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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: S9MI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00122

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **07/01/2015**

6. DATE OF SURVEY **02/27/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **75** (L18)

13.Total Certified Beds **75** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A,5** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	75			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Documentation supporting the facility's request for a continuing waiver involving LSC K521 is being recommended and forwarded to CMS for approval.

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 04/18/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/18/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **06301** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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.

Please contact me if you have any questions.

Sincerely,

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

MDH
Minnesota Department of Health

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.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245417 Y1	A. Building B. Wing Y2	2/27/2017 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0242	Correction	ID Prefix F0281	Correction	ID Prefix F0309	Correction
Reg. # 483.10(f)(1)-(3)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.24, 483.25(k)(l)	Completed
LSC	02/21/2017	LSC	02/21/2017	LSC	02/21/2017
ID Prefix F0311	Correction	ID Prefix F0312	Correction	ID Prefix F0328	Correction
Reg. # 483.24(a)(1)	Completed	Reg. # 483.24(a)(2)	Completed	Reg. # 483.25(b)(2)(f)(g)(5)(h)(i)(j)	Completed
LSC	02/21/2017	LSC	02/21/2017	LSC	02/21/2017
ID Prefix F0332	Correction	ID Prefix F0333	Correction	ID Prefix F0425	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 F0431	Correction	ID Prefix F0441	Correction	ID Prefix F0465	Correction
Reg. # 483.45(b)(2)(3)(g)(h)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(i)(5)	Completed
LSC	02/21/2017	LSC	02/21/2017	LSC	02/21/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	04/18/2017	18623	2/27/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/12/2017	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245417 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/2/2017 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	02/21/2017	LSC K0351	02/21/2017	LSC K0355	02/21/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0372	02/21/2017	LSC K0920	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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	4/18/2017	37009	3/2/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/11/2017

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: S9MI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00122

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **07/01/2015**

6. DATE OF SURVEY **01/12/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **75** (L18)

13.Total Certified Beds **75** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	75			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 02/09/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/16/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **06301** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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.

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. 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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245417	A. BUILDING _____ B. WING _____	C 01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigations into complaints were completed. H5417175 was substantiated at F425. H5417177 was substanitated at F309 and F333.	F 000		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced	F 242		2/21/17

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

Electronically Signed | 02/08/2017

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F 242	Continued From page 1 by: Based on observation, interview, and document review, the facility failed to ensure bathing resident preferences were accommodated for 2 of 3 residents (R101, R95) reviewed for choices in daily routine. Findings include: R101 was interviewed on 1/9/17, at 3:12 p.m. When asked about bathing choices the resident stated she stated she did not have a choice as, "There is no bath in this facility. I wish there was. I would like a bath. I'm sure a lot of people would." In a follow up interview with R101 on 1/11/17, at 8:33 a.m. he stated, "I do not remember them telling me there was no bath in the place. If they would have I would've bitched about it. It's important to me to have a bath instead of a shower...The older I get the more I would like a bath to soak. I have arthritis." The Activity Pursuit Care Plan for R101 dated 4/16, indicated daily preferences were very important to the resident. Although a tub bath was not an option, the form indicated, "Choose between tub bath or shower, bed bath or sponge bath--Preference: shower." R95 was interviewed on 1/9/17, at 4:10 p.m. R95 stated that they would enjoy an Epson salt bath and soaking in the bath tub. R95 then stated the facility did not have a bathtub on any of the floors. When asked if they informed staff of their request for a tub bath and R95 stated, "Yes, on admission I was asked what type of bathing I preferred, I then told a nursing assistant (NA) and a nurse. I do not remember who else I told."	F 242	The submission of this plan of correction is not an admission by the provider of any fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted because it is required by law. However, evidencing Robbinsdale Rehabilitation and Care Center good faith, the facility offers the following plan of correction and has achieved substantial compliance in each of the areas addressed by February 21, 2017 1. R95 is currently not at the facility but prior to return will be given the opportunity, if so desired, to transfer to a different facility where preferences for a tub bath can be met. R101 was interviewed and stated that he is aware that the center does not accommodate a tub bath, but that he does not wish to transfer to another facility. 2 Residents that reside at Robbinsdale Rehab and Care Center have the potential to be affected by this practice. Social Services or designee will meet with residents who currently reside in the facility and review bathing preference. If a tub bath is the preference, discharge planning will be arranged to accomodate. Potential residents will be notified of limited accommodations in regards to tub bathing. 3. Education provided to staff in regards to resident choices and bathing preferences.	

