### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL FE SURVEY AGENCY			ID: S9MI Facility ID: 00122
MEDICARE/MEDICAID PROVID		3. NAME AND AL			TE SURVET AGENCT	4 TVDE	OF ACTIO	
NO.(L1) <b>245417</b>	JEK .	(L3) <b>ROBBINSD</b>			CENTER			<u></u>
2. STATE VENDOR OR MEDICAID	) NO	(L4) 3130 GRIM	ES AVENUE N	NORTH		1. Initia 3. Term		2. Recertification 4. CHOW
(L2) <b>516842200</b>	, , , , , , , , , , , , , , , , , , ,	(L5) ROBBINSD	ALE, MN		(L6) <b>55422</b>	5. Valid		6. Complaint
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEO	GORY	<u>02</u> (L7)		Site Visit	9. Other
(L9) <b>07/01/2015</b>		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full	Survey After	· Complaint
6. DATE OF SURVEY <b>02</b> /2	<b>27/2017</b> <sup>(L34)</sup>	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	EISCAI VI	EAR ENDI	NG DATE: (L35)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID				NO DATE. (E33)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	]	12/31	
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	/ IS CERTIFIED	AS:				
From (a):		A. In Complia	nce With		And/Or Approved Waivers	Of The Following	Requireme	ents:
To (b):			equirements		2. Technical Person	nel 6.	Scope of Se	ervices Limit
		•	e Based On:		3. 24 Hour RN		Medical Dir	
12.Total Facility Beds	<b>75</b> (L18)	1. A	cceptable POC		4. 7-Day RN (Rural	SNF) 8.	Patient Roor	m Size
13.Total Certified Beds	<b>75</b> (L17)	B. Not in Comp	liance with Progr	am	$\underline{X}$ 5. Life Safety Code	9.	Beds/Room	
	, ,		and/or Applied V		* Code: <b>A.5</b>	(L12)		
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):		(L15)	
75								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION :	DATE):				
Documentation supporting the	,			ŕ	21 is being recommended	and forwarded	I to CMS 1	for approval.
17. SURVEYOR SIGNATURE	, ,	Date :			18. STATE SURVEY AGEN	CY APPROVAL		Date:
Gloria Derfus, Unit S	unervisor	0	04/18/2017		Kamala Fiske-Downir	a Enforcem	ont Cnoc	siglist of the teats
	apor vicor		74/10/2017	(L19)	Namaia Fiske-Downii	ig, Emorcem	ent Spec	(L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE	STATE AGI	ENCY	
19. DETERMINATION OF ELIGIBI	LITY		IPLIANCE WITI	H CIVIL	21. 1. Statement of F			
1. Facility is Eligible to l	Participate	RIGI	HTS ACT:		<ol> <li>Ownership/Cor</li> <li>Both of the Ab</li> </ol>		losure Stmt	(HCFA-1513)
2. Facility is not Eligible								
	(L21)							
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTIO	ON:	(	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DA	ГЕ	VOLUNTARY	00	INVOLUN	<u>NTARY</u>
03/01/1987					01-Merger, Closure		05-Fail to !	Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimb	ursement	06-Fail to I	Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termina		<u>OTHER</u>	
	A. Suspension	of Admissions:			04-Other Reason for Withdraw	al	07-Provide	er Status Change
(L27)			(L44)				00-Active	
(DZT)	B. Rescind Su	spension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		06301						
	(L28)			(L31)				
31 RO RECEIPT OF CMS-1539	37	DETERMINATION	I OE A PPROVAI	DATE				

(L33)

DETERMINATION APPROVAL

(L32)



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245417

April 18, 2017

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

Dear Ms. Pankratz:

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

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

Effective February 21, 2017 the above facility is certified for:

75 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 75 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K521 .

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for this deficiency or renew your request for waiver in order to continue your participation in the Medicare and Medicaid Program.

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

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

Robbinsdale Rehab & Care Center April 18, 2017 Page 2

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

April 18, 2017

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

RE: Project Numbers S5417026, H5417175 and H5417177

Dear Ms. Pankratz:

On February 1, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 12, 2017 that included an investigation of complaint numbers H5417175 and H5417177. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On February 27, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 2, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 12, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 21, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 12, 2017, effective February 21, 2017 and therefore remedies outlined in our letter to you dated February 1, 2017, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K521 at the time of the January 12, 2017 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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.

Robbinsdale Rehab & Care Center April 18, 2017 Page 2

Sincerely,

Kumala Fishe Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

Enclosure

cc: Licensing and Certification File

### POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION		D	ATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building				
245417 <sub>Y1</sub>	B. Wing	Y2	. 2/	/27/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
ROBBINSDALE REHAB & CA	RE CENTER	3130 GRIMES AVENUE NORTH			
		ROBBINSDALE, MN 55422			

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

ITE Y4			<b>DATE</b> Y5	ITEM Y4			<b>DATE</b> Y5	ITEM Y4			DATE Y5
ID Prefix Reg. #	F0242 483.10(f)(1)-(3)		Correction Completed	ID Prefix Reg. #		(b)(3)(i)	Correction Completed	ID Prefix Reg. #	F0309 483.24, 483.25(k)	)(I)	Correction Completed
LSC			02/21/2017	LSC			02/21/2017	LSC			02/21/2017
ID Prefix	F0311		Correction	ID Prefix	F0312		Correction	ID Prefix			Correction
Reg. #	483.24(a)(1)		Completed	Reg. #	483.24	(a)(2)	Completed	Reg. #	483.25(b)(2)(f)(g) (j)	(5)(h)(i)	Completed
LSC			02/21/2017	LSC			02/21/2017	LSC			02/21/2017
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	483.45(f)(1)		Completed	Reg. #	483.45	(f)(2)	Completed	Reg. #	483.45(a)(b)(1)		Completed
LSC			02/21/2017	LSC			02/21/2017	LSC			02/21/2017
ID Prefix Reg. # LSC	F0431 483.45(b)(2)(3)	(g)(h)	Correction Completed 02/21/2017	ID Prefix Reg. # LSC	-	(a)(1)(2)(4)(e)(f)	Correction Completed 02/21/2017	ID Prefix Reg. # LSC	F0465 483.90(i)(5)		Correction Completed 02/21/2017
ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC			Correction Completed
REVIEWI STATE A		REVIEW (INITIAL	<i>S)</i>	DATE		SIGNATURE OF	SURVEYOR			DATE	
			GD/ktd	04/18/	2017	TIT1 F		18623			27/2017
CMS RO	ED BY	REVIEW (INITIAL		DATE		TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 1/12/2017						R ANY UNCORRECTED DEFICIENCI				☐ YE	s 🗆 NO

### POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01		DATE OF REVI	SIT
	B. Wing	Y2	3/2/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
ROBBINSDALE REHAB & CAR	E CENTER	3130 GRIMES AVENUE NORTH		
		ROBBINSDALE, MN 55422		
		ledicaid and/or Clinical Laboratory Improvemen		

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).

ITE Y4		<b>DATE</b> Y5	ITEM Y4		<b>DATE</b> Y5	ITEM Y4			DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	A 101	Completed	Reg. #	NFPA 101		Completed
LSC	K0321	02/21/2017	LSC K035	1	02/21/2017	LSC	K0355		02/21/2017
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	A 101	Completed	Reg. #	NFPA 101		Completed
LSC	K0372	02/21/2017	LSC K092	0	02/21/2017	LSC	K0926		02/21/2017
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
REVIEWI STATE A		REVIEWED BY (INITIALS) TL/kfd	<b>DATE</b> 4/18/2017	SIGNATURE OF	SURVEYOR	37009		<b>DATE</b> 3/2	2/2017
REVIEWI CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 1/11/2017				DR ANY UNCORREC				YE	s 🗆 no

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

					TE SURVEY AGENCY		ID: S9MI Facility ID: 00122
MEDICARE/MEDICAID PROVID     NO.(L1)		3. NAME AND AI (L3) ROBBINSD (L4) 3130 GRIM (L5) ROBBINSD	ALE REHAB O	& CARE	CENTER (L6) 55422	4. TYPE OF AC  1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9) <b>07/01/2015</b>		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visi  8. Full Survey	t 9. Other After Complaint
6. DATE OF SURVEY ()1/1 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR E	NDING DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds 13.Total Certified Beds  14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 75 (L37) (L38)	75 (L18) 75 (L17)	Complianc1. A <b>X</b> B. Not in Cor	equirements e Based On:	gram	And/Or Approved Waivers C 2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural S 5. Life Safety Code  * Code:	el 6. Scope 6 7. Medica	of Services Limit al Director Room Size
16. STATE SURVEY AGENCY REM				DATE):			
17. SURVEYOR SIGNATURE  Magdalene Jares, Hi	E NE II	Date :	02/09/2017	(L19)	18. STATE SURVEY AGENCE  Kamala Fiske-Downing		Date:  pecialist 03/16/2017 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	GIONAI	L OFFICE OR SINGLE	STATE AGENCY	Y
DETERMINATION OF ELIGIBIL	articipate		MPLIANCE WITH HTS ACT:	H CIVIL	<ul><li>21. 1. Statement of Fir</li><li>2. Ownership/Com</li><li>3. Both of the Abo</li></ul>	trol Interest Disclosure S	
22. ORIGINAL DATE  OF PARTICIPATION  03/01/1987	23. LTC AGREED BEGINNING		4. LTC AGREEM ENDING DAT		26. TERMINATION ACTION  VOLUNTARY  01-Merger, Closure	<u>INVO</u>	(L30)  DLUNTARY  il to Meet Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	_	VE SANCTIONS n of Admissions: uspension Date:	(L25) (L44) (L45)		02-Dissatisfaction W/ Reimbur 03-Risk of Involuntary Terminat 04-Other Reason for Withdrawa	tion <u>OTHE</u>	ovider Status Change
28. TERMINATION DATE:	29	O. INTERMEDIARY	/CARRIER NO.		30. REMARKS		
	(L28)	06301		(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVAL	DATE			

(L33)

DETERMINATION APPROVAL

(L32)



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered February 1, 2017

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

RE: Project Number S5417026 and Complaint Numbers H5417175 and H5417177.

Dear Ms. Pankratz:

On January 12, 2017, 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. In addition, at the time of the January 12, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5417175 and H5417177.

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

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

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

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

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

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

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

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

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

#### DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

### 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 21, 2017, 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 21, 2017 the following remedy will be imposed:

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

### ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Robbinsdale Rehab & Care Center February 1, 2017 Page 4

#### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

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

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

### Original deficiencies not corrected

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

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

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

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

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

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

If substantial compliance with the regulations is not verified by April 12, 2017 (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

Robbinsdale Rehab & Care Center February 1, 2017 Page 5

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 12, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

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

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

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

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

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. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Robbinsdale Rehab & Care Center February 1, 2017 Page 6

> Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kamala Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 03/16/2017 FORM APPROVED OMB NO. 0938-0391

-	MENT OF DEFICIENCIES AN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245417	B. WING _			C / <b>12/2017</b>	
	PROVIDER OR SUPPLIER	<u>-</u>		STREET ADDRESS, CITY, STATE, ZIP CO 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		12/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 000		of correction (POC) will serve frompliance upon the	F 00	00			
	Department's accepenrolled in ePOC, yat the bottom of the	otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will					
	on-site revisit of you validate that substa	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with					
F 242 SS=D	complaint investiga completed. H54171 H5417177 was sub	vey was conducted and tions into complaints were 75 was substantiated at F425. stanitated at F309 and F333. LF-DETERMINATION - CHOICES	F 24	12		2/21/17	
	schedules (includin health care and pro consistent with his	nas a right to choose activities, g sleeping and waking times), viders of health care services or her interests, assessments, d other applicable provisions					
		nas a right to make choices s or her life in the facility that e resident.					
	members of the corcommunity activitie facility.	nas a right to interact with mmunity and participate in s both inside and outside the					
ARORATOR)		NT is not met as evidenced  DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 

02/08/2017

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245417	B. WING _		01/1	) 1 <b>2/2017</b>	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	·		
				3130 GRIMES AVENUE NORTH			
ROBBIN	SDALE REHAB & CA	ARE CENTER		ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE	
F 242	by: Based on observareview, the facility resident preference of 3 residents (R10 in daily routine.  Findings include: R101 was interview When asked about stated she stated: "There is no bath it would like a bath. In a follow up inter 8:33 a.m. he state telling me there was would have I would important to me to showerThe older bath to soak. I have the state of the presence of the state of the presence of the state o	ation, interview, and document failed to ensure bathing es were accommodated for 2 01, R95) reviewed for choices  wed on 1/9/17, at 3:12 p.m. It bathing choices the resident she did not have a choice as, in this facility. I wish there was. I I'm sure a lot of people would." view with R101 on 1/11/17, at d, "I do not remember them as no bath in the place. If they d've bitched about it. It's have a bath instead of a r I get the more I would like a ve arthritis."  It Care Plan for R101 dated ly preferences were very sident. Although a tub bath was form indicated, "Choose or shower, bed bath or sponge shower."  ed on 1/9/17, at 4:10 p.m. R95 buld enjoy an Epson salt bath bath tub. R95 then stated the e a bathtub on any of the floors. y informed staff of their request R95 stated, "Yes, on admission type of bathing I preferred, I g assistant (NA) and a nurse. I	F 24	The submission of this plais not an admission by the fact or conclusion set forth statement of deficiency. To correction is being submitt required by law. However Robbinsdale Rehabilitation Center good faith, the facifollowing plan of correction achieved substantial compof the areas addressed by 2017  1. R95 is currently not at the prior to return will be given opportunity, if so desired, different facility where prefub bath can be met. R10 interviewed and stated that that the center does not act to bath, but that he does transfer to another facility.  2 Residents that reside at Rehab and Care Center has to be affected by this practices or designee will residents who currently refacility and review bathing tub bath is the preference, planning will be arranged to Potential residents will be limited accommodations in bathing.  3. Education provided to sto resident choices and bath is the previous and bath in the provided to sto resident choices and bath in the provided to sto resident choices and bath is the provided to sto resident choices and bath is the provided to sto resident choices and bath in the provided to sto resident choices and bath is the provided to sto resident choices and bath is the provided to sto resident choices and bath is the provided to sto resident choices and bath is the provided to sto resident choices and bath is the provided to sto resident choices and bath is the provided to sto resident choices and bath is the provided to sto resident choices and bath is the provided to sto resident choices and bath is the provided to sto resident choices and bath is the provided to sto resident choices and bath is the provided to storesident choices and bath is the provident choices.	provider of any in the his plan of ted because it is , evidencing in and Care lity offers the in and has pliance in each rebruary 21, the facility but in the to transfer to a ferences for a 1 was it he is aware ecommodate a not wish to the preference. If a discharge to accomodate, notified of in regards to tub taff in regards		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING							
		245417	B. WING				C 1 <b>2/2017</b>
	PROVIDER OR SUPPLIER	RE CENTER		31	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH COBBINSDALE, MN 55422		.=/=0
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 242	R95's Life Enrichmer Program (LR) the for Preferences: it is we important to: choosed bath, or sponge preference was the "Tub bath/shower."  NA-A was interview and reported caring and stated the reside bath." Registered in 1:00 p.m. that the fa 2007-2009, but wer "leaking." RN-C did tub bath.  In a follow up interva 3:41 p.m. he stated prior to his admission unavailable, and not informed on his behave come to this fithey did not have be [salt] baths and so a R95 added that he going instead to a strange room. The executive direct at 7:36 a.m. they have a storage room. The shown the facility pethey said they prefet them to a sister face.	ge 2 ent/Therapeutic Recreation form dated 8/16, read, "Daily ery important or somewhat e between a tub bath, shower, e bath." The resident's in indicated and R95's read,  ed on 1/12/17, at 12:55 p.m. for R95 on two different floors dent "never asked for a tub urse (RN)-C then stated at acility had tub baths around e no longer in use due to not recall R95 requesting a  iew with R95 on 1/12/17, at he had not been informed on in 8/16, that a tub was one else would been half. R95 stated, "I would not acility if I would have known eathtubs. I like taking Epson liking in the tub." At 3:44 p.m. was never offered a choice of hister facility that had a tub.  ettor (ED) explained on 1/12/17, ad bathtubs approximately 20 e was no desire on the part of e a bath versus a shower. bs were not in use, they had and the room was changed to e ED said residents were rior to their admission and if erred a bath, they would admit ility instead. Current residents ce of a shower or a bed bath.	F 2	.42	4. Audits will be completed on all nadmission by the Director of Social Services and/ or designee to ensurbathing preference has been discuand care planned. Audits to occur weeks for newly admitted residents 3 per month x 3 months.  5. Audits will be reviewed at Quality Assurance Meeting (QAPI) monthly months to determine if any trends a identified and recommendations montinued audits and monitoring new 6. Completion date 2/21/2017	re ssed x 4 s, then y y for 3 are ade for	

