to assess the effect of psychotropic medications.
- The policy indicated, "F. Symptom(s) for antidepressant use must be identified and addressed on the CPL (care plan); antidepressants should be evaluated with each RAI (Resident Assessment Instrument, MDS and CAAs) and documented in the residents' chart.
- The policy indicated dosage reductions of psychoactive medications would be attempted per "regulation;" could be initiated by MD/NP, pharmacy review, case manager, the resident and/or the family. The policy indicated if MD/NP "does not agree to dosage reduction, the rationale will be documented by the MD/NP."

SUGGESTED METHOD OF CORRECTION:

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21525	Continued From page 27 The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure compliance. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21525		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change.	21535		

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21535	Continued From page 28 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate clinical indications for the ongoing use of Seroquel (Quetiapine Fumarate, an antipsychotic) and as needed (PRN) Haldol (haloperidol, an antipsychotic), failed to monitor for efficacy and failed to assess for a potential gradual dosage reduction (GDR) of the antipsychotic medications; the facility failed to evaluate sleep for the ongoing use of Trazodone (an antidepressant medication used to treat sleep problems) (R27); the facility failed to assess and monitor the ongoing use of scheduled Seroquel (R63); for 2 of 5 residents (R27, R63) in the sample reviewed for un-necessary medications. Findings include: R27 received scheduled Seroquel and PRN Haldol without appropriate clinical indications for ongoing use, lacked appropriate target behavior monitoring and lacked evaluation to determine if a potential GDR for the use of the antipsychotics was warranted; although the facility monitored R27's sleep, the facility did not evaluate the sleep to determine the efficacy of ongoing scheduled Trazodone use. Physician's orders dated 11/7/13, indicated R27 received quetiapine fumarate (Seroquel) 50 milligrams (mg) by mouth (PO) daily at the hour of sleep (HS); Haldol 0.25 milliliters (ml) PO for "Agitation/restlessness/abusive behaviors" sublingual (under the tongue) every four hours PRN; Trazodone HCl 25 mg PO twice daily and 50 mg PO every HS. The Physician's Orders	21535		

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identified R27's diagnoses to include unspecified psychosis, dementia without behavioral disturbance, Alzheimer's disease, and encephalopathy.

The significant change Minimum Data Set (MDS) dated 6/6/13, identified R27 had moderate cognitive impairment, no mood or behavior problems and indicated R27 was independent with all activities of daily living (ADLs).
- The Care Area Assessment (CAA) for psychotropic drug use dated 6/11/13, indicated, "Resident receives an antipsychotic medication for a diagnosis of psychosis and an antidepressant for a diagnosis of Alzheimer's Dementia and psychosis. Per previous facility resident has had agitation, restlessness and abusive behaviors, which none have been exhibited since admission here. Will monitor medication side effects and look at gradual dose reduction [GDR] as indicated." Although the CAA indicated the diagnosis of psychosis was used for Seroquel, the CAA did not address resident specific behaviors associated with the diagnosis, such as paranoia or hallucinations. The diagnoses for the use of Trazodone did not include sleep/insomnia and inappropriately identified Alzheimer's (not a psychiatric condition) and psychosis as the diagnoses for the antidepressant. The CAA did not identify factors which warranted a potential GDR, such as lack of indications to warrant the use of the medication. The clinical record lacked further evidence a GDR was considered.
- The CAA for ADL functional/rehabilitation Potential dated 6/11/13, indicated R27's cognition had declined, she remained independent with ADLs and R27 had been recently discharged from Hospice.
- The CAA for falls dated 6/11/13, indicated R27

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had sustained no falls since admission, but remained at risk for falls. The CAA further indicated, "Resident also takes scheduled Trazodone throughout the day which could contribute to falls for resident. Staff is monitoring for side effects."
- The CAA for cognitive loss/dementia dated 6/19/13, identified R27's decline in cognition and indicated, "Resident does have a diagnosis of dementia and cognition fluctuates."

R27's physician's Progress Notes indicated:
- On 9/5/13, the nurse practitioner (NP) had seen R27 and, "Patient offers no concerns or complaints." The note indicated, "Psychiatric: Mood, memory, affect and judgement normal." The note further indicated, "Currently on haldol [sic] PRN and Quetiapine. Uses trazaDCSe [sic] for sleep...Since last visit, patient has been removed from hospice [sic]."
- On 10/11/13, the medical doctor (MD) had seen R27 and identified, "Psychiatric: Her behavior is normal. Dementia: Stable no behavioural [sic] isses [sic] noted. Pt [patient] does not to [sic] have haldol [sic]" Although the Progress Note from 9/5/13, identified R27 was no longer on Hospice, the MD Progress Note contradicted, "Pt on hospice no new concerns."
- On 11/22/13, the NP indicated R27 offered no new complaints, R27 felt "'discouraged sometimes that things are so slow around here [the facility].'" The note indicated, "Dementia - No behaviors reported from staff. Pt unable to recall any previous visits from MD or NP, however. 'Have people been meeting behind my back?'" Although the physician's progress notes appropriately reviewed R27's mood, behavior and psychiatric data, the documentation reflected lack of indication for the ongoing use of antipsychotic medication. The notes lacked review of R27