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F 242	Continued From page 2 R95's Life Enrichment/Therapeutic Recreation Program (LR) the form dated 8/16, read, "Daily Preferences: it is very important or somewhat important to: choose between a tub bath, shower, bed bath, or sponge bath." The resident's preference was then indicated and R95's read, "Tub bath/shower." NA-A was interviewed on 1/12/17, at 12:55 p.m. and reported caring for R95 on two different floors and stated the resident "never asked for a tub bath." Registered nurse (RN)-C then stated at 1:00 p.m. that the facility had tub baths around 2007-2009, but were no longer in use due to "leaking." RN-C did not recall R95 requesting a tub bath. In a follow up interview with R95 on 1/12/17, at 3:41 p.m. he stated he had not been informed prior to his admission in 8/16, that a tub was unavailable, and no one else would been informed on his behalf. R95 stated, "I would not have come to this facility if I would have known they did not have bathtubs. I like taking Epson [salt] baths and soaking in the tub." At 3:44 p.m. R95 added that he was never offered a choice of going instead to a sister facility that had a tub. The executive director (ED) explained on 1/12/17, at 7:36 a.m. they had bathtubs approximately 20 years prior, but there was no desire on the part of the residents to take a bath versus a shower. Although the bathtubs were not in use, they had not been removed and the room was changed to a storage room. The ED said residents were shown the facility prior to their admission and if they said they preferred a bath, they would admit them to a sister facility instead. Current residents were offered a choice of a shower or a bed bath.	F 242	4. Audits will be completed on all new admission by the Director of Social Services and/ or designee to ensure bathing preference has been discussed and care planned. Audits to occur x 4 weeks for newly admitted residents, then 3 per month x 3 months. 5. Audits will be reviewed at Quality Assurance Meeting (QAPI) monthly for 3 months to determine if any trends are identified and recommendations made for continued audits and monitoring needs. 6. Completion date 2/21/2017	

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F 242	Continued From page 3	F 242		

The ED felt there was still no desire on the residents' part to have a tub bath. "I can't lie. We had tubs. We can't get parts--it is very expensive."

The director of nursing (DON) confirmed in an interview on 1/12/17, at 12:11 p.m. the facility bathtubs were not currently available for use. The DON said she could not explain why the bath tubs were not in use, and if a resident wanted a bath they should not have been admitted to the facility.

The maintenance supervisor (MS) stated on 1/12/17, at 12:44 p.m. although he had worked at the facility for many years, he did not recall the bathtubs being in use. He did not know why the tubs had never been replaced, nor had it been discussed. He explained that the old tub rooms were currently used for storage.

The ED stated on 1/12/17, at 12:58 p.m. "I cannot answer why they [bathtubs] were not replaced. I don't know what the thought process was." The ED stated they had no written information related to the tubs.

The director of social services (LSW)-A was interviewed on 1/12/17, at 3:44 p.m. at which time a copy of the Admission Packet was provided. LSW-A explained that she informed prospective residents and/or representatives that the facility was old and they only had a bathtub at either end of the halls.

The Admission Packet, undated which was provided to all residents at the time of their admission did not indicate the facility did not have a bath tub. The admission packet read, "Appropriate Health Care: Residents shall have