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	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE 3130 GRIMES AVENUE NORT ROBBINSDALE, MN 5542	ГН	01/1	12/2017	
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F 242	The ED felt there we residents' part to ha had tubs. We can't expensive."  The director of nursinterview on 1/12/1' bathtubs were not to DON said she could were not in use, and they should not have they should not have the facility for many bathtubs being in use tubs had never beed discussed. He explored were currently used to the ED stated on 1 answer why they [b don't know what the ED stated they had to the tubs.  The director of soci interviewed on 1/12 a copy of the Admis LSW-A explained they or of the halls.  The Admission Pacprovided to all residents and/or regarded to all residents and they or of the halls.  The Admission Pacprovided to all residents and they or of the halls.	ras still no desire on the ave a tub bath. "I can't lie. We get partsit is very  sing (DON) confirmed in an 7, at 12:11 p.m. the facility currently available for use. The d not explain why the bath tubs d if a resident wanted a bath re been admitted to the facility.  upervisor (MS) stated on m. although he had worked at ryears, he did not recall the se. He did not know why the n replaced, nor had it been ained that the old tub rooms	F 2	242				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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F 242	the rights to appropriate the rights to appropriate based on individuationingAccon resident has the rigis ervices in the faciliaccommodation of preferences, except the individual or othendangeredQualifor its residents in a environment that precipied the individual or othendangeredQualifor its residents in a environment of earlier than the life enrichment recreation program 1/12/17, at 3:46 p.r. Enrichment Short Sassessment was coresident's interests important to them, they preferred a betub bath. LE-E reporterence was to informed the option "issue" for the resident, the finding a sister facility had never his the statement and a long time because. The maintenance con 1/12/17, at 4:15 have any bath tubs submitted to the Missister in the statement and a long time because.	priate medical and personal vidual needs, mental amodation of Needs: The into to reside and receive ity with reasonable individual needs and in when the health or safety of her resident would be ity of LifeA facility must care a manner and in an romotes maintains or ith resident's quality of life."  It director/therapeutic (LE)-E was interviewed on in. LE-E indicated a Life stay Care Plan initial impleted that addressed each if ith routines, what is interviewed on in the routines, what is interviewed or interviewed if a resident stated their rake a tub bath, they were in was not available. If it was an ident, it was brought to the and LSW. If it was a problem in ity where a tub was available in ove. Initially LE stated the individual interviewed in the presence of five tubs and the presence of five tubs	F 24	42		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		NG	(X3) DATE S COMPLE	
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F 242	indicated, "You have receive services in	Social Services Manual ethe right to reside and the facility with reasonable	F 2	42		
F 281 SS=D	preferences"	individual needs and VICES PROVIDED MEET TANDARDS	F2	81	2/	/21/17
	as outlined by the comust-  (i) Meet professional This REQUIREMENT	ed or arranged by the facility, omprehensive care plan, all standards of quality.				
	review, the facility facility facility facility for sufficient to meet the resident for 1 of 1 reincontinence.  Findings include:  R150 was not provileast 2 hours, 48 mobservations were of 7:41 a.m. until 10:2 was not provided to a.m. R150 was lying dark. At 8:49 a.m. li (LSW)-A brought R assistant (NA)-K enshe was going to as Toileting assistance.	ion, interview and document ailed to develop a care plan e needs of a newly admitted esident (R150) reviewed for ded toileting assistance for at inutes. Continuous conducted on 1/11/17, from 9 a.m. during which time R150 ileting assistance. At 7:41 g in bed on his back in the censed social worker 150's breakfast tray. Nursing tered R150's room and said esist the resident to eat. was not provided at that time.		The submission of this plan of colis not an admission by the provide fact or conclusion set forth in the statement of deficiency. This plan correction is being submitted becarequired by law. However, eviden Robbinsdale Rehabilitation and Ca Center good faith, the facility offer following plan of correction and hardhachieved substantial compliance if of the areas addressed by Februa 2017  1. R150 is no longer a resident at Robbinsdale Rehab and Care Cere  2. Residents that require assistant staff regarding toileting at Robbins Rehab and Care Center have the to be affected by this practice. Residents and Care Center have the to be affected by this practice.	or of any of ause it is cing are s the as n each ry 21,  other actions are side of the action of the	

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F 281	said to see wheth orange juice, how At 9:51 a.m. NA-k R150's right hip a adjusted the resid don't feel wellAll wrong." R150 info bed. NA-K verified and his incontiner needed two staff t R150 she would b. NA available. Betwo physical therapy a went from R150's practical nurse (LI R150, "Do you was find some." LPN-k side. Continuous of the Nursing Com Collection and Assindicated R150 was assessed as record lacked evict to provide the new related to his incontinence products. The Nursing Com Collection and Assindicated R150 was assessed as record lacked evict to provide the new related to his incontinence products. The Nursing Com Collection and Assindicated R150 was assessed as record lacked evictor provide the new related to his incontinence products. The Nursing Com Collection and Assindicated R150 was assessed as record lacked evictor provide the new related to his incontinence products. The Nursing Com Collection and Assindicated R150 was assessed as record lacked evictor provide the new related to his incontinence products. The Nursing Com Collection and Assindicated R150 was assessed as record lacked evictor provide the new related to his incontinence products. The Nursing Com Collection and Assindicated R150 was assessed as record lacked evictor provide the new related to his incontinence products.	er R150 was drinking his ever, toileting was not offered. A removed a pillow from under and lowered head of bed and lent's shirt. R150 reported, "I led over. I don't know what is armed NA-K he wanted to stay in the R150 did not have pants on the product was wet. NA-K stated to assist the resident. NA-K told to be back when there was another ween 10:07 and 10:17 a.m. assistant (PTA)-A came and room. At 10:24 a.m. licensed PN)-A entered room and asked ant some pants on? I will have to the repositioned R150 onto his observation ended at 10:29 a.m. and dated 1/7/17, indicated R150 from both and bladder.  The prehensive Admission Data are sessment dated 1/7/17, as incontinent. Although R150 being incontinent, the medical dence of sufficient interventions and yellow admitted resident with care national continent. It was done with working with. It was about verified R150 was wet when not the working with a two hours. NA-L ashed up and changed first thing are resident with care of the prehension	F 2	281	that require toileting assistance have assessed and care plans have bupdated as appropriate.  3. Education was provided to RN umananagers regarding bladder assessments and care plan in regal appropriate plan of care. NA/R stable been educated on following the reswritten plan of care in regards to tirtoileting assistance.  4. Audits will be completed by the Director of Nursing and/or designeresidents that need assistance with toileting 3x per week x 4 weeks the per month for 3 months.  5. Audits will be reviewed at Quality Assurance Meeting (QAPI) monthly months to determine if any trends a identified and recommendations monthinued audits and monitoring needs.  6. Completion date 2/21/2017	een  unit  ards to ff have sidents mely  e on n en 3x  y for 3 are ade for	

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	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF CROSS-REFERENCED TO THE APPROPRICE DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 281	said. "I would exped within 15 minutes. I	ge 7  1/12/17, at 11:24 a.m. RN-A ct a resident to be changed f a nursing assistant cannot g assistant they should go get	F 28	31		
	12:26 p.m. "I would to check a resident change program pr they need assistand resident within 10 n assistance. The nu	sing stated on 1/12/17, at expect the nursing assistant who is on a check and etty close to the two hours. If ce they should be in with the ninutes to allow time to obtain rsing assistant should have ait until they could get e change quickly."				
F 309 SS=D	instructed staff: "Th residents who are in appropriate treatment much normal bladd provide treatment a tract infections." 483.24, 483.25(k)(I)	Urinary Incontinence policy to e center strives to ensure that incontinent of bladder receive ent and services to restore as er function as possible, and to and services to prevent urinary of PROVIDE CARE/SERVICES ELL BEING	F 30	09		2/21/17
	applies to all care a residents. Each residents. Each residential facility must provide services to attain or practicable physica well-being, consiste	e indamental principle that and services provided to facility sident must receive and the e the necessary care and maintain the highest l, mental, and psychosocial ent with the resident's ressment and plan of care.				
	100.20					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING		01/1	;  2/2017	
	PROVIDER OR SUPPLIER	RE CENTER	3	STREET ADDRESS, CITY, STATE, ZIP CODE 1130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	1 01/1	2/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	provided to resident consistent with profithe comprehensive and the residents' of the comprehensive and the residents who requiservices, consistent of practice, the compact plan, and the repreferences. This REQUIREMENT by:  Based on interview facility failed to province the sast ordered who allegedly did not be replacement, failure and chronic of the blood thinner instructed staff to we keep a record relate (fluid in the tissues) two pounds over nit week staff was instructed of the well ordered. In April 14 27 out of 31 days, as	<u> </u>	F 309	The submission of this plan of consis not an admission by the provider fact or conclusion set forth in the statement of deficiency. This plan correction is being submitted because required by law. However, evidence Robbinsdale Rehabilitation and Cacenter good faith, the facility offers following plan of correction and has achieved substantial compliance in of the areas addressed by Februar 2017  1. R 154 no longer resides at the factor of the areas addressed by Februar 2017  2. Residents that reside at Robbins Rehab and Care Center have the patone be affected by this practice. Chareviews have been completed to enphysician orders continue to be appropriate and are clearly commutate ensure medications and treatmed being given per Doctors orders.	of any of use it is sing re the seach y 21, acility. sdale potential art nsure		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING			01/1	C 1 <b>2/2017</b>
	PROVIDER OR SUPPLIER  SDALE REHAB & CAI	RE CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 1130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	<u> </u>	
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F 309	not consistently doc Copies of R154's w 2016 were requested.  An allegation of car 5/31/16, noted R15 per physician's order bandages (elastic between not being app "was busy." The allediagnosis of congested.  R154 had an order 2/24/16. The staff of feet and work their Documentation shocompleted as order TARs as follows: No on 4/25, 4/27, or 4/2 missing on the May days. The June 201 documentation of tr 6/7, 6/25, and 6/29/20 R154's discharge No dated 7/27/16, indicinated with no reject listed as chronic ob heart failure, edema On 1/12/17, at 12:5 (DON) reviewed an information related needed medication nebulizer treatment Medication Adminis	d weight, as the weights were cumented.  eights for February to June ed but was not provided.  es not being completed dated 4 did not receive treatments ers. It was alleged ace landages) for R154's legs lied for two days as the staff egation indicated R154 had a stive heart failure.  to wrap both legs dated were to start at bottom of the legs. Wing the treatment was lacking on R154's of documentation was recorded 28/16; nine of 31 days was TAR, as well as nine of 31 to TAR revealed no eatments being completed on	F3	809	3. Education has been provided to that administer medication and pro treatments regarding following the Physician's orders and documentin accordingly.  4. Audits of medication administrat treatments provided, and weights v completed by the Director of Nursir or designee 3x per week for 4 weel 3x per month for 3 months.  5. Audits will be reviewed during the Quality Assurance Meeting (QAPI) monthly for 3 months to determine trend are identified and recomment for continued audits or monitoring.  6. Completion date 2/21/2017	vide ig ion, vill be ng and/ ks then e if any	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION ()	(3) DATE SURVEY COMPLETED
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F 309	off as completed. T cannot complete a their initials and doctreatment administr was not doneI can received the treatment for."	eatments had not been signed he DON stated, "If the nurse treatment, they are to circle cument on the back of the ration record why the treatment nnot tell if this resident ent, as they were not signed	F 309		
F 311 SS=D	IMPROVE/MAINTA  (a)(1) A resident is a treatment and service or her ability to carreliving, including those of this section.  This REQUIREMENT by:  Based on observate review, the facility facts assistance for 1 of received a room transfer include:  R150 was observed in bed on his back, assistant (NA) look not enter. At 8:25 a	given the appropriate ces to maintain or improve his y out the activities of daily se specified in paragraph (b)  NT is not met as evidenced ion, interview and document ailed to provide eating 1 resident (R150) who by.  d on 1/11/17, at 7:01 a.m. lying At 8:22 a.m. a nursing ed into R150's room but did .m. a nurse entered and then	F 311	The submission of this plan of corre is not an admission by the provider of fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted becaus required by law. However, evidencin Robbinsdale Rehabilitation and Care Center good faith, the facility offers the following plan of correction and has achieved substantial compliance in every su	of any  if any i
	a.m. R150's light ware elevated 45 degree he'd get up for brea social worker (LSW wanted for breakfast brought R150's bre bedside table. The	ed from the room. At 8:32 as on, the head of the bed was s. The reported he thought akfast. At 8:44 a.m. a licensed by A asked R150 what he st. At 8:49 a.m. LSW-A akfast tray and set it on the tray was not prepared in any was left covered. At 9:10 a.m.		<ol> <li>R150 no longer resides at Robbins Rehab and Care Center.</li> <li>Resident who require assistance veating at Robbinsdale Rehab and Care Center have the potential to be affect by this practice. Residents who required.</li> </ol>	vith are ted

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	COM	E SURVEY PLETED
		245417	B. WING			C 1 <b>2/2017</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		12/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 311	the breakfast tray lying in bed with hi NA-K entered R15 hands and indicate as he had not eate explained R150 us but had wanted to everything on the can feed himself." hour without assis 9:51 a.m. R150 re wellAll over. I do A Nursing Compre Collection and Assindicated R150 restaff person to eat 1/7/17, indicated F diet, had a poor as swallow. The note difficulty feeding h to eat.  R150's 1/10/17, nowas at potential ris loss as well as a hill plan was to assist tray and assist him During an interview registered nurse (I needs assistance with time to try to do it.)  The director of nurp.m. "I would experience of the second in the control of t	was untouched and R150 was seyes closed. At 9:22 a.m. 60's room and washed her ed she was going to feed R150 en or drank anything. NA-K sually ate in the dining room, stay in bed. NA-K said, "He ate tray with my help. Normally he R150 had been left for one tance to eat his breakfast. At ported to NA-K, "I don't feel n't know what is wrong."  Thensive Admission Data sessment dated 1/7/17, quired the assistance of one. A Progress Note also dated R150 was prescribed a regular opetite and took time to went onto read that R150 had imself and needed assistance attritional care plan indicated he sk for dehydration, had weight istory of loss of appetite. The the resident to set up his meal in to eat as needed.  W on 1/12/17, at 11:24 a.m. RN)-A said, "A resident who to eat a meal should receive hin five minutes to allow him himself."	F 31	assistance with eating and derin their room will have room tropy clinical staff with assistance immediately following.  3. Education regarding meal translation and timely assistance with eat provided to clinical and non clinical and non clinical and the Director of Nursing and designee twice per week for 2 then weekly for one month.  5. Audits will be reviewed durn Assurance Meeting (QAPI) months to determine if any tresidentified and recommendation continued auditing or monitorical.  6. Completion date 2/21/2017	ay delivered etray set upting was inical staff. completed l/ or etweeks, ing Quality onthly for 2 ends are ns for ng.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245417	B. WING _		01/1	C 1 <b>2/2017</b>
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		12/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312 SS=D	ProceduresFeedi instructed staff: "V conditions may preherself, including coneuromuscular disdisease and traum can't feed herself, malnutrition." While mechanics of feedi address timeliness 483.24(a)(2) ADL COEPENDENT RESCOEPENDENT RESCOE	d an 11/11/16, Lippincott ng, Long-Term Care that arious disabilities and event a resident from feeding ognitive deficits, ease, cancer obstructive lung atic injury. When a resident she's susceptible to e procedure addressed the ing a resident, it did not of providing that assistance. CARE PROVIDED FOR SIDENTS  The is unable to carry out ring receives the necessary in good nutrition, grooming, and nygiene.  NT is not met as evidenced tion, interview and document failed to provide timely toileting 1 resident (R150) reviewed for	F 31	1	rection of any of use it is sing re s the s each y 21,	2/21/17
	assistant (NA)-K ei	R150's breakfast tray. Nursing ntered R150's room and said ssist the resident to eat.		Rehab and Care Center.  2. Residents that require assistance		

	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		A. BOILDIN			
	245417	B. WING _			12/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (	CODE	
ROBBINSDALE REHAB & CARE CE	NTFR		3130 GRIMES AVENUE NORTH		
HODDINGDALL HEHAD & GAILE GE			ROBBINSDALE, MN 55422		
(X4) ID SUMMARY STATEMEN' PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 312 Continued From page 13 Toileting assistance was a At 9:45 a.m. NA-K enteres said to see whether R150 orange juice, however, to At 9:51 a.m. NA-K remov R150's right hip and lower adjusted the resident's shadon't feel wellAll over. I wrong." R150 informed N bed. NA-K verified R150 and his incontinent produneeded two staff to assist R150 she would be back NA available. Between 10 physical therapy assistant went from R150's room. A practical nurse (LPN)-A e R150, "Do you want some find some." LPN-A reposiside. Continuous observation of bowel.  The Nursing Comprehens Collection and Assessme indicated R150 was incortinent of bowel.  The Nursing Comprehens Collection and Assessme indicated R150 was incortined as assessed as being in record lacked evidence of to provide the newly admirelated to his incontinence.  During an interview on 1/NA-L said, "I changed him the resident I was working 10:45 a.m." NA-L verified incontinence product was R150 should have been of the provide that was resident to the side of the product was R150 should have been of the provide that was resident to the product was R150 should have been of the provide that was resident to the product was R150 should have been of the provide that was resident to the product was R150 should have been of the provide that was resident to the provide that was resident to the provident to the providen	not provided at that time. If the room at 9:45 and 1 was drinking his ileting was not offered. It was not offered a pillow from under red head of bed and hirt. R150 reported, "I don't know what is A-K he wanted to stay in did not have pants on ct was wet. NA-K stated at the resident. NA-K told when there was another 10:07 and 10:17 a.m. It (PTA)-A came and At 10:24 a.m. licensed intered room and asked a pants on? I will have to tioned R150 onto his ition ended at 10:29 a.m.  7/17, indicated R150 and bladder.  Sive Admission Data int dated 1/7/17, intinent. Although R150 and bladder.  Sive Admission Data interventions itted resident with care e.  11/17, at 11:05 a.m. in when I was done with g with. It was about R150 was wet when a changed. NA-L verified	F 31	toileting needs have the poraffected by this practice. R incontinence have had their reviewed and updated as a sequalified persons in accordance residents' plan of care. Fol residents toileting schedule to have a change in ability, or Nurse Manager.  4. Audit will be completed I Nursing and/ or designee m resident toileting plan is bein per week for 2 weeks then for 2 weeks then weekly for 5. Audits will be reviewed m months during Quality Assu (QAPI) to determine if any tidentified and recommendation continued audits or monitor 6. Completion date 2/21/20	esidents with reare plans ppropriate.  Irsing staff that rvices by ance with each lowing and, if noted updating nurse by Director of nonitoring ng followed 3x twice per week 4 weeks.  Inonthly for 3 irance Meeting trends are tions for ing.	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING CON	_
	C <b>12/2017</b>
NAME OF PROVIDER OR SUPPLIER  ROBBINSDALE REHAB & CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  3130 GRIMES AVENUE NORTH  ROBBINSDALE, MN 55422	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312  Continued From page 14 said, "I got him washed up and changed first thing this morningabout 6:45 a.m."  During interview on 1/12/17, at 11:24 a.m. RN-A said. "I would expect a resident to be changed within 15 minutes. If a nursing assistant cannot find another nursing assistant they should go get a nurse."  The director of nursing stated on 1/12/17, at 12:26 p.m. "I would expect the nursing assistant to check a resident who is on a check and change program pretty close to the two hours. If they need assistance they should be in with the resident within 10 minutes to allow time to obtain assistance. The nursing assistant should have asked therapy to wait until they could get someone and do the change quickly."  The facility's 7/15, Urinary Incontinence policy instructed staff: "The center strives to ensure that residents who are incontinent of bladder receive appropriate treatment and services to restore as much normal bladder function as possible, and to provide treatment and services to prevent urinary tract infections."  F 328  SS=D  (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:  (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and	2/21/17

-	FATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245417	B. WING			C <b>1/12/2017</b>	
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIF 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	•	1/12/2017	
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F 328	(ii) If necessary, as appointments with a arranging for transpappointments  (f) Colostomy, uret The facility must en require colostomy, services, receive suprofessional standar comprehensive per the resident's goals  (g)(5) A resident whreceives the approption prevent compliance including but not limited daministered consists standards of practic physician orders, the person-centered cargoals and preference (i) Respiratory care and tracheal suction that a resident who including tracheosts suctioning, is provided in the person of	sist the resident in making a qualified person, and portation to and from such erostomy, or ileostomy care. Sure that residents who ureterostomy, or ileostomy uch care consistent with urds of practice, the son-centered care plan, and and preferences.  To is fed by enteral means oriate treatment and services lications of enteral feeding nited to aspiration pneumonia, dehydration, metabolic masal-pharyngeal ulcers.  S. Parenteral fluids must be stent with professional ce and in accordance with the comprehensive re plan, and the resident's ces.  Including tracheostomy care ning. The facility must ensure needs respiratory care, only care and tracheal ded such care, consistent with	F3	328			