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21535	Continued From page 31 sleep and Trazodone use. The quarterly MDS dated 11/26/13, indicated no changes in R27's cognition, R27 had mood problem of "feeling tired or having little energy;" had the behavior of "rejecting cares" occur 1-3 days during the assessment period; R27 remained independent with all ADLs. The Psychotropic Medication Review dated 11/26/13, identified R27's current psychotropic medications were Seroquel and Haldol. The behaviors and occurrences listed for both medications were, "Refusal of cares: One occurrence on day shift, no occurrences on evening shift, and no occurrences on night shift." The indications for use for both medications were, "Agitation/Restlessness: No occurrences on day shift, one occurrence on evening shift, and no occurrences on night shift." The assessment indicated R27 had no involuntary movement side effects when last assessed on 10/22/13. Although the review indicated a review of the behaviors, the behaviors were not appropriate for antipsychotic use and did not reflect appropriate indications for use. In addition, although the review identified low numbers of the target behaviors, the review did not address a potential GDR of the antipsychotic medications. Review of the Chemical Restraint assessment dated 11/26/13, indicated the following: - The assessment identified the medication being reviewed was "TrazaDCSe," with the therapeutic goal of, "Diagnosis is sleep/agitation. Goal is to decrease agitation and increase ability to fall asleep, stay asleep, and increase the number of restful sleep hours." - Indications for the use of Trazodone were "Sleeplessness, agitation, verbal aggression,	21535		

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inability to redirect."
- The non-pharmacological interventions to address the indications for the use of the medication were "1:1, reassurance, validation of feelings, redirection, provide quiet, dark environment for sleep."
- The efficacy section of the assessment indicated, "No nursing documentation noted that describes agitation or sleeplessness."
- The GDR section of the assessment indicated, "Will address with the physician this quarter."
- The resident input/education section indicated, "Resident offers no c/o [complaints of] inability to sleep or feeling tired/not rested in the morning."
The assessment indicated R27 required no care plan updates "at this time."
Although the assessment referred to address the GDR with the physician, the clinical record lacked evidence the physician was consulted regarding a potential GDR for Trazodone. The clinical record lacked evidence the use of Seroquel and PRN Haldol were assessed as potential chemical restraints or if a GDR for the use the antipsychotic medictaions was attempted. The clinical record lacked documented evidence why a GDR was clinically contraindicated for R27. In addition, the assessment inappropriately included antipsychotic indications such as "agitation, verbal aggression, inability to redirect" for the use of Trazodone (an antidepressant medication).

The care plan dated 12/13/13, identified R27 was at risk for behaviors of "(paranoia, restlessness, insomnia, and agitation) r/t [related to] Alzheimer's dementia." The care plan identified, " I [R27] currently receive Seroquel every HS to manage these behaviors. I have a strong personality and try to become involved in other residents personal business at times. I do not always understand that I cannot receive

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information regarding other residents health and/or care." The care plan directed, "Monitor/Observe for restlessness, agitation, insomnia, and suspiciousness/fearfulness r/t paranoia and notify nurse and MD/NP [medical doctor/nurse practitioner] as needed. Notify Nurse if I resist ADL care or I refuse to eat. Notify MD/NP as needed if I resist taking medications, which could lead to medical decline. Redirect me as needed when I ask questions about other residents. Remind me that I cannot receive information about other residents." Although the Chemical Restraint assessment indicated no care plan update was warranted on 11/26/13, R27's care plan did not identify the use of Trazodone for sleep, lacked a focus for sleep and non-pharmacological interventions to promote sleep. In addition, the care plan lacked direction for monitoring and evaluation of R27's sleep patterns. Although the care plan identified a "risk for behaviors" of paranoia, restlessness, insomnia, and agitation diagnoses; the care plan did not identify current behaviors warranting the use of antipsychotic medication or resident specific behaviors to reflect the above listed diagnoses.

During all dates of the survey 1/7/14, through 1/10/14, R27 was observed to have no behavioral concerns, was pleasant and interacted appropriately with staff and other residents.

Review of the Medication Administration Records (MARs) from January 2014 through September 2013 indicated the following:
- The September, October, November and December 2013 MARs indicated Seroquel was offered for the diagnoses of "Alzheimer's Dementia" and Trazodone was offered for "Sleep/Agitation." The MARs indicated both

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medications were administered as ordered. No PRN Haldol doses were administered.
- The January 2014 MAR indicated scheduled Seroquel and Trazodone medications were both administered as ordered. MAR indicated on 1/1/14, at 5:00 a.m. R27 had PRN Haldol administered. The MAR did not indicate why the PRN antipsychotic was administered to R27.

Review of the Treatment Administration Records (TARs) from January 2014 through September 2013 indicated beginning on 5/28/13, "Hours of Sleep" was monitored. The documentation included the number of hours slept by 6:45 a.m., 2:45 p.m. and 10:45 p.m. The TARs indicated R27 occasionally slept 0.5 -1 hour 6:45 p.m., rarely slept by 2:45 p.m. and usually had eight hours of sleep documented at 10:45 p.m. The clinical record lacked evaluation of R27s sleep patterns, such as efficacy of Trazodone and R27 usually sleeping for eight hours during the night.

R27's nursing Progress Notes were reviewed from 9/4/13, through 1/8/14 and revealed the following:
- On 9/4/13, at 4:59 a.m. a note indicated, "Hours of Sleep, Did not sleep very well tonight. Up x2 [twice] to void, and incontinent at 0430 [4:30 a.m.]. Offers no complaints of pain, discomfort, states 'one of those nights that cannot fall sleep [sic] well..'" At 7:27 p.m. a note indicated, "Resident was easily agitated today..." and identified R27 asked for "bath soap" from the facility and R27 stating she "pays the bills." The note indicated the clinical coordinator was updated and the house supervisor "came to talk to" R27. R27 refused supper after being re-approached twice, R27 grew "agitated and said she was not hungry." The note indicated R27 accepted her shower and had no further