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F 242	Continued From page 4 the rights to appropriate medical and personal care based on individual needs, mental functioning...Accommodation of Needs: The resident has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other resident would be endangered...Quality of Life--A facility must care for its residents in a manner and in an environment that promotes maintains or enhancement of each resident's quality of life." The life enrichment director/therapeutic recreation program (LE)-E was interviewed on 1/12/17, at 3:46 p.m. LE-E indicated a Life Enrichment Short Stay Care Plan initial assessment was completed that addressed each resident's interests, life routines, what is important to them, etc. This included whether they preferred a bed or sponge bath, shower or tub bath. LE-E reported if a resident stated their preference was to take a tub bath, they were informed the option was not available. If it was an "issue" for the resident, it was brought to the attention of the RN and LSW. If it was a problem for the resident, the staff would assist them in finding a sister facility where a tub was available where they could move. Initially LE stated the facility had never had a tub, but then rephrased the statement and said they had not have one "in a long time because it leaked." The maintenance director (M)-A was interviewed on 1/12/17, at 4:15 p.m. stated the facility did not have any bath tubs. However, floor plans submitted to the Minnesota Department of Health dated 5/13/16, revealed the presence of five tubs on three floors in the facility.	F 242		

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F 242	Continued From page 5 The facility's 10/16, Social Services Manual indicated, "You have the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences...."	F 242		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan sufficient to meet the needs of a newly admitted resident for 1 of 1 resident (R150) reviewed for incontinence. Findings include: R150 was not provided toileting assistance for at least 2 hours, 48 minutes. Continuous observations were conducted on 1/11/17, from 7:41 a.m. until 10:29 a.m. during which time R150 was not provided toileting assistance. At 7:41 a.m. R150 was lying in bed on his back in the dark. At 8:49 a.m. licensed social worker (LSW)-A brought R150's breakfast tray. Nursing assistant (NA)-K entered R150's room and said she was going to assist the resident to eat. Toileting assistance was not provided at that time. At 9:45 a.m. NA-K entered the room at 9:45 and	F 281	The submission of this plan of correction is not an admission by the provider of any fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted because it is required by law. However, evidencing Robbinsdale Rehabilitation and Care Center good faith, the facility offers the following plan of correction and has achieved substantial compliance in each of the areas addressed by February 21, 2017 1. R150 is no longer a resident at Robbinsdale Rehab and Care Center. 2. Residents that require assistance from staff regarding toileting at Robbinsdale Rehab and Care Center have the potential to be affected by this practice. Residents	2/21/17

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F 281	Continued From page 6 said to see whether R150 was drinking his orange juice, however, toileting was not offered. At 9:51 a.m. NA-K removed a pillow from under R150's right hip and lowered head of bed and adjusted the resident's shirt. R150 reported, "I don't feel well...All over. I don't know what is wrong." R150 informed NA-K he wanted to stay in bed. NA-K verified R150 did not have pants on and his incontinent product was wet. NA-K stated needed two staff to assist the resident. NA-K told R150 she would be back when there was another NA available. Between 10:07 and 10:17 a.m. physical therapy assistant (PTA)-A came and went from R150's room. At 10:24 a.m. licensed practical nurse (LPN)-A entered room and asked R150, "Do you want some pants on? I will have to find some." LPN-A repositioned R150 onto his side. Continuous observation ended at 10:29 a.m. A Progress Note dated 1/7/17, indicated R150 was incontinent of bowel and bladder. The Nursing Comprehensive Admission Data Collection and Assessment dated 1/7/17, indicated R150 was incontinent. Although R150 was assessed as being incontinent, the medical record lacked evidence of sufficient interventions to provide the newly admitted resident with care related to his incontinence. During an interview on 1/11/17, at 11:05 a.m. NA-L said, "I changed him when I was done with the resident I was working with. It was about 10:45 a.m." NA-L verified R150 was wet when incontinence product was changed. NA-L verified R150 should have been changed every two hours, but it had been more than two hours. NA-L said, "I got him washed up and changed first thing this morning--about 6:45 a.m."	F 281	that require toileting assistance have been re assessed and care plans have been updated as appropriate. 3. Education was provided to RN unit mananagers regarding bladder assessments and care plan in regards to appropriate plan of care. NA/R staff have been educated on following the residents written plan of care in regards to timely toileting assistance. 4. Audits will be completed by the Director of Nursing and/or designee on residents that need assistance with toileting 3x per week x 4 weeks then 3x per month for 3 months. 5. Audits will be reviewed at Quality Assurance Meeting (QAPI) monthly for 3 months to determine if any trends are identified and recommendations made for continued audits and monitoring needs. 6. Completion date 2/21/2017	