-	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMP		SURVEY PLETED			
		245417	B. WING		01/1	C I <b>2/2017</b>
NAME OF F	PROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/1	12/2017
DODDIN	DALE DELIAD & OA	DE OENTED	3	3130 GRIMES AVENUE NORTH		
ROBBIN	SDALE REHAB & CA	ARE CENTER	F	ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 328	Continued From pa	age 16	F 328			
F 328	resident who has a and assistance, co standards of practi person-centered c and preferences, t prosthetic device. This REQUIREME by: Based on observareview, the facility accordance with president (R150) which is sident (R150). But in a sident (R150) which is sident (R150) which is sident (R150) which is sident (R150). During and observe R150 was sitting on At 8:26 a.m. R150	a prosthesis is provided care prisistent with professional ice, the comprehensive are plan, the residents' goals to wear and be able to use the interview, and document failed to provide oxygen (O2) in hysician's order for 1 of 1 no required oxygen therapy.  Indicate the dark of the	F 328	The submission of this plan of corris not an admission by the provider fact or conclusion set forth in the statement of deficiency. This plan correction is being submitted becarrequired by law. However, evidence Robbinsdale Rehabilitation and Ca Center good faith, the facility offers following plan of correction and has achieved substantial compliance in of the areas addressed by Februar 2017  1. R150 no longer resides at Robbin Rehab and Care Center but on 1/1 Oxygen therapy orders were clarified. 2. Residents with COPD and/or has orders for oxygen therapy have the potential to be affected by this pracent Residents with COPD and/or have for oxygen have had a chart review orders and care plans updated as appropriate with validation that appropriate Physician orders are givith perameters.  3. Education provided to LN staff to	of any of use it is sing re the secondary 1, instale 2/2017 ed. 2/2017 ed. 2/2017 ed. 3/2017 ed. 4/2017 ed. 5/2017 ed. 6/2017 ed. 6/	
	oxygen via nasal c	ont of him. R150 was wearing annula. At 10:22 a.m. R150 heelchair not wearing oxygen.		addresses standards of practice, p and procedures as it relates to oxy therapy, clarification of Physician o	gen	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	` ´COM	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER  SDALE REHAB & CA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422			
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F 328	assistant (PTA)-B s couple of steps. He yesterday. He is me R150's Interagency 1/7/17, indicated di emphysema, chrondisease (COPD), lu (CO2) retention, ac and severe major of An Occupational TI 1/9/17, indicated R R150's 1/10/17, Ac plan identified R15 instructed staff to smonitor for signs/sy oxygen saturations (SOB). The 1/10/17 indicated R150 had oxygen exchange retention, COPD Progoal "sat will be >98%." Staff was dir per protocol and as shortness of breath consciousness. The lacked intervention much oxygen.  During an interview LPN-A said, "I last saturations at 7:00 on oxygen." At 10:2 assistant (PTA)-A safternoon person, references.	and joking. Physical therapy stated, "The resident took a e is doing better today than ore alert."  Transfer Orders signed agnoses of pneumonia, nic obstructive pulmonary ang mass, carbon dioxide ortic stenosis, acute confusion	F 328	and signs and symptoms of COrretention.  4. Audits will be completed by the of Nursing and/ or designee for with COPD and/ or utilize oxyge to ensure appropriate Physician and orders are being followed we Physician perameters. Audits we completed on 3 resident charts then 4 resident charts per month months.  5. Audits will be reviewed at Quant Assurance Meeting (QAPI) mone months to determine if any trendidentified and recommendations continued audits and monitoring.  6. Completion date 2/21/2017	ne Director residents n therapy orders vithin vill be x 4 weeks n for 2 ality thly for 3 ds are		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245417	B. WING				C <b>12/2017</b>	
NAME OF PROVIDER OR SUPPLIER  ROBBINSDALE REHAB & CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  3130 GRIMES AVENUE NORTH  ROBBINSDALE, MN 55422				
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F 328	R150's oxygen satural RN-A was not observe breathing status.  RN-A verified on 1/dining room with oxygen satural shown the order of the control of the state of the staff yesterds status. The had cheep of the staff yesterds of the yesterds of yest	ratory status. LPN-A said arations would be checked. rved checking on R150's  12/17, at 9:07 a.m. was in tygen on at two liters. RN-A er for oxygen 2 liters to keep or equal to 88%. RN-A showed oxygen 2 liters for discomfort on or hypoxia (O2 sats less exported she was aware of the original discount of the erent oxygen/saturation and concerns had been brought any about R150's respiratory eck his sats and they were of oxygen. At 9:21 a.m. RN-A or clarified R150's oxygen be at two liters and keep the requal to 88 percent. When R150 should have been using attions were 96% or higher of the know, maybe for comfort. I or." RN-A reported R150's O2 oxygen when he was in the when off oxygen. At 9:31 giving too much oxygen to a carbon dioxide retention, can cidosis, headache, confusion,	F3	28				

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NAME OF PROVIDER OR SUPPLIER  ROBBINSDALE REHAB & CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		,12/2011	
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F 328	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			28			

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		245417	B. WING		C <b>01</b> /1 <b>2/2017</b>	
NAME OF PROVIDER OR SUPPLIER  ROBBINSDALE REHAB & CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		. = / = V
PREFIX (EACH I	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
themselve same." ME not in resp clarified O admission dioxide ret remained he remain.  At 3:30 p.r retention we respiratory.  An oxyger was not re 483.45(f)(' RATES OF Compared to the second to the	Continued From page 20 themselves, too little oxygen can cause the same." MD-A stated when she saw R150 he was not in respiratory distress. The facility had not clarified O2 orders at the time of R150's admission. R150 had a diagnosis of carbon dioxide retention and although his O2 sats remained above 96% from 1/7 through 1/12/17, he remained unnecessarily on continuous O2.  At 3:30 p.m. the DON said carbon dioxide retention was not covered in the facility's respiratory module.  An oxygen administration policy requested but was not received.  483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  (f) Medication Errors. The facility must ensure that its-  (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced		F 32		of any of use it is ing re the s each	2/21/17

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NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ROBBINSDALE REHAB & CARE CENTER				31	130 GRIMES AVENUE NORTH			
ROBBIN	SUALE REHAD & CA	ARE CENTER		R	OBBINSDALE, MN 55422			
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F 332	Findings include:  R125's insulin was p.m. by licensed p cleaned her hands units of Novolog in R125 received 3 u schedule and 2 un accucheck (meast 232. LPN-D approexplained the procalcohol, administe (just beneath the sfor greater than fivneedle, checked thin the sharps contawashed her hands primed (removed a prior to use. She ethe insulin needles "That's the way we hospital."  On 1/10/17, at 12: facility had not recpackage inserts with delivered from the able to provide mause of the BD [Bec Safety Pen Needle directed staff to "A Pen, Needle beford device with an airs up and press the bliquid should apperepeat as recomminstructions. If the	age 21  s prepared on 1/9/17, at 6:27 ractical nurse (LPN)-D. She s, donned gloves and drew up 5 isulin per FlexPen. She stated nits per his medication its per sliding scale due to an ures blood glucose) reading of ached R125 in his room, redure, cleaned the cite with red the 5 units subqutaneously skin), held the needle in the skin re seconds, removed the ne cite, disposed of the needle ainer, removed the gloves and s. LPN-D verified she had not air bubbles) the insulin needle explained that she only primed s when used with a new pen, redid it when I worked in the  16 p.m. LPN-E explained the eived the manufacturer's hen the flexpens when pharmacy. However, she was unfacturer's instructions for cton Dickenson] Auto Shield red. The instruction pamphlet llways check the flow in the re each injection by priming the shot. Dial 2 units, point the pen outton. A drop or stream of ar at the needle tip. If NOT, rended by the pen's pen still does not prime, reand repeat the priming steps."	F 3	332	1. R151 no longer resides at Robbi Rehab and Care Center. R125 ins pen was not primed, a call was place the Nurse Practitioner who gave and to give the 2 units of insulin that was potentially missed due to not priming pen. Verbal education was provided LPN-D on 1/9/2017 regarding priminsulin pen and holding for 10 secondedication error was completed and Physician updated regarding exceet the 4000mg Tylenol/ Acetaminophed dosage for R151.  2. Residents who have orders for Acetaminophen or medications that contain Tylenol/ Acetaminophen has potential to be affected by this practice. Chart reviewer completed on residents with Physician orders for Tylenol/ Acetaminophen or medications contylenol/ Acetaminophen or medications contylenol/ Acetaminophen or medications contylenol/ Acetaminophen and reside with Physician orders for insulin an updated as appropriate.  3. LN staff were given education or insulin administration via pen and Tacetaminophen perameters. Educated and the completed by the Director of Nursing or designee monitoring insulin via pen included a demonstration.  4. Audits will be completed by the Director of Nursing or designee monitoring insulin pen administration per week for 2 weeks then twice per for 2 weeks then 3x per month for 3	ulin ced to a order as ag the ed to any the ed to any the ed to any the ed to any the ed to ed t		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		COM	(X3) DATE SURVEY COMPLETED			
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F 332	During an interview director of nursing follow standards of provided by the mashe further explain not have a policy for was provided to the as needed.  On 1/12/17, at 12:2 Pharmacy consultate patient education to medication." She further explain the ducation to medication." She furthave utilized inform website or call for wand or FlexPen use.  The facility's undate Instructions/Using (printed from a web avoid injecting air at the dose selector to with the needle poingently a few times, to the top; Press the until the dose selectinsulin should appears of the top; and the dose selectinsulin should appears of the top; and the top; Press the until the dose selectinsulin should appears of the top; and the top; and the top; are the top; are the top; are the top; are the top; and the top; are the top; and the top; are the top; are the top; and the top; are the top; and the top; are the top; are the top; and the top; are t	on 1/12/10, at 11:56 a.m. the stated she expected staff to practice and the guidelines unufacturer when available. ed that although the facility did or the use of flexpens, training e staff upon hire, annually and estaff upon hire, annually and estaff upon hire, annually and estaff upon hire, annually and entry that stated, "We do not provide on nursing homes for any urther explained that staff could nation via the Omnicare verbal instructions on insuling estaff upon the NovoLog Pen training estaff upon the NovoLog Pen training estaff upon the user: "To and ensure proper dosing: Turn to 2 units; Hold your FlexPen enting up, and tap the cartridge which moves the air bubbles e push button all the way in estor is back to 0. A drop of ear at the top of the needle; If hange the needle and of acetaminophen (Tylenol) and diazepam (for anxiety) 5 administration on 1/9/17, at	F 33	months. Audit will be compled Director of Nursing or design monitoring for exceeding the dose of Tylenol/ Acetaminop week for 2 weeks then twice 2 weeks, then 3x per month 5. Audits will be reviewed at Assurance Meeting (QAPI) months to determine if any tridentified and recommendatic continued audits or monitorine 6. Completion date 2/21/201	mee maximum hen 3x per per week for for 2 months.  Quality nonthly for 3 rends are ons for	

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		245417	B. WING			C <b>)1/12/2017</b>
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		71712/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 332	to give acetaminop needed for mild pai substance category Prescription form d give two Percocet 8 mg/acetaminophen need for pain not to acetaminophen per A pain managemer indicated R151 had alteration in comfor abnormality. Staff v pain medication as record effectivenes R151's 1/17, Medic (MAR) revealed the acetaminophen 500 and 5:35 p.m.; Per mg/acetaminophen 1/8/17, at 8:00 p.m 6:50 a.m. 11:07 a.n exceeded the maxi when the resident r During an interview facility's consulting expect that they [numg in a 24 hour pe as a cautionary was adverse effects and and have a problem person."	hen 500 mg every six hours as in. Request for CII (control v II) Continuance of Therapy ated 1/6/17, instructed staff to 5/325 (oxycodone 5 325 mg) every four hours as exceed 4000 mg of 24 hours.  It care plan dated 1/17, I diagnoses of acute pain and it related to cervical spine evere directed to administer ordered and monitor and	F3	32		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		245417	B. WING			C / <b>12/2017</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI		12/2011
ROBBIN	SDALE REHAB & CA	RE CENTER		3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 332	Continued From pa	age 24	F 3	32		
	practitioner (NP)-A is not more than 40 does not have liver call for a clarification would be getting meshould not be using together."	1/12/17, at 4:14 p.m. the nurse said, "The standard of nursing 000 mg of Tylenol a day. [R151] diseaseThe nurses should on or new order if the resident ore than 4 grams. Ideally they g Percocet and Tylenol  Medication Administration				
F 333 SS=D	procedure instructed provide safe admired The licensed nursed will administer medication assistated administer medication assistated administer medication assistated administer medication assistated administer medications, Right dosage resident Right time."	ed staff, "The center strives to histration of all medications. e and/ or medication assistant dication according to State. The licensed nurse and/ or not will check the following to tion: Right medication, Right e form, Right route, Right	F 3	33		2/21/17
	medication errors. This REQUIREME by: Based on observa review, the facility to was primed to ensi residents (R125) of administration. This affect 6 residents received insulin. The significant medicat facility failed to ensi	e free of any significant  NT is not met as evidenced  tion, interview and document failed to ensure an insulin pen fure accurate dosing for 1 of 2 beserved for insulin se practice had the potential to the esiding on the unit who find in error. In addition, the find the potential to the estimation error in addition, the find the blood thinner used to		The submission of this plan of is not an admission by the proffact or conclusion set forth in the statement of deficiency. This properties to correction is being submitted by required by law. However, evice Robbinsdale Rehabilitation and Center good faith, the facility of following plan of correction and achieved substantial compliance.	ider of any e lan of ecause it is encing Care fers the has	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245417	B. WING		C <b>01/12/2017</b>
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	01/12/2017
				3130 GRIMES AVENUE NORTH	
ROBBIN	SDALE REHAB & CA	RE CENTER		ROBBINSDALE, MN 55422	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION
F 333	Continued From pa	age 25	F 333	3	
	prevent clotting) as	ordered		of the areas addressed by Februar 2017	y 21,
	Findings include:			R125 had no adverse effects rel	ated to
	R125's insulin was	prepared on 1/9/17, at 6:27		medication error. Nurse Practition	
		actical nurse (LPN)-D. She , donned gloves and drew up 5		updated and new orders received. no longer resides at the facility.	R154
	units of Novolog in	sulin per FlexPen. She stated			
		nits per his medication its per sliding scale due to an		2. Residents that have orders for a the following have the potential to be	
		res blood glucose) reading of		affected by this practice: Insulin	
		ached R125 in his room,		administration via pen, Coumadin,	
		edure, cleaned the cite with ed the 5 units subqutaneously		Pain medications. Residents receinsulin via pen have had a chart re	
		kin), held the needle in the skin		with Care plans and Medication	VICW
		e seconds, removed the		Administration Record (MAR) upda	
		e cite, disposed of the needle tiner, removed the gloves and		appropriate to include instructions to priming insulin pen prior to	related
		LPN-D verified she had not		administration. Educational instruc	ctions
		ir bubbles) the insulin needle		have also been included in the MA	
		xplained that she only primed		regarding insulin pen administratio	
		when used with a new pen,		Policy and procedure regarding Co	
	hospital."	did it when I worked in the		residents receiving Coumadin have	
	1100pitali			chart and MAR review with updates	
		6 p.m. LPN-E explained the		appropriate. Residents receiving p	
		eived the manufacturer's		medications have had a chart and	
		nen the flexpens when pharmacy. However, she was		review to include updates as appro	priate.
		nufacturer's instructions for		3. Education was provided to LPN	-D on
	•	ton Dickenson] Auto Shield		1/9/2017 regarding priming insulin	
		. The instruction pamphlet		and holding for 10 seconds. On	'
	directed staff to "Al	ways check the flow in the		1/18/2017 formal education was pr	
		e each injection by priming the		to LPN-D and on 1/24/2017 a retur	
		hot. Dial 2 units, point the pen		demonstration was completed. LN	N staff
		utton. A drop or stream of		have been educated on policy and	
	repeat as recomme	ar at the needle tip. If NOT,		procedures regarding Coumadin administration. LN staff have been	,
		pen still does not prime,		educated on procedure and manuf	