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21535	Continued From page 35 behaviors. - On 9/5/13, at 1:46 p.m. R27 refused to have her weight taken. - On 9/18/13, at 4:55 p.m. a note indicated, "Resident refused shower tonight. Said she will have it tomorrow. VSS [vital signs stable]." The clinical record did not indicate if the shower was received the next day. - On 10/23/13, at 10:48 p.m. a note indicated R27 refused the shower. - On 11/20/13, at 10:53 p.m. a note indicated R27 refused the shower. - On 12/4/13, at 10:06 p.m. a note indicated R27 refused the shower. - On 1/1/14, at 5:01 a.m. an "eMAR [electronic medication administration record]-Medication Administration Note indicated, "PRN Administration was: Effective." The note did not identify the PRN medication administered, why the medication was administered and how the medication was effective. The clinical record lacked documented evidence of clinical indications for the ongoing use of the antipsychotic medications. On 1/9/14, at 1:13 p.m. the licensed practical nurse (LPN)-B stated target behavior monitoring was documented in a light blue binder labeled "LH Nursing Documentation." The Behaviors tab of the binder included Target Behavior Forms for documentation of target behaviors. The forms for R27 indicated the resident was monitored for the target behaviors related to "Seroquel/Haldol" use. The target behaviors information included direction to "Document freq [frequency] per shift.": - In September 2013, on 9/4/13, the documentation indicated a "+ [plus sign]" was documented for "Agitation/restlessness" on the evening shift; a "+" was documented for "Refusal of care" on the day shift of 9/5/13. Although the	21535		

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21535	Continued From page 36 "+" indicated the behavior occurred, the documentation did not include the number of times the behavior occurred (frequency). The documentation for the rest of the month indicated R27 had no further behaviors for the month of September. - In both October and November 2013, the documentation indicated all hash marks for both target behaviors of "Refusal of cares" and "Agitation/Restlessness." R27 had no target behaviors identified in the months of October and November. - In December 2013, the documentation indicated all hash marks for both target behaviors the entire month. Although only "Refusal of cares" and "Agitation/Restlessness" were identified as the target behaviors being monitored, the documentation indicated staff documented hash marks and initialed for target behaviors not specified for R27. Spaces for both target behaviors were blank. No target behaviors were identified in the month of December. - In January 2014, R27 was monitored for refusal of cares and agitation/restlessness. The form indicated no documentation for any shift from 1/1/4 thru 1/3/14. A "-" (hash mark) was documented sporadically the rest of the month; No target behaviors were identified in early January 2014. The target behavior monitoring indicated R27 had little to no behavioral problems since September 2013 through January 2014 (for approximately four months) and did not support the ongoing use of antipsychotic medications. On 1/9/14, at 2:01 p.m. LPN-B and the clinical coordinator (RN)-B, were interviewed together. - When asked if R27 had received PRN Haldol, both staff verified PRN Haldol was administered to R27 on 1/1/14.	21535		

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21535	Continued From page 37 - When LPN-B was asked what target behaviors were monitored in relation to the use of the antipsychotic medications, LPN-B stated staff would "look for agitation, restlessness," and described these as, "If she's [R27's] getting antsy." LPN-B further gave examples for restlessness as "pacing, rummaging, getting into all sorts of things;" for agitation LPN-B described R27 as being "upset" and staff would observe for "non-verbal communication" such as "doing something with your hands." - When asked what the indication for administering PRN Haldol was, LPN-B verified there was a note in the clinical record identifying the medication was "effective," LPN-B verified the clinical record did not include a behavior warranting the use of the drug. - When asked the meaning of the hash marks in the documentation, LPN-B stated the hash mark was a "negative" and a "plus sign [+]" indicated a behavior occurred and we "put a progress note on it." - RN-B verified the indications for use and target behavior monitoring were not resident specific, verified the indications for the use of PRN Haldol were not resident specific. RN-B stated R27 was admitted to the facility enrolled in Hospice and had an order for Haldol which was "not discontinued." - RN-B verified she was unclear when R27 was assessed for GDR with the use of antipsychotics. RN-B stated GDRs were addressed either on the "Chemical Restraint or Psychotropic Assessments." RN-B confirmed the assessments did not indicate a GDR was attempted, did not indicate if the physician was notified of a potential GDR and verified the clinical record lacked clinical rational why a GDR was clinically contraindicated. - RN-B verified R27's sleep was tracked, but was	21535		

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unclear which facility staff were supposed to monitor and evaluate the sleep data to determine efficacy of the Trazodone. RN-B verified the clinical record lacked documented evidence R27's sleep or the use of Trazodone had ever been evaluated.

On 1/9/14, at 2:31 p.m. the consultant pharmacist (CP)-F was contacted via telephone and verified the indications for the use of PRN Haldol and Seroquel should be "expanded on." CP-F stated she had alerted the facility Target Behavior monitoring needed to be "expanded on." CP-F verified restlessness and agitation was not enough of a clinical indication for use and stated the reasons should have been noted on review. CP-F stated indications for use, target behavior monitoring and determining GDR was audited by the pharmacy, but was unclear if R27 was included in the audit. CP-F verified the sleep monitoring should have been evaluated to determine the ongoing efficacy of Trazodone.

On 1/10/14, at 9:04 a.m. the director of clinical services (DCS) stated when determining indications for use of a psychotropic medication, she would "look at the behaviors" and determine "what she [R27] was doing" and "how it [behavior] affected her or others" and determine resident specific target behaviors for monitoring. DCS verified restlessness and agitation were not resident specific indications for the ongoing use of Seroquel and PRN Haldol. DCS confirmed indications for the administration of the PRN Haldol on 1/1/14, should have been documented; target behavior monitoring should be reviewed by the clinical coordinator quarterly during the MDS assessments and between the MDS assessment periods, target behavior monitoring should be reviewed by the nurses. DCS verified R27 had no

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behaviors documented to warrant the ongoing use of the antipsychotics. DCS verified Trazodone sleep logs should be evaluated quarterly to determine efficacy of the medication and verified the clinical record lacked evaluation for R27.