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F 281	Continued From page 7 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 281		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25	F 309		2/21/17

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F 309	Continued From page 8 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide physician ordered treatments as ordered for 1 of 1 resident (R154) who allegedly did not receive care as ordered. Findings include: R154's Interagency Transfer Orders dated 2/24/16, indicated diagnoses of diabetes aortic valve replacement, acute on chronic respiratory failure and chronic back pain, as well as the use of the blood thinner Coumadin. The orders instructed staff to weigh R154 every morning and keep a record related to heart failure and edema (fluid in the tissues). If R154's weight increased two pounds over night or four pounds in one week staff was instructed to contact primary care provider or cardiologist related to acute on chronic respiratory failure. R154's Treatment Administration Record (TAR) record lacked evidence of the weights were recorded as ordered. In April 14 of 30 days were missing, May 27 out of 31 days, and June 23 of 30 days. Therefore, it could not be determined if the	F 309	The submission of this plan of correction is not an admission by the provider of any fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted because it is required by law. However, evidencing Robbinsdale Rehabilitation and Care Center good faith, the facility offers the following plan of correction and has achieved substantial compliance in each of the areas addressed by February 21, 2017 1. R 154 no longer resides at the facility. 2. Residents that reside at Robbinsdale Rehab and Care Center have the potential to be affected by this practice. Chart reviews have been completed to ensure physician orders continue to be appropriate and are clearly communicated to ensure medications and treatments are being given per Doctors orders.	

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F 309	Continued From page 9 resident had gained weight, as the weights were not consistently documented. Copies of R154's weights for February to June 2016 were requested but was not provided. An allegation of cares not being completed dated 5/31/16, noted R154 did not receive treatments per physician's orders. It was alleged ace bandages (elastic bandages) for R154's legs were not being applied for two days as the staff "was busy." The allegation indicated R154 had a diagnosis of congestive heart failure. R154 had an order to wrap both legs dated 2/24/16. The staff were to start at bottom of the feet and work their way up, wrapping the legs. Documentation showing the treatment was completed as ordered was lacking on R154's TARs as follows: No documentation was recorded on 4/25, 4/27, or 4/28/16; nine of 31 days was missing on the May TAR, as well as nine of 31 days. The June 2016 TAR revealed no documentation of treatments being completed on 6/7, 6/25, and 6/29/16. R154's discharge Minimum Data Set (MDS) dated 7/27/16, indicated R154 was cognitively intact with no rejection of cares. Diagnoses were listed as chronic obstructive pulmonary disease, heart failure, edema, polyarthritis and anemia. On 1/12/17, at 12:51 p.m. the director of nursing (DON) reviewed and verified the following information related to R154: routine and as needed medications, analgesic/pain flow sheets, nebulizer treatments for breathing, and unlabeled Medication Administration Records dated February through June 2016 were reviewed. The	F 309	3. Education has been provided to LN's that administer medication and provide treatments regarding following the Physician's orders and documenting accordingly. 4. Audits of medication administration, treatments provided, and weights will be completed by the Director of Nursing and/ or designee 3x per week for 4 weeks then 3x per month for 3 months. 5. Audits will be reviewed during the Quality Assurance Meeting (QAPI) monthly for 3 months to determine if any trend are identified and recommendations for continued audits or monitoring. 6. Completion date 2/21/2017	