NAME OF PROVIDER OR SUPPLIER     245417     B. WING	AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION		E SURVEY PLETED
01/12/20			245417	B. WING				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	NAME OF		243417	B. 11.11G		OTREET ARRESTO OITY OTATE ZIR CORE	01/	12/2017
	NAME OF	PROVIDER OR SUPPLIER						
ROBBINSDALE REHAB & CARE CENTER  3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	ROBBIN	SDALE REHAB & CA	RE CENTER					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
Continued From page 26 change the Needle and repeat the priming steps."  During an interview on 1/12/10, at 11:56 a.m. the director of nursing stated she expected staff to follow standards of practice and the guidelines provided by the manufacturer when available. She further explained that although the facility did not have a policy for the use of flexpens, training was provided to the staff upon hire, annually and as needed.  On 1/12/17, at 12:25 p.m. the Omnicare Pharmacy consultant stated, "We do not provide patient education to nursing homes for any medication." She further explained that staff could have utilized information via the Omnicare website or call for verbal instructions on insulin and or FlexPen use.  The facility's undated Novalog FlexPen Instructions/Using The NovoLog Pen training (printed from a website) directed the user: "To avoid injecting air and ensure proper dosing: Turn the dose selector to 2 units; Hold your FlexPen with the needle pointing up, and tap the cartridge gently a few times, which moves the air bubbles to the top; Press the push button all the way in until the dose selector is back to 0. A drop of insulin should appear at the top of the needle; If no drop appears, change the needle and repeat"  Coumadin:  R154's Associated Clinic of Psychology Progress Note dated 2/9/16, indicated the resident had been hospitalized due to "low impact head trauma" and "subtherapeutic INR [international normalized ratio]," R154's Interagency Transfer Orders dated 2/24/16, indicated diagnoses of artic valve replacement, on chronic Coumadin	F 333	change the Needle  During an interview director of nursing selector of provided by the man she further explaint not have a policy for was provided to the as needed.  On 1/12/17, at 12:2 Pharmacy consultated patient education. She for the dication. She for the number of the provided informs website or call for ward or FlexPen used. The facility's undated Instructions/Using of (printed from a website or call for ward or FlexPen used injecting air at the dose selector to with the needle poing gently a few times, to the top; Press the until the dose selectinsulin should appears of the top; Press the until the dose selectinsulin should appears, clarepeat"  Coumadin: R154's Associated Note dated 2/9/16, been hospitalized of trauma" and "subth normalized ratio]." For Orders dated 2/24/10.	and repeat the priming steps."  on 1/12/10, at 11:56 a.m. the stated she expected staff to practice and the guidelines nufacturer when available. ed that although the facility did r the use of flexpens, training e staff upon hire, annually and staff upon hire, annually and staff upon hire, annually and stated, "We do not provide onursing homes for any orther explained that staff could ation via the Omnicare erbal instructions on insuling site) directed the user: "To and ensure proper dosing: Turn of 2 units; Hold your FlexPen of 3 units flex of 3 uni	F3	133	guidlines as it relates to insulin administration via pen. LN staff hat been educated on administration of medications as ordered by the Physiand ensuring there are clear directive regarding perameters for administration perameters for administration of the complete by Director Nursing or designee monitoring inspen administration 3x per week for weeks then twice per week for 2 weeks then 3x per month for 2 months.  5. Audits will be reviewed during Quantification Assurance Meetings (QAPI) to determine any trends are indentified and recommendations for continued automitoring.	f pain sician ons ation. or of ulin 2 eeks	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		TE SURVEY MPLETED
		245417	B. WING _		01	C / <b>12/2017</b>
				STREET ADDRESS, CITY, STATE, ZIP C 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		712/2011
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	therapy, acute on ochronic back pain.  Review of R154's Mecords (MARs) fr 2016, revealed R15 Coumadin ordered clot development rereplacement Coum 2/28/16, 3/23/16, 4.7.5 mg on 5/30/16.  R154 had an order test to determine e dosing. R154's des R154 had an order was not completed later). On 4/18/16, 1.9, which was low ordered range. A halab result was to intoday and to alterna Repeat INR on 4/2.  R154 had an order 5/11/16, which was 5/12/16, the INR was higher the order written on 5/11/16.  An complaint allega R154 was not rece which affected the went onto to state to the state of the	Medication Administration om February through June 54 did not receive the to minimize the risk for blood elated to aortic valve radin 5 mg on 2/26/16, and /15/16, 6/24/16, and Coumadin fectiveness of Coumadin sired INR range was 2.0-2.5. for an INR on 4/15/16, which until 4/18/16 (three days INR was drawn. Result was er than the desired physician and written order on 4/18/16, crease Coumadin to 10 mg ate with Coumadin 5 mg. 5/16.		33		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING _		01	C / <b>12/2017</b>
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		, , = , = ,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 333	were not drawn as  Pain medication: R154 had an order Sulfate ER (extend twice a day for chro R154 had a physici Percocet 5/325 mg hours as needed for hours. Not to excee 24 hours.  Review of R154's M through June 2016 receive the Morphin 2/28/16, 3/27/16, 4.  The Progress Note had a pain level of highest rating of paindicated R154's pain The May Analgesic R154's pain to be r received Percocet scheduled long act medication box wa lacked evidence fo Percocet was giver 5/29/16, R154's pa was seven out of te out of ten, at 4:00 p p.m. the pain was r ten. The record ind needed Percocet ( the scheduled long any documentation versus the Morphin	for scheduled Morphine ed release-long acting) 15 mg onic back pain dated 2/24/16. ian order dated 3/17/16, for 1 tablet by mouth every four or pain max of five tablets in 24 ed 4000 mg acetaminophen in MARs from February 2016, revealed R154 did not ne Sulfate ER on 2/26/16, /16/16, 5/26/16, and 5/29/16. e of 2/26/16, indicated R154 8 out of ten, with ten being the tin. The note dated 4/16/16,	F 3:	33		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ONSTRUCTION	, COV	E SURVEY MPLETED
		245417	B. WING				C / <b>12/2017</b>
	PROVIDER OR SUPPLIER  SDALE REHAB & CA	RE CENTER		3130	EET ADDRESS, CITY, STATE, ZIP CODE OF GRIMES AVENUE NORTH BBINSDALE, MN 55422	1 01/	12/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 333	when the staff was versus the long act Record for Februar reviewed./ There w medications were at the long acting Mordocumentation.  An allegation of a cindicated R154 was medication.  R154's discharge Mated 7/27/16, indicintact with no reject indicated R154 had obstructive pulmon edema, polyarthritis section indicated R and the rating was  During interview on DON reviewed the Analgesic Record/p Neb and unlabeled through June 2016 identified medication administered. The ligive the medication and document on the administration recogiven. DON said, "I [R154] received the signed for. The posterior missed, is un Coumadin is a sign asked if there had be reported for (R154)	to administer the Percocet ing Morphine. The Analgesic ry, March, and April 2016 were ere no as needed (PRN) administered on the days that rphine was void of complaint dated 5/31/16, as not receiving the correct Minimum Data Set (MDS) cated R154 was cognitively tion of cares. R154's MDS I diagnoses of chronic ary disease, heart failure, as, and anemia. The pain 154 to be in pain occasionally		333			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		E SURVEY MPLETED
		245417	B. WING			C / <b>12/2017</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	01/	12/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
F 425 SS=D	The 8/10, Morphine Insert by Watson La "Morphine Sulfate Ean extended-releas sulfate indicated for moderate to severe around-the-clock of an extended-Release as a prn analgesic."  The 2016, Percoce Endo Pharmaceutic "PERCOCET is ind moderate to moder enough to require a which alternative tre. The Medication Adm March 2016, instructives to provide sa medications. The limedication assistant according to State slicensed nurse and check the following Right medication, Fight route, Right resident, Right 483.45(a)(b)(1) PH. ACCURATE PROCES	om 2/1/16, until date of uested but not provided.  Sulfate ER Manufacturer's aboratories ING indicated Extended-Release Tablets is e oral formulation of morphine of the management of a pain when a continuous, bioid analgesic is needed for of time. Morphine Sulfate Tablets is not intended for use of the management of ately severe pain, severe an opioid analgesic and for eatments are inadequate."  In ministration procedure revised contends and the series of all consed nurse and/or and will administer medication assistant will to administer medication: Right dose, Right dosage form, and time."  ARMACEUTICAL SVC -	F 3			2/21/17
	pharmaceutical ser	racility must provide vices (including procedures urate acquiring, receiving,				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING COM		COMF	SURVEY PLETED	
		245417	B. WING			01/1	; 2/2017
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	CODE	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BI E APPROPRI <i>A</i>		(X5) COMPLETION DATE
F 425	dispensing, and adbiologicals) to mee  (b) Service Consultemploy or obtain the pharmacist who  (1) Provides consultemploy or obtain the pharmacist who  (1) Provides consultemploy:  Based on interview facility failed to ensavailable and adminatered as prof 1 resident (R153 unavailable.  Findings include:  R153 was admitted p.m. and discharge Medication Profile resident had diagned damage, seizures addition, the report Keppra 100 milligrativice daily for seizu instructions "DAW Per Medical Doctor The 6/16, Medication (MAR) for R153 revised and again on 6/2/16 had circled and initimas not circled and initimas not circled and	ministering of all drugs and the needs of each resident.  The facility must eservices of a licensed litation on all aspects of the acy services in the facility; NT is not met as evidenced and document review, the ure medications were nistered timely and escribed by the physician, for 1 and on 6/2/16. According to a Report dated 6/1/16, the pass including anoxic brain and respiratory failure. In noted R153 had an order for am (mg)/milliliter (ml) 1250 mg are disorder with special per md [Dispense As Written]	F 4	The submission of this plais not an admission by the fact or conclusion set forth statement of deficiency. To correction is being submitt required by law. However, Robbinsdale Rehabilitation Center good faith, the facil following plan of correction achieved substantial compof the areas addressed by 2017  1. R153 no longer resides Rehab and Care Center.  2. Resident who receive or orders at Robbinsdale Reficenter have the potential to by this practice. Facility to from the hospitals for incomadmissions prior to residen Medications should be revised medication clarification should resident's orders containing should be clarified with the ensure medication is available.	provider of in the in the in the in the in the industry offers the and has oliance in each obtain orders for "Enab and Cato be affect obtain orders in each out occur e "DAW".	of any  for the second of the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	COM	E SURVEY PLETED
		245417	B. WING _			C 1 <b>2/2017</b>
	PROVIDER OR SUPPLIER SDALE REHAB & CA			STREET ADDRESS, CITY, STATE, ZIP COI 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 425	6/1/16 to 6/2/16, who nurse had indicated not been administed currently has no super doctor recommindicated the doctor order was called, ker [okay] for generic recame"  A fax dated 6/1/16 Care Unit (TCU) in the medication Ker A Situation Backgr Recommendation dated 6/2/16, indices respirations, high provided the Keppra. Family reprovided the social work patients allergy"  On 1/10/17, at 1:00 to R153's discharg licensed social work patient who dischard Report with all the was faxed over to facility's responsibe the admitting resides "To my understand not have what they when asked the moted on R153's dischard report, the hospital inquire with the distinguire with the distinguire with the distinguire with the distinguire on page.	d bedtime [HS] Keppra had bedtime [HS] Keppra had bered "Because pharmacy upply of Keppra Brand name as nendations" The writer or who wrote the discharge but was "unable to give ok name Keppra until Brand name, sent by the facility Transitional urse clarified the diagnosis for ppra was for seizures.	F 42	If pharmacy is unable to accordacility to make arrangements pharmacy other that Omnicar  3. Education provided to nurse admission staff who receive of discharging facility to contact ensure medication will be avained available, conclevated to the Director of Nurdesignee.  4. Audits will be completed of admission orders and admission orders are deartisper minor of the complete	s through a re. sing staff and orders from pharmacy to allable; if neern to be arsing or n all new sion process rs weekly for onth for 3 ing Quality of determine if the audits or	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245417	B. WING				C 1 <b>2/2017</b>
	PROVIDER OR SUPPLIER	RE CENTER		3130	EET ADDRESS, CITY, STATE, ZIP CODE D GRIMES AVENUE NORTH BBINSDALE, MN 55422	, , ,	, _ ,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 425	was what the patien hospital. The physician PER MD " meant the administered Kepper The physician had the order.  On 1/10/16, at 3:28 (DON) was intervied my understanding the brand." The DON hospital then stated generic form of Kepinstructed the staff Keppra, however, the DON stated, "In had taken care of out and facility to the resident was seizin had been reviewed been reviewed and however, they did not find out the until late on 6/1/16, delivered. The DON facility had a back the until late on 6/1/16, delivered. The DON stated the phacommunicated they available, which led believe R153's swo was related to the thowever, the reside hospital on 6/2/16, after the correct means.	the was being given at the cian's intention was "DAW he resident was to be ra and not the generic form. In the director of nursing wed. The DON stated, "From charmacy sent the generic not by said the physician at the IR153 should not receive the opra. The medical director then to administer the generic he family did not want it given. Mom was very intense as she laughter and wanted her sent he hospital. Mom thought the g." When asked if the ordered, the DON stated orders had were sent to the pharmacy, not realize and had not been armacy staff they did not have illable. The DON said the nurse medication was unavailable when medications were IN was unsure whether the up plan such as contacting to obtain the medication. The	F 4	.25			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  IG	COM	COMPLETED	
		245417	B. WING _			C <b>12/2017</b>	
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	<u> </u>	12/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 425	The CP stated the case either "dispense indicated the brand would have expecte indicated dispensed expected the pharm	ge 34 th the DON were interviewed. order should have been written as written" or should have name. The CP stated she ed the medication to have d as written, and would have hacy to communicate with the em the medication was	F 42	25			
F 431 SS=E	the following: "1. Fanotify Pharmacy when Physician/Prescribed require an interim/s necessary medicatification and the facility's interim/state Facility's interim/state Facility determines delivery is necessary Pharmacy for one of Pharmacy to includ medication(s) in an or a special delivery Pharmacy delivery Pharmacy to arranged dispensed and delivery Pharmacy to ensure 483.45(b)(2)(3)(g)(b) LABEL/STORE DROTTHE facility must predrugs and biologicate them under an agres §483.70(g) of this punlicensed personner.	ency Deliveries policy directed acility should immediately pen Facility receives from a er a medication order that may tat/emergency delivery. 2. If a on is not contained within at/emergency supply, and that an interim/stat/emergency ry, Facility should arrange with of the following actions: 2.1 For e the interim/stat/emergency earlier scheduled delivery ry, as required, or 2.2 For by contract courier, or 2.3 For ge for the medication to be received by a Third Party e timely receipt"  a) DRUG RECORDS, UGS & BIOLOGICALS  Devide routine and emergency als to its residents, or obtain the ement described in eart. The facility may permit all to administer drugs if State by under the general	F 43	.1		2/21/17	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		
	C <b>01/12/2017</b>	
NAME OF PROVIDER OR SUPPLIER  ROBBINSDALE REHAB & CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  3130 GRIMES AVENUE NORTH  ROBBINSDALE, MN 55422	2,2311	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431  (a) Procedures. 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.  (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who  (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and  (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  (g) Labeling of Drugs and Biologicals.  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.  (h) Storage of Drugs and Biologicals.  (1) 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.  (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Stoedule II of the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01/12	L/ <b>L</b> O 1 /		
				3130 GRIMES AVENUE NORTH				
ROBBIN	SDALE REHAB & CA	ARE CENTER		ROBBINSDALE, MN 55422				
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F 431	Continued From pa	age 36	F 431					
	abuse, except when package drug district quantity stored is rise readily detected. This REQUIREME by:  Based on observations.	NT is not met as evidenced ation, interview and document		The submission of this plan of cor				
	1 of 3 medication r authorized personi diversion. This had residents (R60, R5	failed to ensure medications in rooms were only accessible to nel to minimize the risk of the potential to affect 4 of 4 of R106, R154) whose andled by unauthorized supervision.		is not an admission by the provider fact or conclusion set forth in the statement of deficiency. This plan correction is being submitted becarequired by law. However, evidence Robbinsdale Rehabilitation and Canter good faith, the facility offers following plan of correction and has	of use it is cing ure s the			
		9 a.m. the maintenance as observed in the Transitional		achieved substantial compliance ir of the areas addressed by Februar 2017	n each			
	Care Unit (TCU) we nurse. The MS was refrigerator to another nurse or a trained maintenance superasked if he was superficient medication room we need to the maintenance superasked if he was superficient medication room we need to the maintenance superasked in the maintenance	rithout supervision by a licensed s moving medications from one ther. When asked if he was a medication aide (TMA), the rvisor replied, "No." When apposed to be allowed in the vithout a nurse present he urse was here when I started."		1. R60, R59, R106 and R154's medications were counted promptl incident occured in medication roo the Director of Nursing and Assista Director of Nursing to confirm all medications accounted for. R154 longer resides at the facility.	m by ant			
	The MS verified the On 1/12/17, at 7:11 came by the medicing the hall but had minutes." RN-A verthe medication root secured to the refraction would have been partially to remove the	ere was no nurse in the area.  I a.m. registered nurse (RN)-A cation room and stated, "I was to go down the hall for a few rified narcotics were stored in m and the box was not igerator. RN-A acknowledged it possible for the unauthorized a narcotic box, but did not think into the box, as it was locked.		<ol> <li>Resident who reside at Robbins Rehab and Care Center and receiv medications that at any time are st the medication room have the pote be affected by this practice.</li> <li>Education was immedicately proto the Maintenance Supervisor and on who is able to access medication rooms. Staff both clinical and non have been educated on who is aut</li> </ol>	ored in ential to ovided d RN-A on clinical			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING			(3) DATE SURVEY COMPLETED	
		245417	B. WING			C <b>12/2017</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	1 01/	12/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETION DATE	
F 431	handled without sup RN-A: Three vials of (mg)/milliliter (ml) (a in a clear plastic tac locked inside the bl lock on box but was addition, R60's Dap (antibiotic) 445 mg boxes Tylenol (a mi two boxes bisacody R154's Neupogen ( Humalog (insulin); t solution); R106's La pens for R136; one	refrigerator that the MS pervision were verified by of Ativan 2 milligram anti-anxiety medication) stored ckle box with zip tie that was ack box with chain and pad on attached to anything. In atomycin intravenous and Novolog (insulin pen); two ld analgesic) suppositories; rl suppositories (laxative); for neutropenia); R59's wo vials of Aplisol (tuberculin antus (insulin); two Lantus vial of Influenza vaccine es of Fluzone high dose	F 43	to be in the medication rooms in eminimize the risk for diversion.  4. Audits will be conducted by Dire Nursing or designee to monitor thauthorized personnel do not have to medication rooms weekly for 4 then monthly for 2 months.  5. Audits will be brought to Quality Assurance Meeting (QAPI) for 3 in for continued opportunities for quaimprovement.  6. Completion date 2/21/2017	ector of at non access weeks		
F 441 SS=D	(DON) stated only rallowed in the medishould not have been own unsupervised although it was lock been allowed access On 1/12/17, at 3:00 policy requested bu 483.80(a)(1)(2)(4)(6) PREVENT SPREAL  (a) Infection prevent	e)(f) INFECTION CONTROL, D, LINENS tion and control program. tablish an infection prevention on (IPCP) that must include, at	F 44	41		2/21/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY MPLETED
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NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		12/2017
ROBBINSDALE REHAB & CARE	E CENTER		3130 GRIMES AVENUE NORTH		
HODBINGDALL HEHAD & CARL	LOUNTER		ROBBINSDALE, MN 55422		
PREFIX (EACH DEFICIENCY M	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
investigating, and corcommunicable disease volunteers, visitors, a providing services un arrangement based us conducted according accepted national state implementation is Ph.  (2) Written standards for the program, which limited to:  (i) A system of surveit possible communicable communicable disease reported;  (ii) When and to whom communicable disease reported;  (iii) Standard and trant to be followed to previous followed to previous formulations of the program of the involved, and  (A) The type and durate depending upon the involved, and  (B) A requirement that least restrictive possicircumstances.	renting, identifying, reporting, ntrolling infections and ses for all residents, staff, and other individuals of a contractual upon the facility assessment to §483.70(e) and following andards (facility assessment asse 2);  as, policies, and procedures of must include, but are not dillance designed to identify ble diseases or infections and to other persons in the massible incidents of se or infections should be used for a ut not limited to:	F 4	141		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245417	B. WING				) 12/2017
	PROVIDER OR SUPPLIER	RE CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE  130 GRIMES AVENUE NORTH  ROBBINSDALE, MN 55422	<b>0.</b> 7.	
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F 441	contact with reside contact will transmit (vi) The hand hygie by staff involved in  (4) A system for required the facility's actions taken by the (e) Linens. Person process, and transspread of infection.  (f) Annual review. annual review of its program, as neces This REQUIREMED by:  Based on observation review, the facility of hygiene and pericate that minimized infereviewed for activity.  Findings include:  R13's morning care at 7:12 a.m. by nur while wearing glove incontinence brief at Although NA-K the she did not wash his anitizer. NA-K prochest and back. Natincontinent pad ungloves and applied	skin lesions from direct ints or their food, if direct it the disease; and ine procedures to be followed direct resident contact.  cording incidents identified IPCP and the corrective e facility.  Inel must handle, store, port linens so as to prevent the The facility will conduct an is IPCP and update their	F 4	411	The submission of this plan of correis not an admission by the provider of fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted because required by law. However, evidencian Robbinsdale Rehabilitation and Card Center good faith, the facility offers of following plan of correction and has achieved substantial compliance in of the areas addressed by February 2017  1. R13 plan of care was reviewed and remains current. A resident choice of in relation to how she prefers to be cleansed was completed and reside was educated on female hygeine and interventions to prevent UTI's. Residents.	of any of se it is ng e the each 21, and form	