The facility's Psychotropic Medications and Monitoring policy and procedure dated 8/2012, identified all residents receiving a medication "to alter behavior" were to have an "approved diagnosis" and "reason for use" of the medication. The policy indicated there should be a "therapeutic goal, and symptoms monitored."
- The policy further indicated, "The drug chosen should be administered in the lowest dose possible only after non pharmaceutical interventions to control/alter the behavior have been attempted." The procedure identified appropriate non pharmaceutical interventions to attempt, directed to obtain "an approved therapeutic goal" and diagnosis from MD/NP "as related to the behavior altering medication."
- The procedure directed to determine target behaviors to monitor and "B. Behaviors must be specific and appropriate to the drug ordered. Agitation, anxiety, abusive, etc. need further explicit behaviors identified." In addition, the procedure directed, "C. Behaviors for use of antipsychotic medication must potentially be distressful or harmful to self or others" and listed examples such as physical aggression "(hitting, kicking, hurting self or others, destroying property, physical sexual advances)," physical non-aggression behaviors "(pacing, disrobing, trying to leave without authorization)," verbally agitated behaviors "(screaming, cursing, verbal sexual advances, etc.)" The procedure directed to document on the "target behavior form" each shift and identified the "Clinical Coordinator" would be

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21535	Continued From page 40 responsible to evaluate the target behavior forms and the Psychotropic Medication Quarterly Review would be utilized to assess the effect of psychotropic medications. - The policy indicated, "F. Symptom(s) for antidepressant use must be identified and addressed on the CPL (care plan); antidepressants should be evaluated with each RAI (Resident Assessment Instrument, MDS and CAAs) and documented in the residents' chart. - The policy indicated dosage reductions of psychoactive medications would be attempted per "regulation;" could be initiated by MD/NP, pharmacy review, case manager, the resident and/or the family. The policy indicated if MD/NP "does not agree to dosage reduction, the rationale will be documented by the MD/NP." R63 received Seroquel 25 mg every Friday and the facility failed to identify, assess and monitor for ongoing use of the medication. The Admission Record for R63 dated 12/4/13, included diagnoses of dementia, aphasia, and depression. The Order Summary Report dated 1/9/14, revealed R63 was prescribed Seroquel 25mg every bedtime and 25mg every Friday for anxiety to be given before bath/shower on Friday mornings. The every Friday Seroquel orders dated 8/13/13, included directions of may try bed bath/sponge bath instead. R63 also had a physician ' s order for Ativan (an anti-anxiety medication) 0.25mg for anxiety 30 minutes prior to dental procedure. R63's annual MDS dated 11/5/13, established R63 had severely impaired cognitive skills for	21535		

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daily decision making, responded to simple direct communication only, required physical help of one person for transfer only with bathing. The MDS indicated rejection of care did not occur. The Care Area Assessment (CAA) for behaviors dated 11/5/13, indicated R63 had a diagnosis of dementia with agitation, R63 had some behaviors with daily cares and behaviors that required Seroquel use. The CAA noted R63 would make statements of staff trying to kill her or wanting her dead when staff attempted to give her medications and noted some anxiety in regards to bathing. The psychotropic medication CAA dated 11/5/13, identified R63 was receiving Seroquel for dementia with agitation. The CAA did not address any non-pharmacological interventions being used for R63. The communication CAA dated 11/5/13, indicated R63 was not always able to make her needs known.

The bathing care plan dated 11/6/13, indicated R63 had a history of refusing showers, becoming very agitated and upset during the shower activity and identified R63 did not like water on her head. The care plan directed staff to administer a psychotropic medication prior to shower, directed not to wash R63's hair with the bath, directed to provide a calm approach and offer reassurance during the shower. The care plan directed to re-approach at a later time if R63 became agitated or upset. The care plan did not include direction to offer a bed bath to R63.

Review of R63's Progress Notes indicated the following:
- On 7/26/13, the note indicated R63 continued to get very agitated during the shower and seemed very distressed at the mention of shower.
- On 8/2/13, the note indicated R63 was very agitated during the shower, verbally very

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aggressive to staff assisting with shower.
- On 8/3/13, the note indicated R63 seemed upset all shift, the writer gathered from listening to resident she "felt staff hated her" since receiving shower "on evening shift last night." " Will update nurse practitioner [NP] to see if a small dose of Ativan would be appropriate before showers to reduce agitation and anxiety."
- On 8/9/13, the note indicated R63 did not receive shower, became anxious and agitated at mention of shower, pleaded with writer to let her go to bed after supper. Noted anxiety for shower getting worse each week.
- On 8/16/13, noted R63 to be verbally and physically aggressive with staff during shower. The note indicated the shower was upsetting for R63 every week.
- On 8/23/13, the note indicated R63's shower was given, resident was very upset after shower, swearing and striking out at staff.
- On 9/13/13, the note indicated an extra dose of Seroquel was given to R63. The shower was not given, R63 was "very agitated and verbally aggressive at mention of shower," and indicated R63 refused to enter spa room and told staff "you got me last time, not today."
- On 9/20/13, the note indicated Seroquel was given prior to R63's shower. The note indicated R63 was still physically and verbally aggressive during the shower.
- On 9/27/13, the note indicated Seroquel was given at 5:00 p.m., R63 was still physically and verbally aggressive.
- On 10/4/13, the note indicated Seroquel was given prior to the shower. At mention of shower R63 became "very anxious," restless and verbally and physically aggressive. The note discribed R63 as very upset after the shower and crying to the point she started having emesis (vomited). The note indicated attempts to calm R63 agitated

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT OXBOW LAKE	5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 43	21535		

her further. The note indicated R63 calmed down when staff left her alone.
- On 10/25/13, the note indicated R63 was given a shower and verbal aggression was still noted.

A physician Progress Note dated 9/6/13, indicated a nursing concern of non-cooperative behavior with cares, was getting aggressive at times and noted R63 had been on Seroquel with no changes.

A nurse practitioner Progress Note dated 10/8/13, noted staff reported behavioral issues with bathing and noted R63 received Seroquel 25 mg every bedtime, 12.5mg as needed for agitation and 25mg prior to weekly bath.

The Target Behavior Forms from August 2013 - January 2014, indicated R63 had target behaviors of increased rambling speech, verbally agitated, and yelling out. Behaviors with bathing were not included for monitoring.