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F 309	Continued From page 10 DON verified the treatments had not been signed off as completed. The DON stated, "If the nurse cannot complete a treatment, they are to circle their initials and document on the back of the treatment administration record why the treatment was not done...I cannot tell if this resident received the treatment, as they were not signed for."	F 309		
F 311 SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide eating assistance for 1 of 1 resident (R150) who received a room tray. Findings include: R150 was observed on 1/11/17, at 7:01 a.m. lying in bed on his back. At 8:22 a.m. a nursing assistant (NA) looked into R150's room but did not enter. At 8:25 a.m. a nurse entered and then immediately emerged from the room. At 8:32 a.m. R150's light was on, the head of the bed was elevated 45 degrees. The reported he thought he'd get up for breakfast. At 8:44 a.m. a licensed social worker (LSW)-A asked R150 what he wanted for breakfast. At 8:49 a.m. LSW-A brought R150's breakfast tray and set it on the bedside table. The tray was not prepared in any way, and the food was left covered. At 9:10 a.m.	F 311	The submission of this plan of correction is not an admission by the provider of any fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted because it is required by law. However, evidencing Robbinsdale Rehabilitation and Care Center good faith, the facility offers the following plan of correction and has achieved substantial compliance in each of the areas addressed by February 21, 2017 1. R150 no longer resides at Robbinsdale Rehab and Care Center. 2. Resident who require assistance with eating at Robbinsdale Rehab and Care Center have the potential to be affected by this practice. Residents who require	2/21/17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 11 the breakfast tray was untouched and R150 was lying in bed with his eyes closed. At 9:22 a.m. NA-K entered R150's room and washed her hands and indicated she was going to feed R150 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 well...All 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."	F 311	assistance with eating and desire to stay in their room will have room tray delivered by clinical staff with assistance immediately following. 3. Education regarding meal tray set up and timely assistance with eating was provided to clinical and non clinical staff. 4. Audits of room trays will be completed by the Director of Nursing and/ or designee twice per week for 2 weeks, then weekly for one month. 5. Audits will be reviewed during Quality Assurance Meeting (QAPI) monthly for 2 months to determine if any trends are identified and recommendations for continued auditing or monitoring. 6. Completion date 2/21/2017	

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F 311	Continued From page 12 The facility provided an 11/11/16, Lippincott Procedures--Feeding, Long-Term Care that instructed staff: "Various disabilities and conditions may prevent a resident from feeding herself, including cognitive deficits, neuromuscular disease, cancer obstructive lung disease and traumatic injury. When a resident can't feed herself, she's susceptible to malnutrition." While procedure addressed the mechanics of feeding a resident, it did not address timeliness of providing that assistance.	F 311		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely toileting assistance for 1 of 1 resident (R150) reviewed for bowel and bladder incontinence. Findings include: R150 was not provided toileting assistance for at least 2 hours, 48 minutes. Continuous observations were conducted on 1/11/17, from 7:41 a.m. until 10:29 a.m. during which time R150 was not provided toileting assistance. At 7:41 a.m. R150 was lying in bed on his back in the dark. At 8:49 a.m. licensed social worker (LSW)-A brought R150's breakfast tray. Nursing assistant (NA)-K entered R150's room and said she was going to assist the resident to eat.	F 312	The submission of this plan of correction is not an admission by the provider of any fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted because it is required by law. However, evidencing Robbinsdale Rehabilitation and Care Center good faith, the facility offers the following plan of correction and has achieved substantial compliance in each of the areas addressed by February 21, 2017 1. R150 no longer resides at Robbinsdale Rehab and Care Center. 2. Residents that require assistance with	2/21/17

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F 312	Continued From page 13 Toileting assistance was not provided at that time. At 9:45 a.m. NA-K entered the room at 9:45 and said to see whether R150 was drinking his orange juice, however, toileting was not offered. At 9:51 a.m. NA-K removed a pillow from under R150's right hip and lowered head of bed and adjusted the resident's shirt. R150 reported, "I don't feel well...All over. I don't know what is wrong." R150 informed NA-K he wanted to stay in bed. NA-K verified R150 did not have pants on and his incontinent product was wet. NA-K stated needed two staff to assist the resident. NA-K told R150 she would be back when there was another NA available. Between 10:07 and 10:17 a.m. physical therapy assistant (PTA)-A came and went from R150's room. At 10:24 a.m. licensed practical nurse (LPN)-A entered room and asked R150, "Do you want some pants on? I will have to find some." LPN-A repositioned R150 onto his side. Continuous observation ended at 10:29 a.m. A Progress Note dated 1/7/17, indicated R150 was incontinent of bowel and bladder. The Nursing Comprehensive Admission Data Collection and Assessment dated 1/7/17, indicated R150 was incontinent. Although R150 was assessed as being incontinent, the medical record lacked evidence of sufficient interventions to provide the newly admitted resident with care related to his incontinence. During an interview on 1/11/17, at 11:05 a.m. NA-L said, "I changed him when I was done with the resident I was working with. It was about 10:45 a.m." NA-L verified R150 was wet when incontinence product was changed. NA-L verified R150 should have been changed every two hours, but it had been more than two hours. NA-L	F 312	toileting needs have the potential to be affected by this practice. Residents with incontinence have had their care plans reviewed and updated as appropriate. 3. Education provided to nursing staff that address need to provide services by qualified persons in accordance with each residents' plan of care. Following residents toileting schedule and, if noted to have a change in ability, updating nurse or Nurse Manager. 4. Audit will be completed by Director of Nursing and/ or designee monitoring resident toileting plan is being followed 3x per week for 2 weeks then twice per week for 2 weeks then weekly for 4 weeks. 5. Audits will be reviewed monthly for 3 months during Quality Assurance Meeting (QAPI) to determine if any trends are identified and recommendations for continued audits or monitoring. 6. Completion date 2/21/2017	