STATEMENT OF DE AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
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NAME OF PROV	IDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE	U I/	12/2017
NAME OF THOS	IDEN ON OUT LIEN				130 GRIMES AVENUE NORTH		
ROBBINSDA	LE REHAB & CA	RE CENTER			OBBINSDALE, MN 55422		
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Nyano NA so per wa act glo a c glo R1 9/2 inc inc from Ma day (UT R1 1/1 and per free ind infer L7/8 100 tree UT	d under the reside. K to get perfurwithout changing in area from from she cloth from basion three times. It was NA-K applied lean top sheet of ves and washed as and washed as and washed as a front to back. It was a front to back. It was a front to back. It was a front to back are to a front and insontinent pad as a front to back. It was a front to back. It was a front to back are to a front and the required assists and hygiene a front to back a front to back. It was a front to back a front to back. It was a front to back a front to back a front to back. It was a front to back a front to back a front to back a front to back. It was a front to back	or fungus) to abdomen folds dent's breasts. R13 requested ne out of her drawer. NA-K did g gloves. NA-K washed R13's to back and then brought the ack to front. NA-K repeated Without changing the soiled a gown on R13 and then put over R13. NA-K then changed	F 4	141	that reside at Robbinsdale Rehab a Care Center who receive assist wit perineal care have the potential to affected by this practice. Policy and Procedure in relation to the Bowel as Bladder program were reviewed as as procedure regarding perineal care.  2. Education was provided to NA-K 1/13/2017 related to perineal care, Personal Protective Equipment (PF and hand Hygeine. Education provoursing staff related to perineal care policy and procedures related to PF hand hygeine including use of sanitiand infection prevention standards practice.  3. Audits will be completed by Direct Nursing or designee monitoring for perineal care, use of gloves, and has hygeine 3x per week for 2 weeks, then 3 month for 2 months.  4. Audits will be reviewed during Quasurance Meeting (QAPI) monthly months to determine if any trends a identified and recommendations for continued audits or monitoring.  5. Completion date 2/21/2017	h be l and well re. on PE) and rided to e, E; cizer of tor of proper and hen x per uality for 3 are	

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	PROVIDER OR SUPPLIER  SDALE REHAB & CAI	RE CENTER		313	REET ADDRESS, CITY, STATE, ZIP CODE 80 GRIMES AVENUE NORTH 9BBINSDALE, MN 55422	. = . = .	
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F 441	NA-K said, "I got diswashing the peri arwanted staff "to put and scrub around reacknowledge going the cloth, back to th have just left it dow then removed it with clean area."  Registered nurse (F11:24 a.m. "Staff arfront to back and the front."  During an interview director of nurses edone front to back. cleaned several time changed the cloth. Tract infection if staff the facility's 1/17, If water Procedure in its the most importated Healthcare Associated [Centers for Diseased Hygiene Guideline) personnel to use having an alcohol hand rub resident care if most contaminatedbody removing gloves."  The facility provided	except at the start of cares. Stracted." NA-K explained ea last because the resident so much soap down there eally hard." NA-K did front to back and then pulling the front. NA-K said, "I could in there until I was done and nout coming back over the early." A stated on 1/12/17, at the to clean [the perineum] from en not come back to the explained, "Pericare should be lf a resident wanted the area es the staff should have the staff should have. There is a possibility of urinary if wipe back to front."  Hand HygienePlain Soap and structed staff, "Hand hygiene int procedure for preventing ted infections (Refer to CDC e Control] 2002, Hand at the center requires and hygiene to remove dirt, do transient microorganisms." It is that plain soap and water or on may be used. "During	F 4	41			

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	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422			
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F 441	includes care of the anal area, should be bath and if the patient urination and bowel promotes cleanlines using a washcloth: water from a spigot disinfected bath bases separate the patient patient has an indwinder, use the other meatus with the walk catheter-associated aggressively clean incleaning can lead to the risk for infection strokes, clean the patient back of the periorganisms form convagina. Avoid the acclean section of walk folding each used scontamination with 483.90(h)(5) SAFE/FUNCTIONAL ENVIRON  (h) Other Environmental The facility must presanitary, and comforms anitary, and comforms anitary anitary.	external genitalia and the external movements. The procedure is and prevents infectionFor Wet a washcloth with warm (or from a clean and sin) and apply mild soap. In the Labia with one hand. If the relling urinary catheter in rhand to clean the urethral sholoth to reduce the risk for durinary tract infection. Don't the meatal area; aggressive or meatal irritation increasing in. Using gentle downward perineal area from the front to meum to prevent intestinal intaminating the urethra or a rea around the anus and use a sholoth for each stroke by section inward to prevent secretions or discharge."  AL/SANITARY/COMFORTABL  ental Conditions  ovide a safe, functional, ortable environment for the public.  icies, in accordance with State, and local laws and ng smoking, smoking areas,	F 4			2/21/17	
	and smoking safety	that also take into account					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY PLETED
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NAME OF PROVIDER OR SUPPLIER	₹		STREET ADDRESS, CITY, STATE, ZIP	•	,
			3130 GRIMES AVENUE NORTH		
ROBBINSDALE REHAB & CA	ARE CENTER		ROBBINSDALE, MN 55422		
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by: Based on observer review, the facility working order for potential to affect  Findings include:  The executive dire at 7:36 a.m. they be years prior, but the residents to tate Although the bath not been removed a storage room. To shown the facility they said they prest them to a sister factor of the ED felt there residents' part to be had tubs. We can expensive."  The director of number interview on 1/12/bathtubs were not DON said she county were not in use, at they should not have the facility for mar bathtubs being in	<u>₹</u>	F 4	The submission of this pla is not an admission by the fact or conclusion set forth statement of deficiency. The correction is being submitted required by law. However, Robbinsdale Rehabilitation Center good faith, the facility following plan of correction achieved substantial compof the areas addressed by 2017  1. R95 is currently not at the R101 stated that he knows does not have a tub bath a want to transfer to a facility bath.  2. Residents that reside at Rehab and Care Center has to be affected by this practice will meet with all represented at the facility and respected at the facility and residents to Robbinsdale Resi	provider of any in the his plan of ed because it is evidencing and Care ity offers the and has liance in each February 21, he facility and that the facility and that the facility and he does not with a tub.  Robbinsdale ave the potential ice. Social esidents that view dmitted aehab and Care the facility does hey wish to will assist with bath.  The Activity is the need to idents plan of	

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		245417	B. WING			01/1	C 1 <b>2/2017</b>
ROBBIN	PROVIDER OR SUPPLIER  SDALE REHAB & CAF			3	STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
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F 465	were currently used The ED stated on 1 answer why they [bd don't know what the ED stated they had to the tubs.  The maintenance d on 1/12/17, at 4:15 have any bath tubs. submitted to the Min dated 5/13/16, reve on three floors in the Based on observative on three floors in the Based on observative working order for repotential to affect the Findings include:  R101 was interview When asked about stated she stated she "There is no bath in would like a bath. I'm In a follow up interv 8:33 a.m. he stated telling me there was would have I would important to me to be showerThe older bath to soak. I have R95 was interviewe stated that they would and soaking in the be	I for storage.  /12/17, at 12:58 p.m. "I cannot athtubs] were not replaced. I be thought process was." The no written information related irector (M)-A was interviewed p.m. stated the facility did not. However, floor plans nnesota Department of Health aled the presence of five tubs be facility.  on, interview and document ailed to ensure a tub was in resident use. This had the resident use for residents in the facility.  red on 1/9/17, at 3:12 p.m. bathing choices the resident need id not have a choice as, this facility. I wish there was. I m sure a lot of people would." iew with R101 on 1/11/17, at , "I do not remember them is no bath in the place. If they we bitched about it. It's nave a bath instead of a I get the more I would like a	F 4	165	would like a tub bath. Activities will Social Services so they can meet veresident and assist with locating a with a tub bath.  4. Audits will be completed by the I of Social Services or designee that monitor next business day for newl admitted residents for proper bathic choice for 3 weeks and then weekl for 4 weeks.  5. Audits will be reviewed at Quality Assurance Meeting (QAPI) monthly months to determine if trends are identified and recommendations for continued audits and monitoring new 6. Completion date 2/21/2017	with the facility  Director will ly ng y audits  ty y for 3	

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F 465	When asked if they for a tub bath and F I was asked what ty then told a nursing do not remember winterview with R95 of stated he had not be admission in 8/16, the notion one else would be R95 stated, "I would have known I like taking Epson tub." At 3:44 p.m. From the offered a choice of facility that had a tub. The executive direct at 7:36 a.m. they have years prior, but they are prior, but they have a storage room. The shown the facility profession they said they prefet them to a sister fact were offered a choice of the ED felt there were interview on 1/12/13 bathtubs were not on DON said she could were not in use, and	informed staff of their request R95 stated, "Yes, on admission repe of bathing I preferred, I assistant (NA) and a nurse. I who else I told." In a follow up on 1/12/17, at 3:41 p.m. he een informed prior to his that a tub was unavailable, and been informed on his behalf. If not have come to this facility we they did not have bathtubs. It is added that he was never going instead to a sister b.  Stor (ED) explained on 1/12/17, at bathtubs approximately 20 are was no desire on the part of the abath versus a shower. The were not in use, they had and the room was changed to be ED said residents were rior to their admission and if the interest a bath, they would admit a still ity instead. Current residents were of a shower or a bed bath. The last ill in odesire on the layer a tub bath. "I can't lie. We	F 46	65			

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NAME OF PROVIDER OR SUPPLIER  ROBBINSDALE REHAB & CARE CENTER				STREET ADDRESS, CITY 3130 GRIMES AVENUE ROBBINSDALE, MN	NORTH	017	12/2011
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F 465	The maintenance s 1/12/17, at 12:44 p. the facility for many bathtubs being in u tubs had never bee discussed. He expl. were currently used. The ED stated on 1 answer why they [b don't know what the ED stated they had to the tubs.  The director of soci interviewed on 1/12 a copy of the Admis LSW-A explained the residents and/or relevance of the halls.  The maintenance of on 1/12/17, at 4:15 have any bath tubs submitted to the Midated 5/13/16, reveron three floors in the The Admission Paciprovided to all residents and not in a bath tub. Based of document review, the tub was in working	upervisor (MS) stated on m. although he had worked at years, he did not recall the se. He did not know why the n replaced, nor had it been ained that the old tub rooms of for storage.  /12/17, at 12:58 p.m. "I cannot athtubs] were not replaced. I be thought process was." The no written information related all services (LSW)-A was extra 3:44 p.m. at which time existence that the facility had a bathtub at either end lirector (M)-A was interviewed p.m. stated the facility did not. However, floor plans nnesota Department of Health ealed the presence of five tubs	F 4	65			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  ROBBINSDALE REHAB & CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	)DE	017	12/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD I	BE	(X5) COMPLETION DATE
F 465	When asked about stated she stated she stated she "There is no bath in would like a bath. I'll na follow up interv 8:33 a.m. he stated telling me there was would have I would important to me to his showerThe older bath to soak. I have R95 was interviewe stated that they wou and soaking in the facility did not have When asked if they for a tub bath and FI was asked what ty then told a nursing ado not remember with the told a nursing ado not remember with review with R95 stated he had not be admission in 8/16, the no one else would be R95 stated, "I would if I would have know I like taking Epson [tub." At 3:44 p.m. Roffered a choice of facility that had a ture the residents to take the residents to take the state of the residents to take the r	ed on 1/9/17, at 3:12 p.m. bathing choices the resident ne did not have a choice as, this facility. I wish there was. I m sure a lot of people would." iew with R101 on 1/11/17, at if iew with R101 on the place. If they we bitched about it. It's nave a bath instead of a liget the more I would like a if iew arthritis."  I get the more I would like a iew arthritis."  I don 1/9/17, at 4:10 p.m. R95 and enjoy an Epson salt bath both tub. R95 then stated the a bathtub on any of the floors. informed staff of their request informed staff of the	F4	65			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING		0	C <b>1/12/2017</b>
NAME OF PROVIDER OR SUPPLIER  ROBBINSDALE REHAB & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  3130 GRIMES AVENUE NORTH  ROBBINSDALE, MN 55422			1712/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 465	not been removed a storage room. The shown the facility puthey said they prefet them to a sister factor of the ED felt there were offered a chould the ED felt there were identified by the can't expensive."  The director of nurrinterview on 1/12/1 bathtubs were not in use, and they should not have the facility for many bathtubs being in the facility for many bathtubs had never been discussed. He explayere currently used.  The ED stated on answer why they [be don't know what the ED stated they had to the tubs.  The director of soci interviewed on 1/12 a copy of the Admit LSW-A explained the residents and/or residents and/or residents.	and the room was changed to the ED said residents were prior to their admission and if the erred a bath, they would admit sility instead. Current residents ice of a shower or a bed bath. Was still no desire on the ave a tub bath. "I can't lie. We get partsit is very  sing (DON) confirmed in an 7, at 12:11 p.m. the facility currently available for use. The d not explain why the bath tubs and if a resident wanted a bath we been admitted to the facility. Supervisor (MS) stated on .m. although he had worked at y years, he did not recall the lise. He did not know why the en replaced, nor had it been lained that the old tub rooms	F 4	65		

	D DI AN OF CODDECTION IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245417	B. WING			C <b>01/12/2017</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	DDE '	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 465	on 1/12/17, at 4:15 have any bath tube submitted to the M dated 5/13/16, reve on three floors in the Admission Parprovided to all residuals.	director (M)-A was interviewed to p.m. stated the facility did not so. However, floor plans innesota Department of Health ealed the presence of five tubs the facility.  Country the facility was dents at the time of their indicate the facility did not have	F 4	65			

PRINTED: 02/09/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245417 B. WING 01/11/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH **ROBBINSDALE REHAB & CARE CENTER ROBBINSDALE, MN 55422** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ΙĐ (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 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 FORM WILL BE USED AS VERIFICATION OF 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on January 11, 2017. At the time of this survey, Robbinsdale Rehab and Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC). Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. 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 (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

02/08/2017

**Electronically Signed** 

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A: BUILDING 01 - MAIN BUILDING 01 245417 B. WING 01/11/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH **ROBBINSDALE REHAB & CARE CENTER** ROBBINSDALE, MN 55422 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID iΩ (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 Continued From page 1 K 000 St. Paul, MN 55101-5145, OR By email to: Marian. Whitney@state, mn.us and Angela.Kappenman@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. Robbinsdale Rehab and Care Center is a 4-story building that was determined to be of Type II(222) construction. It has no basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 75 beds and had a census of 68 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 Hazardous Areas - Enclosure K 321 K 321 2/21/17 SS=D Hazardous Areas - Enclosure 2012 EXISTING

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG <b>01 - MAIN BUILDING 01</b>	(X3) DATE SURVEY COMPLETED
		245417	B. WING _		01/11/2017
NAME OF PROVIDER OR SUPPLIER  ROBBINSDALE REHAB & CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422	1 01/11/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
K 321	having 1-hour fire rated doors) or system in accordar approved automatio option is used, the other spaces by small doors in accordance self-closing or autohave nonrated or fit that do not exceed the door.  Describe the floor a hazardous areas the 19.3.2.1  Area  Separation N/A  a. Boiler and Fuel-F  b. Laundries (larget c. Repair, Maintenad. Soiled Linen Rode. Trash Collection (exceeding 64 gallof. Combustible Stor (over 50 square feeg. Laboratories (if chazard - see K322) This STANDARD is Based on observatifacility did not proper hazardous areas. 1 could affect all reside compartment.  Findings include:	are protected by a fire barrier esistance rating (with 3/4-hour an automatic fire extinguishing are with 8.7.1. When the crime extinguishing system areas shall be separated from noke resisting partitions and the with 8.4. Doors shall be matic-closing and permitted to eld-applied protective plates 48 inches from the bottom of and zone locations of that are deficient in REMARKS.  Automatic Sprinkler A Fired Heater Rooms of that 100 square feet) ance, and Paint Shops oms (exceeding 64 gallons) Rooms ons) age Rooms/Spaces et) classified as Severe	K 32	This plan of correction constitute facility's written allegation of comfor the deficiencies cited. This submission of this plan of correct an admission of or agreement with deficiencies or conclusions contained the Department's inspection reports.  K 321 door to storage propped of The one door to the office/ storage.	tion is not ith the ained in ort.