When interviewed on 1/8/14, at 9:03 a.m. family member (FM)-A reported R63 had problems with bathing and did not like to take baths or showers. FM-A stated R63 would become very upset during and after bathing. FM-A further stated R63 used to take showers regularly without problems and did not know what had caused the change.

On 1/9/14, at 9:24 a.m. nursing assistant (NA)-A stated R63 did not like water and would scream, kick, yell and call angry names with showers. NA-A reported noting no difference in R63's behaviors since Seroquel was started and stated R63 now needed two staff members to assist with a shower. NA-A further stated when she gave R63 a bed bath, R63 was "happy." At 9:34 a.m.

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21535	Continued From page 44 registered nurse (RN)-A stated R63 would get very upset, verbally and physically abusive during baths, and verified the behavior had not improved since the Seroquel was started on 8/13/13. RN-A stated R63 was much calmer with a bed bath. On 1/9/14, at 9:57 a.m. the clinical coordinator (RN)-B stated R63's family had requested Ativan (an anti-anxiety medication), but the staff wanted to use Seroquel. RN-B stated she had not seen any notes about behaviors with baths and if staff "doesn't tell" her, she "doesn't know." RN-B reported R63 got a shower weekly versus a bed bath per her family's request. On 1/9/14, at 12:27 p.m. FM-A was interviewed again and stated it was not a family request R63 got a shower every week and stated she did not know a bed bath was an option. FM-A reported she noted R63 was still very upset when she visited the day after her showers. On 1/9/14, at 12:39 p.m. the director of clinical services (DCS) stated weekly residents do not need to have a shower and if a bed bath was more comfortable for them, that was "their choice." The DCS stated she would expect alternatives to be used prior to using an antipsychotic for bathing. On 1/9/14, at 1:44 p.m. R63's physician (MD)-A stated he ordered Seroquel for R63 because he did not like the side effects of benzodiazepines. MD-A further stated he used Seroquel because that was what he usually used in nursing homes. MD-A stated he would expect facility staff to explain things to residents to increase their comfort before starting any medications for behavior.	21535		

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21535	Continued From page 45 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure compliance. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21535		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the	21630		

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21630	Continued From page 46 witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure Fentanyl patches were destroyed in a manner to prevent potential diversion for 1 of 1 resident (R27). Findings include: During the medication pass observation, the following was randomly observed: On 1/9/14, at 7:28 a.m. the licensed practical nurse (LPN)-B stated she had to apply a Fentanyl patch and offer an oral Percocet to R27. LPN-B was observed to remove one sealed Fentanyl patch from a box, two sealed patches were observed to remain in the box. LPN-B counted the patches and recorded the number of Fentanyl patches and Percocet in the Individual Narcotic Record. - At 7:33 a.m. LPN-B opened the patch, wrote date and initials on the patch. - At 7:39 a.m. LPN-B entered R27's room and explained the medications to R27. LPN-B handed the Percocet, a full glass of water to R27, who took the medication and drank the water. LPN-B then retrieved gloves, removed the old Fentanyl patch from R27's left shoulder/back area and applied the new patch to the right shoulder/back area. LPN-B was observed to place the spent patch in the empty package. LPN-B left the room and returned to the nurses station, opened the cupboard under the sink and bent to place the spent patch and Fentanyl patch package in a Sharps container (a plastic container used to dispose of sharp hazardous equipment such as	21630		

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21630	Continued From page 47	21630		

used medication needles). LPN-B stated the container was "full" and stated she would use the Sharps container at the other second floor nursing station. LPN-B carried the spent patch over to neighboring unit nursing station and placed the spent Fentanyl patch in the Sharps container under the sink. LPN-B was observed to be alone and did not seek out another nurse to witness the disposal of the narcotic patch.
- At 8:30 a.m. LPN-B stated she was trained to dispose of the Fentanyl patch in the Sharps container and stated she was aware of other facility policies to dispose of the patches differently, "I was told there could be fines for putting anything other than Sharps in the container." LPN-B was unclear on the actual policy and stated she was going to ask the clinical coordinator (RN)-B "right now."
- At approximately 8:35 a.m. RN-B was asked by LPN-B (with surveyor present) regarding Fentanyl patch disposal. RN-B stated she believed LPN-B could dispose of the patch in the Sharps container alone.

On 1/9/14, at 9:05 a.m. RN-B provided a copy of the Medications: Controlled Substances policy and procedure dated 5/2005. Review of the policy indicated, "D. Narcotic pain patches that are removed from residents should be disposed of in sharps container or flushed in sewer system." RN-B confirmed the policy directed to dispose the patches in Sharps, but verified the policy directed to dispose of or destroy "narcotics" with two staff. The policy directed to "request another nurse to verify the amount of drug being wasted" and disposal of "medication in the sewer system with nurse/nurse or nurse/TMA [trained medication aide] present to witness the disposal."

On 1/9/14, at 12:27 p.m. the consultant

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21630	Continued From page 48 pharmacist (CP)-F was contacted via telephone. CP-F stated "it was not regulation," but her "recommendation" to have the Fentanyl patches "flushed" and "witnessed" when disposed of. The surveyor explained the facility Medications: Controlled Substances policy to CP-F, CP-F stated she was not familiar with the policy and she had not seen the policy. "That [policy] does not go through me, I'm not part of QA [quality assurance], it's not a requirement." CP-F verified she was not consulted regarding disposal of Fentanyl patches, verified it should be the same as any narcotic and verified there was a high risk for diversion as "there is enough medication left in the patch to cause harm or to give affect/relief." On 1/9/14, at 12:42 p.m. the director of clinical services (DCS) verified Fentanyl patches should be disposed of either in a Sharps container or to "flush them." DCS stated a pharmacist was consulted when the policy was developed, but CP-F was not the same pharmacist. DCS verified the policy identified "narcotics" and the Fentanyl patches should be treated the same. DCS verified the facility had not required a second nurse to witness the destruction of the narcotic patches and verified there was a high risk for diversion of the medication. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure compliance. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance.	21630		