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F 312	Continued From page 14 said, "I got him washed up and changed first thing this morning--about 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 312		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (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	F 328		2/21/17

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F 328	Continued From page 15 (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a	F 328		

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F 328	Continued From page 16 resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide oxygen (O2) in accordance with physician's order for 1 of 1 resident (R150) who required oxygen therapy. Findings include: R150 was observed wearing an oxygen nasal cannula on 1/11/17, at 7:01 a.m. The resident was lying on his back in the dark. At 8:51 a.m. R150 lying in bed with head of bed up approximately 60 degrees, wearing the nasal cannula for oxygen therapy. R150's eyes were closed. R150's breakfast tray was on the over-bed table untouched. At 9:51 a.m. NA-K was assisting the resident when he reported, "I don't feel well...All over. I don't know what is wrong." R150's breathing pattern was irregular with periods of rapid respirations followed by periods of no respiration. At 10:24 a.m. licensed practical nurse (LPN)-A repositioned R150 onto his side. LPN-A denied having been told by NA-K R150 was not feeling well. LPN-A was asked to assess R150. During and observation on 1/12/17, at 7:05 a.m. R150 was sitting on edge of bed wearing oxygen. At 8:26 a.m. R150 was in dining room at a table with breakfast in front of him. R150 was wearing oxygen via nasal cannula. At 10:22 a.m. R150 was sitting up in wheelchair not wearing oxygen.	F 328	The submission of this plan of correction is not an admission by the provider of any fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted because it is required by law. However, evidencing Robbinsdale Rehabilitation and Care Center good faith, the facility offers the following plan of correction and has achieved substantial compliance in each of the areas addressed by February 21, 2017 1. R150 no longer resides at Robbinsdale Rehab and Care Center but on 1/12/2017 Oxygen therapy orders were clarified. 2. Residents with COPD and/ or have orders for oxygen therapy have the potential to be affected by this practice. Residents with COPD and/ or have orders for oxygen have had a chart review with orders and care plans updated as appropriate with validation that appropriate Physician orders are given with perameters. 3. Education provided to LN staff that addresses standards of practice, policies, and procedures as it relates to oxygen therapy, clarification of Physician orders,	