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TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY PLETED		
		245417	B. WING			01/	11/2017		
	PROVIDER OR SUPPLIER	RE CENTER	l,	3	TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH OBBINSDALE, MN 55422	1 0	1112011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIC DATE		
K 351	Continued From page 4 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1). This deficient practice could affect all 68 residents.  Findings include:  On a facility tour between the hours of 0930 and 1730 on January 11, 2017, observation revealed that the sprinkler riser does not have the required main drain, check valve, pressure gauge, flow-switch, and inspector's test. The riser was not properly installed in accordance with NFPA 13, the Standard for the Installation of Sprinkler Systems.		K 351		deficiencies or conclusions contained in the Department's inspection report.  F351 Fire sprinkler system riser The facility has contracted with a qualified contractor to make changes per state inspector to bring our fire sprinkler system up to the code requirements. The plan of correction is in place and will be in compliance upon installation. The Administrator will monitor this process to ensure compliance.Proposed completion date is 2/28/2017				
K 355 SS=B	of Maintenance at the NFPA 101 Portable Fire Exting Portable fire exting inspected, and main NFPA 10, Standard Extinguishers.  18.3.5.12, 19.3.5.12 This STANDARD in Based on observations.	guishers uishers are selected, installed, ntained in accordance with for Portable Fire  2, NFPA 10 s not met as evidenced by: tion and staff interview, the			K 355		This plan of correction constitutes		2/21/17
	extinguishers in acc 19.3.5.12. This defi residents within the Findings include: On a facility tour be 1730 on January 1° that the fire extingu	ect and maintain portable fire cordance with NFPA 10. cient practice could affect all smoke compartment.  tween the hours of 0930 and 1, 2017, observation revealed ishers in Room 111 and the t Room were missing required			facility's written allegation of comp for the deficiencies cited. This submission of this plan of correctic an admission of or agreement with deficiencies or conclusions contain the Department's inspection report K355 Fire extinguishers  The two fire extinguishers that were missed for their monthly inspection dated with the time of inspection were submissed for their monthly inspection was a submissed for their monthly ins	on is not the ned in t. re n and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01			E SURVEY PLETED
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NAME OF F	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
ROBBINS	SDALE REHAB & CAI	RE CENTER		3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 355		ge 5 ce was verified by the Director he time of discovery.	K 3	completed on 1/16/2017. The maintenance director was responsible to prevent reoccumonitoring maintenance insumonthly. To ensure the defiwill not reoccur an audit too developed of all locations of extinguishers and the maint director will randomly audit to	curance by spection icient practice I has been f fire enance the fire	
	NFPA 101 Subdivis Smoke Barrie	on of Building Spaces -	K 3	extinguisher inspections to deficient practice will not red		2/21/17
	Construction 2012 EXISTING Smoke barriers sha fire resistance rating be permitted to tern Smoke dampers are penetrations in fully an approved sprinkl smoke compartmer barrier. 19.3.7.3, 8.6.7.1(1) Describe any mecha in REMARKS. This STANDARD is Based on observat facility did not proper walls free of penetra This deficient practi the smoke compart Findings include:		18	This plan of correction confacility's written allegation of for the deficiencies cited. The submission of this plan of can admission of or agreement deficiencies or conclusions the Department's inspection	f compliance his orrection is not ent with the contained in	
	On a facility tour be	ween the hours of 0930 and		K372 Smoke Barriers		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01			E SURVEY IPLETED
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	PROVIDER OR SUPPLIER  SDALE REHAB & CA			STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 521 SS=F	1730 on January 1 that there were per walls above the do on the North end.  This deficient pract of Maintenance at the North end.  NFPA 101 HVAC HVAC Heating, ventilation	1, 2017, observation revealed netrations in the smoke barrier ors on the 1st and 4th floors, tice was verified by the Director the time of discovery.	K 372	The two smoke barrier penetra the ceiling were fire stopped or 1/16/2017.  The maintenance director wil b responsible to prevent a reoccumonitoring maintenance work to department and/ or vendors that have to penetrate the smoke bounded will inspect smoke barriers to effire stop becomes loose.  To ensure the deficient practice reoccur and audit tool has been place. This audit will be compliper year.	e urance by ot theire at if they arriers rected e director ensure no	2/21/17
	Based on observation facility's heating, version not in compliance 9.2, 19.5.2.1 and N practice could effect Findings include:	s not met as evidenced by: tion and staff interview, the entilation, and air conditioning e with the 2012 LSC NFPA 101 FPA 90A. This deficient et all 68 residents.		This plan of correction constitute facility's written allegation of conformation of the deficiencies cited. This submission of this plan of correct an admission of or agreement deficiencies or conclusions conthe Department's inspection results.	mpliance ection is not with the itained in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			E SURVEY IPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
K 521	that the facility was as an exhaust plen	age 7 1, 2017, observation revealed susing their egress corridors num. This deficiency need not the approval of an annual	K 5	A request for an annual was submitted. See waiver redocumentation. Waiver wor e mailed.	equest and	
K 920 SS=D	This deficient practice was verified by the Director of Maintenance at the time of inspection.  NFPA 101 Electrical Equipment - Power Cords		K 920			2/21/17
	This STANDARD i	D) (NFPA 70), TIA 12-5 s not met as evidenced by: tion and staff interview, the		This plan of correction co	onstitutes this	

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

PRINTED: 02/09/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
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	DER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 130 GRIMES AVENUE NORTH		
ROBBINSDAL	E REHAB & CAF	RE CENTER			ROBBINSDALE, MN 55422		
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
facilia cord prece (NFF TIA) resident for a 1730 that Room This of M NFP Trair Gas Pers Pers main cylin provinguide serving main 11.5. This Bas facilia staff main (NFF	Is in a manner to cautions. 10.2.3. PA99), 400.8 (N 12-5. This deficients within the lings include:  In facility tour beto on January 11 there were dais m 120.  Is deficient practical laintenance at the PA 101 Gas Equining  Equipment - Question of the continuing elines and usagiced only by perintenance and on the proper intenance of medical the proper intenance of the proper inte	ower cords and extension hat exercises general 6 (NFPA 99), 10.2.4 FPA 70), 590.3(D) (NFPA 70), ient practice could affect all	K 9		facility's written allegation of complifor the deficiencies cited. This submission of this plan of correction an admission of or agreement with deficiencies or conclusions contains the Department's inspection report.  K920  The relocatable power strip that was used improperly was removed 1/11. Other office areas were audited to compliance. Office staff was educated the proper usage of relocatable powstrips. The maintenance director was responsible to prevent reoccurance monitoring office space monthly.  This plan of correction constitutes facility's written allegation of complifor the deficiencies cited. This submission of this plan of correction and mission of or agreement with deficiencies or conclusions contains the deficiencies or conclusions contains.	n is not the ed in  s being /2017. ensure ated on wer rill be e by	2/21/17

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

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		245417	B. WING_		01/	11/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ROBBIN	SDALE REHAB & CA	RE CENTER		3130 GRIMES AVENUE NORTH		
				ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 926	Findings include:  On a facility tour be 1730 on January 1 that the facility did training program for handling of medical.  This deficient pract	etween the hours of 0930 and 1, 2017, observation revealed not have a documented or staff that are involved in the	K 92	The nursing staff has been trained proper usage, storage, and mainte of oxygen. Staff education will be completed by February 20, 2017. Director of Maintenance with the D of Nursing will ensure training and will be completed on an annual bas	nance The irector audits	

## Name of Facility

## ROBBINSDALE, MINNESOTA ROBBINSDALE REHABILITATION AND CARE CENTER

# PART III - RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

## PROVISION NUMBER(S)

JUSTIFICATION

K400

K521

The building Heating ventilation & Air Conditioning Equipment (HVAC) does not comply with LSC (12) section 9.2 and NFPA 90A, 1999 ED., because the corridors are being used as a plenum.

An annual/continuing waiver is being requested for K521.

- A) compliance with this provision will cause an unreasonable hardship because
  - 1. the most recent cost estimate dated March 17, 2015 for complying ducted HVAC system is \$900,000.00.
  - 2. Efforts to obtain an estimate for a ducted system have been unsuccessful.
  - 3. A ducted system would decrease the corridor headroom to less than that required by the LSC.
  - 4. The building electrical system would need to be upgraded to support a new ducted system.

  - 5. The ducted system would need to penetrate load bearing walls, decreasing the building structural integrity.
  - 6. Existing non-complying HVAC systems can be allowed to continue in use.
  - B) There will be no adverse effect on the building occupant's safety because:
- 1. The building is protected by a complete fire sprinkler system that complies with NFPA13, 1999 Edition.
- 2. The existing HVAC system ventilation fans do automatically shut down upon activation of the fire alarm
- system, or detection of smoke in the HVAC system.
- 3. The corridors are equipped with a complying smoke detection system.
- 4. The facility is in compliance with all other fire safety requirements, or
- 5. The facility has obtained an approved plan of correction for any other fire safety deficiencies that were
- 6. This annual/continuing waiver has been approved in the past.

	annual/continuing waiver has	Office Office	Date
Surveyor (Signature)		Office	Date
Fire Authority Official (Signature)		State Fire Marshal Division	02-09-2017
Thomas Linhoff 12424 & Dr	File Salety Superior		

酉



March 17, 2015

Mr. Torn Gilbride Extendicare 111 West Michigan Street Milwaukee, WI 53203

Subject: Federal Monitoring Survey Results

Notice of Imposition of Remedy from February 18, 2015

ID Prefix Tag K 067

Yale Agreement #S15-0554

Dear Mr. Gilbride:

We offer the following budget proposal to furnish and install individual Packaged Terminal Air Conditioner units (PTAC). The PTAC units will provide the outdoor air requirements for the space occupancy and for bathroom exhaust.

### This budget includes:

- 180 PTAC through the wall units
- 45 PTAC units per floor
- Start-up and commissioning

#### Excludes:

- General construction
- Overtime labor
- Line voltage, electrical
- Structural modifications
- Additional diagnostics or corrections found while contractual service is performed

The budget cost for the work as described above is NINE HUNDRED THOUSAND DOLLARS (\$900,000). This proposal is firm for thirty (30) days. If an extension is required, it must be obtained in writing.

All equipment furnished and installed by Yale that is found to be defective within the period of one (1) year following completion of installation shall be repaired or replaced by Yale at no cost to the purchaser.

Payment shall be made by the tenth (10<sup>th</sup>) of the month on all invoices issued by the first (1<sup>st</sup>) of the month for all material and equipment installed or on hand and all labor performed. Final payment to be made within thirty (30) days after substantial completion of the work.

Thank you for the opportunity to present this proposal to you. Should you have any questions regarding this matter, please do not hesitate to contact us. We hope to be of further service to you on this project.

Sincerely,	AGREED BY: EXTENDICARE	
Ronald M. Gundershaug	SIGNED BY:	
V.P. Service Division	DATE:	_



#### Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted February 1, 2017

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5417026, Complaint Numbers H5417175 and H5417177.

#### Dear Ms. Pankratz:

The above facility was surveyed on January 9, 2017 through January 12, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaints numbers H5417175, which was substantiated at F425 and H5417177, which was substantiated at F309 and F333. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

Robbinsdale Rehab & Care Center February 1, 2017 Page 2

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gloria Derfus, Unit Supervisor at (651) 201-3792.

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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00122		B. WING			C 1 <b>2/2017</b>
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROBBIN	SDALE REHAB & CA	RE CENTER		MES AVENU DALE, MN	=		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC / MUST BE PRECEDED I SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 000	Initial Comments			2 000			
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION OF	RDER				
	In accordance with 144A.10, this correspursuant to a surve found that the deficiency have a surved found that the deficiency have a schedule of a surved found that the deficiency have a schedule of a surved for the Minnesota Depicture. Determination of what will be a surved for the minnesota Depicture for the found for the	ction order has bee y. If, upon reinspe iency or deficiencie ected, a fine for eace be assessed in acc ines promulgated le artment of Health.  hether a violation he compliance with all e rule provided at the ule number indicate ns several items, fa the items will be co Lack of complian iny item of multi-pa ment of a fine ever	en issued ction, it is es cited ch violation cordance by rule of as been as been as tag ed below. Eallure to considered ce upon rt rule will if the item				
	You may request a that may result from orders provided that the Department with notice of assessment.	n non-compliance wat a written request hin 15 days of rece	with these is made to ipt of a				
	INITIAL COMMENT Minnesota Departm the State Licensing federal software. To assigned to Minnes nursing homes. The appears in the far le Tag." The state state	nent of Health is do Correction Orders ag numbers have b tota state statutes/i e assigned tag num eft column entitled	using the een rules for hber "ID Prefix				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

02/08/17 **Electronically Signed** 

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

A. BUILDING:		
	COMPLETED	
00122 B. WING 01/12/20	2017	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
ROBBINSDALE REHAB & CARE CENTER  3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)    COMPARISON   PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETE DATE	
2 000  Continued From page 1  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.  During the recertification survey on 1/9/17 through 1/12/17, complaint investigations were conducted time of the standard survey, H5417175 was substantiated at MN Rule 4658.1325 Subpart 1. H5417177 was substantiated at MN Rule 4658.0520 Subpart 1 and MN Rule 4658.1320.  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 RECUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. Minnesota Department of Health is documenting the State Licensing Correction Orders using the 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 which are in violation of the state state test ter in violation of the vorection order. This column also includes the findings which are in violation of the state state test ter in violation of the vorection order. This column also includes the findings which are in violation of the state state test ter the violation of the vorection order. This		

Minnesota Department of Health

STATE FORM S9MI11 If continuation sheet 2 of 32

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00122	B. WING		01/1	2/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROBBIN	SDALE REHAB & CA	RE CENTER	MES AVENUI DALE, MN  5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	the surveyors finding	et as evidenced by." Following igs are the Suggested Method ne Time Period for Correction.				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			2/21/17
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ang home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.				
	by: Based on interview facility failed to prov treatments as order	and document review, the vide physician ordered red for 1 of 1 resident (R154) ot receive care as ordered.		Corrected		
	Findings include:					
	2/24/16, indicated of valve replacement, failure and chronic of the blood thinner instructed staff to wkeep a record related	Transfer Orders dated diagnoses of diabetes aortic acute on chronic respiratory back pain, as well as the use Coumadin. The orders reigh R154 every morning and ed to heart failure and edema . If R154's weight increased				

AND BLAN OF CORRECTION \ \ \ \ IDENTIFICATION NUMBER: \ \ \ \ \		` '	LE CONSTRUCTION :		(X3) DATE SURVEY COMPLETED		
		A. DOILDING	•		С		
		00122	B. WING			12/2017	
NAME OF F	PROVIDER OR SUPPLIER	STRE	EET ADDRESS, CITY,	STATE, ZIP CODE			
ROBBINS	SDALE REHAB & CA	RE CENTER	GRIMES AVENU BBINSDALE, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 830	two pounds over ni week staff was inst provider or cardiolo chronic respiratory. Administration Recevidence of the wei ordered. In April 14 27 out of 31 days, a Therefore, it could resident had gained not consistently documentation of car 5/31/16, noted R15 per physician's ordebandages (elastic twere not being app "was busy." The all diagnosis of conger R154 had an order 2/24/16. The staff of feet and work their Documentation shocompleted as order TARs as follows: Non 4/25, 4/27, or 4/missing on the May days. The June 20 documentation of to 6/7, 6/25, and 6/29/R154's discharge Notated Type 1/27/16, indicintact with no reject listed as chronic obtained to the completed as chronic obtained to the complete of th	ght or four pounds in one cructed to contact primary of agist related to acute on failure. R154's Treatment for (TAR) record lacked ights were recorded as of 30 days were missing, and June 23 of 30 days. not be determined if the dweight, as the weights woumented.  Weights for February to Juned but was not provided.  Weights for February to Juned but was not provided.  Weights for February to Juned but was not provided.  Weights for February to Juned but was not provided.  Weights for February to Juned but was not provided.  Weights for February to Juned but was alleged ace pandages) for R154's legs alled for two days as the state of the way up, wrapping the legs owing the treatment was ared was lacking on R154's of documentation was reconstant to the way was lacking on R154's of documentation was reconstant as well as nine of 3 to TAR revealed no reatments being completed.	May ere e ated ats aff ad a ne a. orded s 1 d on				

Minnesota Department of Health

STATE FORM S9MI11 If continuation sheet 4 of 32

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ROBBIN	SDALE REHAB & CA	RE CENTER	MES AVENU DALE, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 4	2 830				
	(DON) reviewed an information related needed medication nebulizer treatment Medication Administ February through J DON verified the treoff as completed. T cannot complete a their initials and doctreatment administr was not doneI cal	1 p.m. the director of nursing d verified the following to R154: routine and as s, analgesic/pain flow sheets, is for breathing, and unlabeled stration Records dated une 2016 were reviewed. The eatments had not been signed the DON stated, "If the nurse treatment, they are to circle cument on the back of the ration record why the treatment nnot tell if this resident ent, as they were not signed					
	Director of Nursing polices and proced monitoring of treatm or her designee coupolicies and proced or her designee cousystem to ensue reappropriate care.	THOD OF CORRECTION: The or designee could develop ures regarding assessing and nents. The Director of Nursing uld educate staff on the lures. The Director of Nursing uld develop a monitoring sidents receive the					
2 915	, ,	5 Subp. 6 A Rehab - ADLs	2 915			2/21/17	
	comprehensive res home must ensure A. a resident is treatments and ser abilities in activities	of daily living. Based on the ident assessment, a nursing that: given the appropriate vices to maintain or improve of daily living unless ormal or characteristic part of					

AND BLAN OF CORRECTION TO IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		A. BUILDING.		С			
		00122		B. WING			2/2017
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROBBIN	SDALE REHAB & CA	RE CENTER		MES AVENU DALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 915	Continued From parthe resident's cond part, activities of daresident's ability to: (1) bathe, dres (2) transfer an (3) use the toi (4) eat; and (5) use speed functional communational community c	age 5 ition. For purposes aily living includes the ses, and groom; and ambulate; let; h, language, or othe ication systems; and ent is not met as evicon, interview and do ailed to provide eating 1 resident (R150) what are don 1/11/17, at 7:01. At 8:22 a.m. a nursi	of this e ridenced ocument ng ho a.m. lying ng	2 915			
	assistant (NA) look not enter. At 8:25 a immediately emerg a.m. R150's light w elevated 45 degree he'd get up for breasocial worker (LSW wanted for breakfabrought R150's bre bedside table. The way, and the food withe breakfast tray v lying in bed with his NA-K entered R150	ed into R150's room and an anurse entered and from the room. A ras on, the head of the arrows. The reported he takfast. At 8:44 a.m. at a set in a	but did and then at 8:32 ne bed was hought a licensed at he I-A t on the ed in any 9:10 a.m. R150 was 2 a.m. d her				

Minnesota Department of Health

STATE FORM S9MI11 If continuation sheet 6 of 32

	(X3) DATE SURVEY COMPLETED		
A. Boileands.	)		
==	2/2017		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			
ROBBINSDALE REHAB & CARE CENTER  3130 GRIMES AVENUE NORTH  ROBBINSDALE, MN 55422			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
2 915  Continued From page 6 as he had not eaten or drank anything, NA-K explained R150 usually ate in the dining room, but had wanted to stay in bed. NA-K said, "He ate everything on the tray with my help. Normally he can feed himself." R150 had been left for one hour without assistance to eat his breakfast. At 9:51 a.m. R150 reported to NA-K, "I don't feel wellAll over. I don't know what is wrong."  A Nursing Comprehensive Admission Data Collection and Assessment dated 1/7/17, indicated R150 required the assistance of one staff person to eat. A Progress Note also dated 1/7/17, indicated R150 was prescribed a regular diet, had a poor appetite and took time to swallow. The note went onto read that R150 had difficulty feeding himself and needed assistance to eat.  R150's 1/10/17, nutritional care plan indicated he was at potential risk for dehydration, had weight loss as well as a history of loss of appetite. The plan was to assist the resident to set up his meal tray and assist him to eat as needed.  During an interview on 1/12/17, at 11:24 a.m. registered nurse (RN)-A said, "A resident who needs assistance to eat a meal should receive the assistance within five minutes to allow him time to try to do it himself."  The director of nursing stated on 1/12/17 at 12:26 p.m. "I would expect the staff member who brings food to a resident assist them if need or get someone who can assist them."  The facility provided an 11/11/16, Lippincott Procedures—Feeding, Long-Term Care that instructed staff: "Yarious disabilities and			