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21630	Continued From page 49 TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21630		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause	21980		

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21980	Continued From page 50 (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to immediately report injuries of unknown origin (bruises and skin tears) to the administrator and the designated State agency (SA); in addition, the facility failed to ensure a resident was protected during investigation of alleged verbal abuse for 3 of 4 residents (R75, R35, R30) reviewed for abuse prohibition. Findings include: INJURIES OF UNKNOWN ORIGIN R75's bruises of unknown origin to both forearms were not immediately reported to the administrator, immediately reported to the SA or thoroughly investigated. On 01/07/14, at 1:44 p.m. R75 was observed to have several dark purple bruises to both forearms at different stages of healing. R75 was unable to explain how she got the bruises.	21980		

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21980	Continued From page 51 - At 5:22 p.m. R75 was observed sitting at the dining room table eating independently. A nursing assistant (NA)-B was sitting between R75 and other resident cuing her to eat. NA-B was not observed to acknowledge or asked R75 about the bruises. On 1/8/14, at 2:27 p.m. NA-B stated if she noticed any resident with bruises, she would report to the nurse immediately to ensure the nurse assessed the bruising. Although NA-B stated she would report bruises immediately, the clinical record lacked evidence the observed bruises were reported. On 1/9/14, at 7:30 a.m. R75 was observed to be sitting on the couch in the middle lounge with her eyes closed. The administrator was observed to be reading the paper outloud to R75 and four other residents. The administrator sat next to R75; R75's forearms and the bruises were clearly visible during the activity. Although the administrator was present and the bruises were clearly visible, the clinical record lacked documented evidence the bruises were identified. R75's significant change Minimum Data Set (MDS) dated 9/20/13, indicated R75's diagnoses included Alzheimer's disease and macular degeneration of the retina. The MDS indicated R75 had severe cognitive impairment and require extensive assistance for all activities of daily living. The Pressure Ulcer Care Area Assessment (CAA) dated 10/3/13, indicated R75 was at risk for pressure ulcers related to dementia, not always being able to verbalize needs. The CAA lacked R75's risk for bruising due to being a wanderer. R75's care plan dated 11/20/12, identified for skin	21980		

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21980	Continued From page 52 integrity, "[R75 was] At risk for impaired skin integrity due to always being incontinent of bladder and occasionally incontinent of bowel, fall risk and self-care deficit related to dementia." The care plan did not identify R75's risk for bruising, but directed to "monitor for skin changes during baths/showers, during am/pm cares and notify the nurse." Although the vision focus identified R75 had potential for change in vision related to macular degeneration; the behavior focus identified R75 wandered around the unit and into other resident rooms, neither focus included how R75 was at risk for injury or bruising. Review of R75's Progress Notes revealed on 11/25/13, 12/2/13, and 12/16/13, old bruising had been noted on both of R75's forearms. A nursing Progress Note dated 1/9/14 (after concern had been brought to the attention of facility staff by the surveyor), indicated R75 had eight bruises to both arms. The note indicated the measurements of the bruises were as follows: - right upper forearm 6 centimeter (cm) x 8 cm; - right mid forearm 3 cm 1 cm; - right wrist 2 cm x 2.5 cm; - below right index finger 4 cm x 2.5 cm; - at base of right thumb 3 cm x 1 cm; - left upper forearm 5 cm x 5.5 cm; - left mid forearm 5 cm x 3 cm; - area to left wrist/top of hand 5 cm x 3 cm. Although the condition of bruising was documented on the above dates, the medical record lacked evidence R75's current bruises were assessed and measures were put in place to prevent further bruising. On 1/9/14, at 8:40 a.m. the registered nurse clinical coordinator (RN)-D stated, "I am supposed to be notified and my boss [director of clinical services- DCS], of any bruises or falls	21980		

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21980	Continued From page 53	21980		

immediately. For the bruises of unknown origin, the nurses are supposed to measure, document and start the investigation." She further stated all residents skin was supposed to be checked weekly with bath/shower and the nurses were supposed to document the resident skin condition with cares. RN-D stated if anything was noted it needed to be addressed immediately. The RN-D confirmed both of R75's forearms had dark purple bruises and verified after looking at both forearms and stated the bruises were at different stages of healing.

On 1/9/14, at 9:42 a.m. DSC stated all bruises were supposed to be documented by the nurses and if the bruise was of unknown origin, the DSC stated she was supposed to be notified immediately or as soon as possible. DSC stated she was to be notified even when she was on call. DSC further stated the nurses were supposed to let the clinical coordinator know to update the care plan and monitor the skin issue every shift until resolved.

On 1/9/14, at 2:10 p.m. clinical coordinator (RN)-D stated she was not aware R75 had the bruises. RN-D stated R75 "was a wanderer" and may have bumped or "ran into something" causing the bruising.

On 1/9/14, at 3:03 p.m. DSC stated R75's bruises were not brought to her attention and she was not aware of the bruises. DSC stated if she had been aware of the bruises, she would have started an investigation immediately, reported it immediately to the administrator and immediately to SA. DSC further stated an investigation had been started and the bruising was reported to SA.

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21980	Continued From page 54 R35 sustained a skin tear to the right wrist on 10/19/13, redness and swelling to the right hand on 10/20/13, and bruising to the right hand of unknown origin on 11/2/13; none of the injuries were immediately reported to the administrator and the SA. The quarterly MDS dated 10/3/13, indicated R35's diagnoses included osteoporosis and history of a close fracture unspecified part upper end humerus. The MDS indicated R35's Brief Interview of Mental Status (BIMS-tool used to measure cognitive status) score was 15 (which indicated intact cognitive status). The MDS in addition indicated R35 required limited to extensive physical assist of one staff with activities of daily living (ADL's), R35 was identified as being unsteady with balance with transitions, was able to walk with without assist and used a walker and/or wheelchair. R35's nursing Progress Notes revealed the following: -On 10/19/13, a skin tear to the right wrist measuring 2 centimeter (cm) x 1.5cm was noted and R35 had reported she had bumped her hand over her walker. Steri-strips were applied and the note indicated staff would continue to monitor. -On 10/20/13, R35's right hand was noted to be red, swollen, warm to touch and the Steri-strips remained intact. R35 denied pain and the note indicated staff would continue to monitor. -On 11/2/13, R35's top of right hand was observed to have one Steri-strip from previous skin tear and hand was bruised, swollen and tender to touch. R35 was not able to explain exactly what happened when asked and stated she was constantly bumping the hand on something. Ice was applied to hand two times during the shift with decreased swelling. The note	21980		

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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) COMPLETE DATE
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revealed staff would continue to monitor R35's needs.
-On 11/3/13, two notes indicated R35's right hand remained swollen/puffy, bruised, warm, and tender to touch and R35 reported pain. Scheduled pain medication and ice were administered and R35 reported relief.
-On 11/4/13, an earlier note indicated top of right hand was bruised, reddened and swollen. Later that same day the bruise was noted to be dark red, measured 35 cm x 15 cm, was swollen all the way down to the fingers. R35 reported pain with range of motion and with pressure. The nurse practitioner (NP) was updated and an x-ray was ordered. The x-ray results dated 11/4/13, indicated there was no evidence of acute bony injury.

On 1/10/14, at 11:11 a.m. DCS stated she would have liked both herself and the administrator to have been notified of the right hand injury. The DCS verified the administrator should have been notified immediately.

On 1/10/14, at 12:33 p.m. the licensed practical nurse (LPN)-C was interviewed via telephone. LPN-C confirmed he worked with R35 on 11/2/13, verified he recalled the bruising incident and was able to recall the nursing Progress note from that day. LPN-C stated there was more swelling, than bruising at the time and stated he had updated the next shift to continue to monitor the right hand. LPN-C confirmed he did not update the supervisor about the condition of R35's right hand. LPN-C stated he asked the NA assigned to R35 regarding the skin issue. LPN-C stated he and the NA both thought the bruise was caused "by the vanity." LPN-C stated R35 had told him she went to the toilet "back and forth" and probably had bumped herself "on something."

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	27752	A. BUILDING: _____ B. WING _____	01/10/2014

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VERBAL ABUSE ALLEGATION
R30 was not protected during an investigation of alleged verbal abuse.

A vulnerable adult (VA) report dated 6/27/13, indicated R30 had reported a nursing assistant (NA) who had worked with R30 the evening before (on 6/26/13) was abusive. The report indicated R30 reported the NA screamed and yelled at R30 that her (R30's) eyes were okay and R30 was "not blind."

An email dated 6/27/13, at 3:45 p.m. from the household coordinator to DSC indicated R30's "reported to me just now" a [NA staff] "who helped her get to bed last night was 'abusive.'" The email discribed the abusive behaviors of "yelling and screaming at her [R30]and telling her that her eyes are okay and that she [R30] is not blind." Although the email indicated the allegation was reported to the DSC, the clinical record lacked evidence the allegation was reported to the administrator immediately, reported to the SA, and lacked evidence the incident was documented in the medical record.

The quarterly MDS dated 10/24/13, indicated R30's diagnoses included dementia and chronic kidney disease. R30's Brief Interview of Mental Status (BIMS-tool used to measure cognitive status) score was 15 (which indicated intact cognitive status).

The vision care plan dated 5/17/13, identified R30 had decreased vision due to macular degeneration and was legally blind. The visual function CAA dated 2/5/13, also identified R30 with an impairment with risk factors including

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21980	Continued From page 57 blindness and dementia. On 1/10/14, at 10:58 a.m. DCS stated the incident was called in by telephone to the SA (versus online reporting) as the facility did not have a Medicare provider number at the time (and could not complete online reports to SA). After the DCS reviewed the VA log, DCS stated the administrator had been notified the same day on 6/27/13, at 4:50 p.m. DCS recalled the incident and stated she would need to "go back" and review the incident. DCS stated during the investigation, "That NA was asked not to take care of her [R30]." DCS further stated during the investigation the NA "went back and apologized to her [R30] too" and the NA continued to work on the unit. When asked how the facility ensured R30 was safe from the alleged perpetrator while they continued worked on the same unit as R30 during the investigation, DCS was unclear how R30 was protected. DCS confirmed the household coordinator should have documented the complaint in the clinical record including the actual report, what the follow up at the time was and that he had reported the incident to his immediate supervisor and herself. Review of the VA log confirmed the administrator had been notified on 6/27/13, at 4:50 p.m. as indicated earlier by DSC during interview. On 1/10/14, at 11:56 a.m. when interviewed about the procedure handling the allegation of abuse, the administrator stated she expected R30 to have been interviewed. The administrator stated this had been done by the clinical coordinator. The administrator added she would have expected the employee in question not to work with R30 providing direct care until education was provided. The administrator verified she would	21980		

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not know if a resident was protected during the investigation if the staff continued to work in the unit unless she was "sitting right there." She further stated the facility had suspended staff during an investigation in the past and verified R30 was not protected during the investigation. The administrator verified R30's incident should have been documented in the clinical record and should have included: the initial complaint, notification, details of the incident and what had been done.

On 1/10/14, at 12:16 p.m. the household coordinator stated usually he would document the basics on the incident/report, who he spoke with, send an email and immediately report to "my supervisors" who were the DCS and administrator. The household coordinator verified the allegation and incident, including reporting to the DSC, was not documented in the medical record. The household coordinator verified he should have documented the incident.