Minnesota Department of Health

STATE FORM 5999 S9MI11 If continuation sheet 7 of 32

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  (X3) DATE COM			SURVEY LETED
					С	
		00122	B. WING		01/1	2/2017
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROBBINS	SDALE REHAB & CA	RE CENTER	MES AVENU DALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 7	2 915			
	herself, including coneuromuscular disease and trauma can't feed herself, smalnutrition." While mechanics of feedinaddress timeliness  SUGGESTED MET The DON or design as necessary the peregarding the need DON or designee (sappropriate staff on procedures and important to the DON or design all residents are recappropriate care.	ognitive deficits, ease, cancer obstructive lung atic injury. When a resident she's susceptible to a procedure addressed the eng a resident, it did not of providing that assistance.  THOD FOR CORRECTION: thee(s) could review and revise colicies and procedures for assistance withADLs. The es) could provide training for all				
2 920	Subp. 6. Activities comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,	2 920			2/21/17
	by: Based on observati review, the facility for	ent is not met as evidenced on, interview and document ailed to provide timely toileting 1 resident (R150) reviewed for incontinence.		Corrected		

Minnesota Department of Health

STATE FORM S9MI11 If continuation sheet 8 of 32

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			LETED
		00122	B. WING		01/1	2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROBBIN	SDALE REHAB & CAI	RE CENTER	MES AVENU			
		ROBBINS	DALE, MN 5		N	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 8	2 920			
	Findings include:					
	R150 was not provi least 2 hours, 48 m	ded toileting assistance for at inutes. Continuous				
	observations were	conducted on 1/11/17, from				
		9 a.m. during which time R150 ileting assistance. At 7:41				
	a.m. R150 was lying	g in bed on his back in the				
	dark. At 8:49 a.m. licensed social worker (LSW)-A brought R150's breakfast tray. Nursing					
		tered R150's room and said				
		ssist the resident to eat.  was not provided at that time.				
		entered the room at 9:45 and				
		R150 was drinking his ver, toileting was not offered.				
	At 9:51 a.m. NA-K r	emoved a pillow from under				
		d lowered head of bed and nt's shirt. R150 reported, "I				
		over. I don't know what is				
		ned NA-K he wanted to stay in R150 did not have pants on				
		product was wet. NA-K stated				
		assist the resident. NA-K told back when there was another				
		een 10:07 and 10:17 a.m.				
	went from R150's ro	sistant (PTA)-A came and com. At 10:24 a.m. licensed				
	practical nurse (LPI	N)-A entered room and asked				
		t some pants on? I will have to repositioned R150 onto his				
		oservation ended at 10:29 a.m.				
	A Progress Note da was incontinent of b	ted 1/7/17, indicated R150 bowel and bladder.				
	Collection and Asse	rehensive Admission Data essment dated 1/7/17, incontinent. Although R150				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						<b>)</b>
		00122	B. WING		01/1	2/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROBBIN	SDALE REHAB & CA	RE CENTER	MES AVENU DALE, MN 3			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 9	2 920			
	was assessed as b record lacked evide to provide the newly related to his inconstruction.  During an interview NA-L said, "I chang the resident I was verificated to his inconstruction." NA-L verificated to have I hours, but it had be said, "I got him was this morningabout During interview on said. "I would expect	eing incontinent, the medical ence of sufficient interventions y admitted resident with care tinence.  on 1/11/17, at 11:05 a.m. ed him when I was done with working with. It was about erified R150 was wet when ct was changed. NA-L verified been changed every two en more than two hours. NA-L shed up and changed first thing to 6:45 a.m."				
	find another nursing a nurse."  The director of nurs 12:26 p.m. "I would to check a resident change program president within 10 massistance. The nursident within 10 massistance. The nursident within 10 massistance and do the The facility's 7/15, Uninstructed staff: "The residents who are in appropriate treatment appropriate treatment and tract infections."	f a nursing assistant cannot g assistant they should go get sing stated on 1/12/17, at expect the nursing assistant who is on a check and etty close to the two hours. If ce they should be in with the ninutes to allow time to obtain raing assistant should have ait until they could get e change quickly."  Urinary Incontinence policy e center strives to ensure that noontinent of bladder receive ent and services to restore as er function as possible, and to and services to prevent urinary.				

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION (X3) D A. BUILDING:			
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		00122	B. WING		01/	12/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
ROBBIN	SDALE REHAB & CAI	RE CENTER	RIMES AVENU ISDALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 10	2 920			
	cares provided to re needs, educate sta	sing could monitor personal esidents to determine residen ff, and monitor for compliance R CORRECTION: Twenty-one	). 			
21390	MN Rule 4658.0800	O Subp. 4 A-I Infection Contro	I 21390			2/21/17
	control program muprocedures which pare A. surveillance collection to identify residents;  B. a system for control of outbreaks.  C. isolation and reduce risk of trans.  D. in-service exprevention and con.  E. a resident he immunization progration of resident in part 465 procedures of resident the prevention and.  F. the development of the procedures including defined in part 465.  G. a system for the products which affer disinfectants, antise incontinence products.	ealth program including an am, a tuberculosis program a 8.0810, and policies and lent care practices to assist intreatment of infections; ment and implementation of plicies and infection control a tuberculosis program as 3.0815; reviewing antibiotic use; review and evaluation of lect infection control, such as eptics, gloves, and	s			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00122	B. WING		01/1	2/2017
	PROVIDER OR SUPPLIER SDALE REHAB & CAI	3130 GRII	DRESS, CITY, S	STATE, ZIP CODE E NORTH		
HUBBIN	SDALE REHAD & CAI	ROBBINS	DALE, MN	55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 11	21390			
	by: Based on observati review, the facility for hygiene and peri-ca that minimized infections.	ent is not met as evidenced on, interview, and document ailed to ensure proper hand are was provided in a manner ction for 1 of 3 residents (R13) of daily living (ADLs).		Corrected		
	Findings include:	, 3,				
	at 7:12 a.m. by nurs while wearing glove incontinence brief at Although NA-K there she did not wash he sanitizer. NA-K proceeds and back. Natincontinent pad under gloves and applied barrier cream to R1 Nystatin Powder (for and under the resid NA-K to get perfum so without changing peri area from front wash cloth from baraction three times. gloves NA-K applied a clean top sheet or gloves and washed R13's urinary incon 9/23/16, indicated the incontinent and institucontinent pad as a from front to back.	es were observed on 1/11/17, sing assistant (NA)-K. NA-K es, NA-K removed R13's wet and washed the resident. In changed her soiled gloves, er hands or utilize hand beeded to apply lotion to R12's a-K placed a clean sheet and der R13. NA-K removed the new gloves, then applied 3's bottom. NA-K applied or fungus) to abdomen folds ent's breasts. R13 requested e out of her drawer. NA-K did g gloves. NA-K washed R13's to back and then brought the book to front. NA-K repeated Without changing the soiled d a gown on R13 and then put over R13. NA-K then changed hands.  Itinence care plan dated the resident was frequently tructed staff to change needed and clean perineum orders dated 12/27/16, dminister the antibiotic				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X2) A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00122	B. WING			C <b>12/2017</b>
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
ROBBIN	SDALE REHAB & CA	RF (.FN1FR	IMES AVENUI SDALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 12	21390			
		rams twice daily for seven of a urinary tract infection				
	1/1/17, noted the re and required assist personal hygiene a frequently incontine	imum Data Set (MDS) dated esident was cognitively intact ance with toileting, dressing, and bed mobility, and was ent of bladder. R13's MDS including urinary tract				
	1/8/17, instructed s 100 milligrams twic treatment of a UTI.	one Order for R13 dated taff to administer Macrobid e daily for three days for R13 was being treated for a ne observation on 1/11/17.				
	verified not washing during R13's cares NA-K said, "I got diswashing the peri arwanted staff "to put and scrub around racknowledge going the cloth, back to the have just left it dow	on 1/11/17, at 7:42 a.m. NA-kg hands or using sanitizer except at the start of cares. stracted." NA-K explained ea last because the resident so much soap down there eally hard." NA-K did front to back and then pulling he front. NA-K said, "I could n there until I was done and hout coming back over the				
	11:24 a.m. "Staff ar	RN)-A stated on 1/12/17, at e to clean [the perineum] from en not come back to the				
	director of nurses e done front to back.	on 1/12/17 at 12:26 p.m. the explained, "Pericare should be If a resident wanted the area les the staff should have				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			A. DOILDING.			С	
		00122	B. WING	<del></del>		) 1 <b>2/2017</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-		
		3130 GRI	MES AVENU				
ROBBIN	SDALE REHAB & CAI	RE CENTER	DALE, MN				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)	
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)		COMPLETE DATE	
21390	Continued From pa	ge 13	21390				
	changed the cloth.	There is a possibility of urinary					
		ff wipe back to front."					
	The facility's 1/17, I	Hand HygienePlain Soap and					
	Water Procedure in	structed staff, "Hand hygiene					
		nt procedure for preventing					
		ted infections (Refer to CDC					
	[Centers for Disease Control] 2002, Hand Hygiene Guideline). The center requires personnel to use hand hygiene to remove dirt, organic material and transient microorganisms." It						
		f that plain soap and water or					
	resident care if mov	o may be used. "During					
		y site to a clean body site, after					
	removing gloves."	,					
	The facility provided	d an 11/11/16, Lippincott					
	ProceduresPerine	eal care of the female resident					
		: "Perineal care, which					
		e external genitalia and the e performed during the daily					
		ent is incontinent after					
	urination and bowe	I movements. The procedure					
		ss and prevents infectionFor					
		Wet a washcloth with warm					
		(or from a clean and soap.					
		nt's Labia with one hand. If the					
	patient has an indw	elling urinary catheter in					
		r hand to clean the urethral					
		sholoth to reduce the risk for					
		d urinary tract infection. Don't the meatal area; aggressive					
		o meatal irritation increasing					
		n. Using gentle downward					
	strokes, clean the p	perineal area from the front to					
		neum to prevent intestinal					
		ntaminating the urethra or					
	vagina. Avoid the a	rea around the anus and use a					

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STATEMENT OF DEFICIENCIES (X1)

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '			ATE SURVEY OMPLETED	
			A. BUILDING:		С		
		00122	B. WING			1/12/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ROBBIN	SDALE REHAB & CA	RE CENTER	MES AVENU DALE, MN (				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21390	folding each used s contamination with SUGGESTED MET The facility DON or review and revise p relation to the facilit Education could be Audits could be cor nursing (DON) or d review, and/or revis and ensure that res monitored and anal	shcloth for each stroke by section inward to prevent secretions or discharge."  CHOD OF CORRECTION: infection control nurse could olicies and procedures in sy's infection control program. provided as appropriate. Inducted. The director of esignee could develop, see Infection Control program ident and staff infections are	21390				
21545	A nursing home mu. A. Its medication percent as described Guidelines for Code 42, section 483.25 the State Operation Surveyors for Long incorporated by refe purposes of this pa (1) a discrepain prescribed and who administered to res (2) the administered to res (2) the administered to res (2) the administered to res (3) the administered to res (4) the administered to res (5) the administered to res (6) the administered to res (7) the administered to res (8) the administered to res (9) the administered to res (11) an error of the results (12) and results (13) an error of the results (14) an error of the results (15) and (15) an	on error rate is less than five ed in the Interpretive e of Federal Regulations, title (m), found in Appendix P of is Manual, Guidance to-Term Care Facilities, which is erence in part 4658.1315. For it, a medication error means: incy between what was at medications are actually idents in the nursing home; or stration of expired	21545			2/21/17	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		С	
		00122	B. WING	<del> </del>		2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROBBIN	SDALE REHAB & CA	RE CENTER	MES AVENU SDALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21545	(2) medication requires the medication error conception are record toxicity. All medicate prescribed. An incomprescribed. An incomprescribed are reactions of that occurs. Any significant or the physician or the phyresident or the resident occurs. Any signification occurs occu	ge 15 on from a category that usually ation in the resident's blood to cific blood level and a single uld alter that level and arrence of symptoms or ions are administered as ident report or medication error gnificant medication errors or must be reported to the ysician's designee and the dent's legal guardian or ntative and an explanation e resident's clinical record. One are administered as dent report or medication error for any medication error that cant medication errors or must be reported to the ysician's designee and the dent's legal guardian or ntative and an explanation e resident's clinical record.				
	by: Based on observati review, the facility for the was primed to ensure residents (R125) of administration. This rate of 8 percent, a six residents residir insulin. In addition, dosages were not example (MD) orders for 1 or the review of the same resident of t	ent is not met as evidenced on, interview and document ailed to ensure an insulin penure accurate dosing for 1 of 2 pserved for insulin a resulted in a medication error and had the potential to affect ag on the unit who received the facility failed to ensure exceeded per medical doctor of 2 residents (R151) who as containing acetaminophen		Corrected		

Minnesota Department of Health

	ta Department of the					
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					С	
		00122	B. WING			2/2017
		00122			01/1	<i>L, L</i>
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DODDING	CDALE DELIAD & CAL	DE CENTED 3130 GRII	MES AVENU	E NORTH		
KOBBIN	SDALE REHAB & CAI	ROBBINS	DALE, MN	55422		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	PRIATE	DATE
				DEFICIENCY)		
21545	Continued From pa	nge 16	21545			
21010	Continued From pa	ige 10	21010			
	Findings include:					
		prepared on 1/9/17, at 6:27				
		actical nurse (LPN)-D. She				
		donned gloves and drew up 5				
		sulin per FlexPen. She stated				
		nits per his medication				
		ts per sliding scale due to an				
		res blood glucose) reading of				
		ched R125 in his room,				
		edure, cleaned the cite with				
	alcohol, administere	ed the 5 units subqutaneously				
	(just beneath the sk	kin), held the needle in the skin				
	for greater than five	e seconds, removed the				
	needle, checked the	e cite, disposed of the needle				
	in the sharps contain	iner, removed the gloves and				
	washed her hands.	LPN-D verified she had not				
		ir bubbles) the insulin needle				
		plained that she only primed				
		when used with a new pen,				
		did it when I worked in the				
	hospital."					
	op.ia					
	On 1/10/17. at 12:1	6 p.m. LPN-E explained the				
	-	eived the manufacturer's				
	•	en the flexpens when				
		oharmacy. However, she was				
		nufacturer's instructions for				
		ton Dickenson] Auto Shield				
		The instruction pamphlet				
		ways check the flow in the				
		e each injection by priming the				
		not. Dial 2 units, point the pen				
		utton. A drop or stream of				
		r at the needle tip. If NOT,				
	repeat as recomme					
		pen still does not prime,				
ļ	change the Needle	and reneat the priming steps "	II .			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		).	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:		(3) DATE SURVEY COMPLETED	
		00122	B. WING _			C <b>12/2017</b>
NAME OF P	PROVIDER OR SUPPLIER	STF	REET ADDRESS, CIT	/, STATE, ZIP CODE		
ROBBINS	SDALE REHAB & CAI	RE CENTER	80 GRIMES AVEN BBINSDALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
	During an interview director of nursing so follow standards of provided by the mater She further explains not have a policy for was provided to the as needed.  On 1/12/17, at 12:2 Pharmacy consultate patient education. She further explains at the ducation to medication. She further website or call for wand or FlexPen used.  The facility's undated Instructions/Using of (printed from a web avoid injecting air at the dose selector to with the needle point gently a few times, to the top; Press the until the dose selectinsulin should appear no drop appears, of repeat"  R151's one caplet of 500 milligrams (mg mg was set up for a 5:33 p.m. by registed R151's discharge of 1/3/17, indicated R1 low back pain, acut lymphoma. The discrepation of the provided R1 low back pain, acut lymphoma. The discrepation of the provided R1 low back pain, acut lymphoma. The discrepation of the provided R1 low back pain, acut lymphoma. The discrepation of the provided R1 low back pain, acut lymphoma. The discrepation of the provided R1 low back pain, acut lymphoma. The discrepation of the provided R1 low back pain, acut lymphoma. The discrepation of the provided R1 low back pain, acut lymphoma. The discrepation of the provided R1 low back pain, acut lymphoma. The discrepation of the provided R1 low back pain, acut lymphoma. The discrepation of the provided R1 low back pain, acut lymphoma. The discrepation of the provided R1 low back pain, acut lymphoma. The discrepation of the provided R1 low back pain acut lymphoma.	on 1/12/10, at 11:56 a.m. stated she expected staff practice and the guidelin nufacturer when available ed that although the facility the use of flexpens, trainers that although the facility of the use of flexpens, trainers that the use of flexpens, trainers that the commicare of nursing homes for any or the explained that staff ation via the Omnicare erbal instructions on insufficient of the NovoLog Pen training estite) directed the user: "Independent of the cartification with the cartification of the cartification of the needle and of acetaminophen (Tyleng) and diazepam (for anxional diaz	to es e. ty did ining rand vide could alin growing for a form of the could growing for a form of the could growing for a form of the could growing form of the could grow			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00122	B. WING		01/1	C 1 <b>2/2017</b>
	PROVIDER OR SUPPLIER  SDALE REHAB & CA	RE CENTER 3130 GRI	DDRESS, CITY, S MES AVENUI BDALE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21545	needed for mild pais substance category. Prescription form dive two Percocet 5 mg/acetaminophen need for pain not to acetaminophen per A pain managemer indicated R151 had alteration in comfor abnormality. Staff vigain medication as record effectivenes. R151's 1/17, Medic (MAR) revealed the acetaminophen 500 and 5:35 p.m.; Percomg/acetaminophen 1/8/17, at 8:00 p.m. 6:50 a.m. 11:07 a.m. exceeded the maximal when the resident rouring an interview facility's consulting expect that they [numg in a 24 hour perasis a cautionary was adverse effects and and have a problem person."	n. Request for CII (control vII) Continuance of Therapy ated 1/6/17, instructed staff to 5/325 (oxycodone 5 325 mg) every four hours as exceed 4000 mg of 24 hours.  It care plan dated 1/17, I diagnoses of acute pain and trelated to cervical spine were directed to administer ordered and monitor and s, and side effects.  ation Administration Record eresident had received mg on 1/9/17, at 9:10 a.m. cocet 5/325 (oxycodone 5 325 mg) two tablets on, and on 1/9/17, at 12:15 a.m., n. and 3:30 p.m. This amount mum ordered by the physician eceived 4250 mg in 24 hours.  If on 1/12/17, at 9:50 a.m. the pharmacist stated "I would urses] would not exceed 4000 riod, because the limit is there rining. Some people have no disomeone could get 2000 mg in. It really depends on the	21545			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		С	
		00122	B. WING			2/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ROBBINS	SDALE REHAB & CA	RE CENTER	MES AVENU DALE, MN (			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21545	Continued From pa	ge 19	21545			
	practitioner (NP)-A said, "The standard of nursing is not more than 4000 mg of Tylenol a day. [R151] does not have liver diseaseThe nurses should call for a clarification or new order if the resident would be getting more than 4 grams. Ideally they should not be using Percocet and Tylenol together."					
	The facility's 3/16, Medication Administration procedure instructed staff, "The center strives to provide safe administration of all medications. The licensed nurse and/ or medication assistant will administer medication according to State specific regulation. The licensed nurse and/ or medication assistant will check the following to administer medication: Right medication, Right dose, Right dosage form, Right route, Right resident Right time."					
	The facility adminis (DON) or designee and procedures, econgoing monitoring	THOD OF CORRECTION: trator and director of nursing could review facility policies ducate staff and implement an system to ensure all resident or transcribed and implemented dician orders.				
	TIME PERIOD FOR days.	R CORRECTION: Thirty (30)				
21550	MN Rule 4658.132 Medications; Pharn	5 Subp. 1 Adminiatration of nacy Serv.	21550			2/21/17
		acy services. A nursing home e provision of pharmacy				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			SURVEY LETED	
		00122	B. WING		01/1	) 2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
ROBBIN	SDALE REHAB & CAI	RE CENTER	MES AVENU SDALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21550	Continued From pa	ge 20	21550			
	by: Based on interview facility failed to ensi available and admir administered as pre	and document review, the ure medications were nistered timely and escribed by the physician, for 1 ) whose medications were		Corrected		
	Findings include:					
	p.m. and discharge Medication Profile F resident had diagno damage, seizures a addition, the report Keppra 100 milligra twice daily for seizu	to the facility on 6/1/16, 5:30 d on 6/2/16. According to a Report dated 6/1/16, the bases including anoxic brain and respiratory failure. In noted R153 had an order for m (mg)/milliliter (ml) 1250 mg re disorder with special per md [Dispense As Written]."				
	(MAR) for R153 rev Keppra had been m and again on 6/2/16	on Administration Record realed two scheduled doses of hissed on 6/1/16, 8:00 p.m. 6, 8:00 a.m. Although a nurse aled the MAR on 6/1/16, it initialed on 6/2/16.				
	6/1/16 to 6/2/16, we nurse had indicated not been administe currently has no super doctor recommindicated the doctor order was called, but	nary Progress Notes from ere reviewed. On 6/1/16, a dedtime [HS] Keppra had red "Because pharmacy pply of Keppra Brand name as endations" The writer who wrote the discharge ut was "unable to give ok ame Keppra until Brand name				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE : COMPL	
			7.1. 20.25		C	<u>,                                     </u>
		00122	B. WING			2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROBBIN	SDALE REHAB & CA	RF CENTER	MES AVENUI SDALE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21550	Continued From pa	ge 21	21550			
	Care Unit (TCU) nu	sent by the facility Transitional urse clarified the diagnosis for pra was for seizures.				
	Recommendation (dated 6/2/16, indicarespirations, high p Keppra. Family rep	SBAR) Communication Form ated "Pt [patient] has high ulse. Pt has missed 2 doses of orted swollen arm. Eye family concerned about latex	:			
	to R153's dischargi licensed social work patient who dischar Report with all their was faxed over to the facility's responsibilithe admitting reside "To my understandinot have what they When asked the moted on R153's discharge with the discipled the LSW stated the indicated on page 1 Keppra was to be dwas what the patier hospital. The physic PER MD "meant the administered Keppra The physician had the order.	p.m. a phone call was made ng hospital. The hospital ker (LSW) explained when any ged, a Medication Profile medications they were taking he admitting facility. It was the ity to obtain the medication for ent. The hospital LSW stated ng, I found out the facility did needed for the patient later." eaning of "DAW PER MD" as scharge Medication Profile LSW stated she would charging doctor. At 1:38 p.m. physician explained he had of the medication record lispensed as written, as that it was being given at the cian's intention was "DAW he resident was to be and not the generic form. not received a call clarifying				
	(DON) was intervied	p.m. the director of nursing wed. The DON stated, "From pharmacy sent the generic not				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)	) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		(X3) DATE :	
				С	
	00122	B. WING		01/1	2/2017
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROBBINSDALE REHAB & CARE (	CENTER	MES AVENUI DALE, MN 5			
PREFIX (EACH DEFICIENCY MUS	IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
the brand." The DON's hospital then stated R1 generic form of Keppra instructed the staff to a Keppra, however, the family to the however, they did not resident was seizing." In had been reviewed, they been reviewed and were however, they did not reinformed by the pharmathe medication available did not find out the medicality had a back up phandle and however, they did not pharmate the medication available did not find out the medicality had a back up phandle and however, they did not pharmacy to old DON stated the pharmate communicated they did available, which led to be believe R153's swollen was related to the two however, the resident however, the resident hospital on 6/2/16, at a after the correct medical control of the brand narwould have expected the indicated dispensed as indicated dispensed as	said the physician at the 153 should not receive the a. The medical director then administer the generic family did not want it given. In was very intense as she ghter and wanted her sent ospital. Mom thought the When asked if the ordered to DON stated orders had are sent to the pharmacy, realize and had not been acy staff they did not have le. The DON said the nurse dication was unavailable en medications were as unsure whether the plan such as contacting btain the medication. The acist had not do not have the medication the problem. She did not arm and eye twitching missed doses of Keppra, and been sent to the approximately noon, right ation had been delivered.  In the consultant the DON were interviewed. For should have been written written or should have the medication to have se written, and would have the communicate with the the communicate with the said and the communicate with the the communicate with the the communicate with the the communicate with t	21550	DEFICIENCY)		