The Incident Report/Falls Scene Investigation policy dated August 2012, indicated the report was completed whenever a resident is involved in an unusual situation, such as a fall, roll onto a matt, (unless it is on care plan that resident intentionally places self on matt), lowered to floor, bruises greater than a quarter, bruises in vulnerable areas ie:groin, breast, face, fingerprint appearing, elopement, resident to resident altercation or unaccounted injuries.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure compliance.
The director of nursing (DON) or designee could educate all appropriate staff on the policies and

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21980	Continued From page 59 procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21980		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies	22000		

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22000	Continued From page 60 and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to implement their abuse prohibition policy regarding immediately reporting bruise and skin tear injuries of unknown origin to the administrator, immediately report to the State agency (SA) and to thoroughly investigate the injury to rule out potential abuse (R75, R35); in addition, the facility failed to protect a resident (R30) during investigation of alleged verbal abuse for 3 of 4 residents (R75, R35, R30) reviewed for abuse prohibition. Findings include: The facility Vulnerable Adult, Reporting of Maltreatment of policy dated 8/28/2013, defined abuse as, "An act against a vulnerable adult that	22000		

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22000	Continued From page 61 constitutes a violation or, an attempt to violate, or aiding, and abetting a violation ..." and further defined unexplained injuries (injuries of unknown source) as, "An injury, which is not associated with an explainable current medical condition." The policy identified bruises, skin tears and fractures as reportable injuries. The procedure directed to report abuse/neglect allegations orally to the appropriate department head and the administrator immediately. The procedure also directed upon receiving an oral or written report of abuse/neglect the director of clinical services (DCS) would review it and determine if to report it externally to the SA immediately. The policy further directed, "e. If staff to resident abuse/neglect is suspected, determine with the involved supervisor and/or appropriate department head if the named employee(s) should be placed on investigative suspension based on the potential of further resident abuse/neglect and/or disruption of the work environment. The employee(s) will be given a notice of investigative leave... pending investigation by the supervisor." INJURIES OF UNKNOWN SOURCE R75's bruises of unknown origin to both forearms were not investigated and reported to the administrator and SA. On 1/7/14 and 1/9/14, R75 was observed to have eight clearly visible dark purple bruises at different stages of healing to both forearms. R75 was unable to explain how she got the bruises and a facility staff was present during the observations. The clinical record lacked evidence the bruises were identified and/or reported immediately to the administrator and SA; the clinical record lacked evidence the bruises were thoroughly investigated.	22000		

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22000	Continued From page 62 Review of R75's Progress Notes dated 11/25/13, 12/2/13, and 12/16/13, indicated R75 had old bruises noted on both forearms. On 1/9/14, at 3:03 p.m. DSC stated R75's bruises were not brought to her attention and she was not aware of the bruises. DSC stated if she had been aware of the bruises, she would have started an investigation immediately, reported it immediately to the administrator and immediately to SA. DSC further stated an investigation had been started and the bruising was reported to SA. R35 skin tear to right wrist and bruise to right hand of unknown origin were not reported to the facility administrator and SA. R35's nursing Progress Notes indicated on 10/19/13, 10/20/13, 11/2/13, and 11/3/13 a skin tear to the right wrist and the right hand redness, bruising, swelling and warm to touch had been noted. The medical record lacked documented evidence the skin tear and bruising of unknown origin had been reported to the administrator and SA for 16 days since the first time the issue had been identified on 10/19/13. The nursing Progress Note dated 11/4/13, indicated top of the right hand was bruised, reddened and swollen. Later that same day the bruise was noted to be dark red, measured 35 cm x 15 cm and was swollen all the way down to the fingers. R35 reported pain with range of motion and with pressure. The nurse practitioner had been updated and an x-ray was ordered. The x-ray results dated 11/4/13, indicated there was no evidence of acute bony injury. On 1/10/14, at 11:11 a.m. DCS stated she would have liked both herself and the administrator to	22000		

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22000	Continued From page 63 have been notified of the right hand injury. The DCS verified the administrator should have been notified immediately. On 1/10/14, at 11:41 a.m. the administrator stated she was supposed to be notified "Right away" of anything including building, resident or staff issues. She added the staff are to notify her of any VA issues such as any suspicion of abuse, neglect, bruising, anything they report to the State immediately. She further stated the DCS should have been notified on 11/2/13, and DCS should have contacted her which had not been done. The administrator verified skin tears of unknown origin should have been investigated to determine the root cause analysis and verified investigation would not be started until after reporting has been completed. ALLEGATION OF VERBAL ABUSE R30 was not protected during an investigation of alleged verbal abuse. A Vulnerable Adult (VA) report dated on 6/27/13, indicated R30 had reported to staff a nursing assistant (NA) who had worked with her evening before 6/26/13, was abusive. R30 reported the NA was screaming and yelling at her that her eyes were okay and that she was not blind. During further document review, it was revealed R30 had reported to the household coordinator on 6/27/13, at 3:45 p.m. through e-mail correspondence to the DSC. The household coordinator never documented R30's complaint in the clinical resident record. On 1/10/14, at 10:58 a.m. DCS was interviewed stated during the investigation "That nursing assistant was asked not to take care of her (resident)." DCS further stated during the	22000		

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22000	Continued From page 64 investigation the staff "went back and apologized to her (R30) too" and the staff continued to work on the unit. DCS was unclear how she ensured the resident was protected with the staff person still working on the unit during the investigation. DCS confirmed the household coordinator should have documented the complaint in the clinical record including the actual report, what the follow up at the time was and that he had reported the incident to his immediate supervisor and herself. On 1/10/14, at 11:56 a.m. the administrator was interviewed verified she would not know R30 was protected during the investigation if the staff continued to work in the unit unless she was sitting right there. She further stated facility had suspended pending investigation in the past and verified the R30 was not protected during the investigation. The administrator verified the incident should have been documented in the clinical record, including initial complaint, notification, details of the incident and what had been done which was lacking. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure compliance. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	22000		