Minnesota Department of Health

The facility's 11/21/16, Receipt of

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00122	B. WING		01/1	2/ <b>2017</b>
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 01/1	2/2017
ROBBIN	SDALE REHAB & CAI	RE CENTER	MES AVENU SDALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21550	Interim/Stat/Emerge the following: "1. Fa notify Pharmacy whe Physician/Prescribe require an interim/s necessary medication Facility's interim/state Facility determines delivery is necessary Pharmacy for one of Pharmacy to include medication(s) in an or a special delivery Pharmacy delivery Pharmacy delivery Pharmacy to arrange dispensed and delivery Pharmacy to ensure SUGGESTED MET The DON and/or determined the facility's policy a ordering of medicate period. A member of randomly review medicate priod the facility of the period of of the p	ency Deliveries policy directed acility should immediately then Facility receives from a ter a medication order that may stat/emergency delivery. 2. If a son is not contained within at/emergency supply, and that an interim/stat/emergency ry, Facility should arrange with of the following actions: 2.1 For the the interim/stat/emergency earlier scheduled delivery ry, as required, or 2.2 For the contract courier, or 2.3 For the medication to be reced by a Third Party the timely receipt"  THOD FOR CORRECTION: Pesignee could review with staff and procedure regarding the citions within a specified time of the nursing staff could redication carts and medication medications have been and				
	TIME PERIOD FOR (14) days.	R CORRECTION: Fourteen				
21610	MN Rule 4658.1340 and Preparation Are	O Subp. 1 Medicine Cabinet ea;Storage	21610			2/21/17
	must store all drugs under proper tempe	e of drugs. A nursing home is in locked compartments erature controls, and permit sing personnel to have				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DAT  A. BUILDING:		(X3) DATE COMF	SURVEY	
		00122	B. WING			C 1 <b>2/2017</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
ROBBIN	SDALE REHAB & CAI	RE CENTER	MES AVENU			
	OLIMANA DV. OTA		SDALE, MN		1011	2.5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21610	Continued From pa	ge 24	21610			
	by: Based on observati review, the facility for 3 medication reauthorized personn diversion. This had residents (R60, R55)	on, interview and document ailed to ensure medications in forms were only accessible to el to minimize the risk of the potential to affect 4 of 4 9, R106, R154) whose andled by unauthorized upervision.		Corrected		
	supervisor (MS) was Care Unit (TCU) wirnurse. The MS was refrigerator to anoth nurse or a trained nurse or a trained nurse or a trained nurse of the MS verified the On 1/12/17, at 7:11 came by the medication the hall but had to minutes." RN-A ver the medication room	a.m. the maintenance is observed in the Transitional thout supervision by a licensed in moving medications from one iner. When asked if he was a nedication aide (TMA), the visor replied, "No." When oposed to be allowed in the ithout a nurse present he irse was here when I started." For every was no nurse in the area.  a.m. registered nurse (RN)-A ation room and stated, "I was o go down the hall for a few iffied narcotics were stored in and the box was not				
	would have been postaff to remove the the MS could get in  The contents of the handled without sup RN-A: Three vials of	gerator. RN-A acknowledged it ossible for the unauthorized narcotic box, but did not think to the box, as it was locked.  refrigerator that the MS pervision were verified by of Ativan 2 milligram anti-anxiety medication) stored				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00122	B. WING		01/1	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROBBIN	SDALE REHAB & CA	RE CENTER	MES AVENU SDALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21610	in a clear plastic tac locked inside the bl lock on box but was addition, R60's Dap (antibiotic) 445 mg boxes Tylenol (a mit two boxes bisacody R154's Neupogen (Humalog (insulin); t solution); R106's Lapens for R136; one solution; five syring (influenza vaccine).  On 1/12/17, at 7:22 (DON) stated only rallowed in the medishould not have beroom unsupervised although it was lock been allowed accessory of the DON or design and/or revise policies medications including appropriately stored ensure the medicat The DON could eduthe policies and prodesignee could devensure ongoing corrections.	ckle box with zip tie that was ack box with chain and pad is not attached to anything. In stomycin intravenous and Novolog (insulin pen); two Id analgesic) suppositories; if suppositories (laxative); for neutropenia); R59's wo vials of Aplisol (tuberculin antus (insulin); two Lantus vial of Influenza vaccine es of Fluzone high dose  a.m. the director of nursing nurses and TMA's were cation room and the MS en allowed in the medication. DON also stated that and, the MS should not have so to the narcotics box.  p.m. a medication storage to the was not received.  CHOD OF CORRECTION:  The could develop, review, and procedures to ensure and not expired. In addition, ion room(s) are safeguarded. Jucate all appropriate staff on incedures. The DON or elop monitoring systems to	21610			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILBING.	<del></del>		)
		00122	B. WING			2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROBBIN	SDALE REHAB & CAI	RE CENTER	MES AVENU DALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
21810	Continued From pa	ge 26	21810			
21810	MN St. Statute 144. Residents of HC Fa	.651 Subd. 6 Patients & ac.Bill of Rights	21810			2/21/17
	residents shall have medical and person needs. Appropriate care designed to en highest level of phy This right is limited reimbursable by put	riate health care. Patients and the right to appropriate hal care based on individual e care for residents means hable residents to achieve their sical and mental functioning. Where the service is not blic or private resources.				
	by: Based on observati review, the facility for 1 of 3 medication reauthorized personn diversion. This had residents (R60, R55)	on, interview and document ailed to ensure medications in coms were only accessible to el to minimize the risk of the potential to affect 4 of 4 9, R106, R154) whose andled by unauthorized upervision.		Corrected		
	On 1/12/17, at 7:09 supervisor (MS) wa Care Unit (TCU) with nurse. The MS was refrigerator to anoth nurse or a trained in maintenance super asked if he was supmedication room with replied, "Nothe nurse of the supervision	a.m. the maintenance is observed in the Transitional thout supervision by a licensed in moving medications from one incr. When asked if he was a medication aide (TMA), the visor replied, "No." When incoposed to be allowed in the lithout a nurse present he increase was here when I started."				

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  ROBBINSDALE REHAB & CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  3130 GRIMES AVENUE NORTH  BORRINSDALE MN. 55422		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
ROBBINSDALE BEHAB & CARE CENTER 3130 GRIMES AVENUE NORTH			00122	B. WING			_	
ROBBINSDALE, MN 55422			RE CENTER 3130 GRI	MES AVENUE	NORTH			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF	HOULD BE	(X5) COMPLETE DATE	
On 1/12/17, at 7:11 a.m. registered nurse (RN)-A came by the medication room and stated, "I was in the hall but had to go down the hall for a few minutes." RN-A verified narcotics were stored in the medication room and the box was not secured to the refrigerator. RN-A acknowledged it would have been possible for the unauthorized staff to remove the narcotic box, but did not think the MS could get into the box, as it was locked.  The contents of the refrigerator that the MS handled without supervision were verified by RN-A: Three valse of Ativan 2 milligram (mg)/milliliter (ml) (anti-anxiety medication) stored in a clear plastic tackle box with zip tie that was locked inside the black box with chain and pad lock on box but was not attached to anything. In addition, R60's Daptomycin intravenous (antibiotic) 445 mg and Novolog (insulin pen); two boxes Tylenol (a mild analgesic) suppositories; two boxes bisacodyl suppositories (laxative); R154's Neupogen (for neutropenia); R59's Humalog (insulin); two vials of Aplisol (tuberculin solution); R106's Lantus (insulin); two Lantus pens for R136; one vial of Intleunza vaccine solution; five syringes of Fluzone high dose (influenza vaccine).  On 1/12/17, at 7:22 a.m. the director of nursing (DON) stated only nurses and TMA's were allowed in the medication room unsupervised. DON also stated that although it was locked, the MS should not have been allowed access to the narcotics box.  On 1/12/17, at 3:00 p.m. a medication storage policy requested but was not received.  SUGGESTED METHOD OF CORRECTION: The	21810	On 1/12/17, at 7:11 came by the medici in the hall but had to minutes." RN-A very the medication room secured to the refrise would have been postaff to remove the the MS could get in the MS could get in the contents of the handled without surgen RN-A: Three vials of (mg)/milliliter (ml) (in a clear plastic tallocked inside the block on box but was addition, R60's Day (antibiotic) 445 mg boxes Tylenol (a matwo boxes bisacody R154's Neupogen Humalog (insulin); solution); R106's Lapens for R136; one solution; five syring (influenza vaccine)  On 1/12/17, at 7:22 (DON) stated only allowed in the med should not have be room unsupervised although it was local been allowed access.  On 1/12/17, at 3:00 policy requested but the med should not have be room unsupervised although it was local been allowed access.	a.m. registered nurse (RN)-A ration room and stated, "I was to go down the hall for a few rified narcotics were stored in m and the box was not gerator. RN-A acknowledged it ossible for the unauthorized narcotic box, but did not think not the box, as it was locked.  Perfrigerator that the MS pervision were verified by of Ativan 2 milligram anti-anxiety medication) stored ckle box with zip tie that was lack box with chain and pad is not attached to anything. In promycin intravenous and Novolog (insulin pen); two ild analgesic) suppositories; yl suppositories (laxative); (for neutropenia); R59's two vials of Aplisol (tuberculin antus (insulin); two Lantus e vial of Influenza vaccine ges of Fluzone high dose  2 a.m. the director of nursing nurses and TMA's were ication room and the MS een allowed in the medication d. DON also stated that ked, the MS should not have set to the narcotics box.					

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY DMPLETED	
		00122	B. WING			C 1 <b>2/2017</b>	
NAME OF PROVIDER OR S	UPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	•		
ROBBINSDALE REH	B & CARE CE	·NIER	RIMES AVENU ISDALE, MN				
PREFIX (EACH D	FICIENCY MUST	IT OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
Director of procedures needs, edu changes ar procedures	for accommon cate the approduced appoint a do to ensure on	I review the policies and odation of resident opriate personnel in any esignee to monitor the going compliance.  RRECTION: Twenty-one					
A nursing hone sink for or tub for 20 capacity is part 4658.4 resident toil bars are no according to room arrangmust have with hot and This MN Reby: Based on oreview, the working ordential to facility.  Findings ind R101 was in When asket	cist.Const  ome must have eight beds, as of beds. When the control of the control	ve at least one toilet and and at least one shower in the licensed bed a requirements under the new addition. In the grab bars or towel ars must be installed 145 to the extent that the permit. A toilet room sinks must be provided terview and document to ensure a tub was in the tresidents residents in the residents resident at 1/9/17, at 3:12 p.m. In gehoices the resident and have a choice as,		Corrected		2/21/17	

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  (X3) DATE COMPI			
					C	;
		00122	B. WING		01/1	2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ROBBIN	SDALE REHAB & CA	RE CENTER	MES AVENUI			
(V4) ID	SUMMARV STA	TEMENT OF DEFICIENCIES	DALE, MN 5	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
23095	Continued From pa	ge 29	23095			
	In a follow up interved 18:33 a.m. he stated telling me there was would have I would important to me to showerThe older bath to soak. I have					
	stated that they wo and soaking in the facility did not have When asked if they for a tub bath and F I was asked what ty then told a nursing do not remember winterview with R95 stated he had not badmission in 8/16, in o one else would I R95 stated, "I would if I would have know I like taking Epson tub." At 3:44 p.m. F	ed on 1/9/17, at 4:10 p.m. R95 ald enjoy an Epson salt bath bath tub. R95 then stated the a bathtub on any of the floors. Informed staff of their request R95 stated, "Yes, on admission type of bathing I preferred, I assistant (NA) and a nurse. If the else I told." In a follow up on 1/12/17, at 3:41 p.m. he een informed prior to his that a tub was unavailable, and been informed on his behalf. In a follow up on the else I told." In a follow up on 1/12/17, at 3:41 p.m. he een informed prior to his that a tub was unavailable, and been informed on his behalf. In the last and soaking in the last added that he was never going instead to a sister b.				
	at 7:36 a.m. they hayears prior, but their the residents to take Although the bathtunot been removed a storage room. The shown the facility puthey said they prefet them to a sister facility.	ctor (ED) explained on 1/12/17, and bathtubs approximately 20 re was no desire on the part of e a bath versus a shower. The was reported by the explain the room was changed to e ED said residents were rior to their admission and if erred a bath, they would admit illity instead. Current residents ce of a shower or a bed bath.				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
			B 14/10		C	
		00122	B. WING		01/1	2/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROBBIN	SDALE REHAB & CAI	RE CENTER	IMES AVENU SDALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
23095	Continued From pa	ge 30	23095			
		ras still no desire on the ave a tub bath. "I can't lie. We get partsit is very				
	interview on 1/12/17 bathtubs were not of DON said she could were not in use, and	sing (DON) confirmed in an 7, at 12:11 p.m. the facility currently available for use. The d not explain why the bath tubed if a resident wanted a bath we been admitted to the facility	5			
	1/12/17, at 12:44 p. the facility for many bathtubs being in us tubs had never bee	upervisor (MS) stated on m. although he had worked at years, he did not recall the se. He did not know why the n replaced, nor had it been ained that the old tub rooms if for storage.				
	answer why they [b don't know what the	/12/17, at 12:58 p.m. "I canno athtubs] were not replaced. I e thought process was." The no written information related				
	interviewed on 1/12 a copy of the Admis LSW-A explained the residents and/or rep	al services (LSW)-A was 2/17, at 3:44 p.m. at which timesion Packet was provided. nat she informed prospective presentatives that the facility nly had a bathtub at either end				
	on 1/12/17, at 4:15 have any bath tubs. submitted to the Mi	lirector (M)-A was interviewed p.m. stated the facility did not . However, floor plans nnesota Department of Health aled the presence of five tubs e facility.				

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	01/12/2017
(EACH CORRECTIVE ACTION SHOUL	D BE COMPLETE
ı	ENORTH 55422  PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)

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