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F 328	Continued From page 17 R150 was talking and joking. Physical therapy assistant (PTA)-B stated, "The resident took a couple of steps. He is doing better today than yesterday. He is more alert." R150's Interagency Transfer Orders signed 1/7/17, indicated diagnoses of pneumonia, emphysema, chronic obstructive pulmonary disease (COPD), lung mass, carbon dioxide (CO2) retention, aortic stenosis, acute confusion and severe major depression. An Occupational Therapy Evaluation dated 1/9/17, indicated R150 was cognitively impaired. R150's 1/10/17, Actual/Potential for Infection care plan identified R150 had pneumonia and instructed staff to see respiratory care plan and to monitor for signs/symptoms of infection: low oxygen saturations (sats) and shortness of breath (SOB). The 1/10/17, respiratory care plan indicated R150 had potential /actual alteration in oxygen exchange related to "lung mass, CO2 retention, COPD Pneumonia Emphysema" with a goal "sat will be >92%> (Greater than or equal to) 88%." Staff was directed to check R150's O2 sats per protocol and as needed, monitor for cyanosis, shortness of breath or change in level of consciousness. The respiratory care planned lacked interventions regarding the risk of too much oxygen. During an interview on 1/11/17, at 10:03 a.m. LPN-A said, "I last checked [R150's] oxygen saturations at 7:00 a.m. and the sats were 96% on oxygen." At 10:21 a.m. physical therapy assistant (PTA)-A said, "He seems to be an afternoon person, maybe he will be more alert then." At 10:29 a.m. RN-A and LPN-A were asked	F 328	and signs and symptoms of CO2 retention. 4. Audits will be completed by the Director of Nursing and/ or designee for residents with COPD and/ or utilize oxygen therapy to ensure appropriate Physician orders and orders are being followed within Physician perameters. Audits will be completed on 3 resident charts x 4 weeks then 4 resident charts per month for 2 months. 5. Audits will be reviewed at Quality Assurance Meeting (QAPI) monthly for 3 months to determine if any trends are identified and recommendations for continued audits and monitoring needs. 6. Completion date 2/21/2017	

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F 328	Continued From page 18	F 328		

about R150's respiratory status. LPN-A said R150's oxygen saturations would be checked. RN-A was not observed checking on R150's breathing status.

RN-A verified on 1/12/17, at 9:07 a.m. was in dining room with oxygen on at two liters. RN-A was shown the order for oxygen 2 liters to keep O2 sats less than or equal to 88%. RN-A showed a different order for oxygen 2 liters for discomfort (shortness of breath) or hypoxia (O2 sats less than 92%). RN-A reported she was aware of the diagnosis of carbon dioxide retention, but had not clarified the two different oxygen/saturation orders. RN-A verified concerns had been brought to the staff yesterday about R150's respiratory status. The had check his sats and they were 97% on two liters of oxygen. At 9:21 a.m. RN-A stated the physician clarified R150's oxygen order, which was to be at two liters and keep the sats greater than or equal to 88 percent. When asked if that meant R150 should have been using the oxygen if saturations were 96% or higher RN-A replied, "I don't know, maybe for comfort. I will talk to the doctor." RN-A reported R150's O2 sats were 99% on oxygen when he was in the dining room and 97% when off oxygen. At 9:31 a.m. RN-A stated, "giving too much oxygen to a resident who has carbon dioxide retention, can cause respiratory acidosis, headache, confusion, shortness of breath, rapid breathing, disorientation, and elevated blood pressure. Potential side effects include coma or death."

During interview on 1/12/17, at 11:24 a.m. RN-A verified LPN-A and medical doctor (MD)-A had seen R150 after the above concerns were brought to her attention. R150 did not report SOB. RN-A said the physician said that the

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F 328	Continued From page 19	F 328		

paperwork was in error, and should have read keep sats greater than or equal 88%. RN-A said, "The physician said 'No oxygen if he is greater than 88%.' We checked his sats--they were 99%. We removed his oxygen."

At 11:48 a.m. RN-A called MD-A to ask if it was okay for R150 to use O2 if SOB and his oxygen sats were 93%. MD-A reportedly stated, "'No, he is not to wear oxygen for discomfort, unless sats are below 88%.'"

During an interview on 1/12/17, at 12:26 p.m. the DON and director of clinical services, were asked about R150's order "oxygen 2l [2 liters] O2 prn [as needed] for discomfort (shortness of breath) or hypoxia (SpO2 >92%)." The DON said it meant, "It is okay to use oxygen for complaints of shortness of breathe." The DON reviewed vital signs and progress notes from 1/7 through 1/12/17 and verified there was no documentation R150 had been experiencing SOB, and no sats were documented as less than 92%. However, the resident had been on O2 the entire time he was at the facility. The DON verified the reason for continuous O2 had not been documented, and the nurse should have clarified the O2 orders with the MD.

MD-A was interviewed on 1/12/17, at 2:37 p.m. and stated, "[R150's] order was not written the way it should have been. I was very specific they need to stop oxygen if [R150's] are over 92% regardless of how he feels." MD-A reported the nurses had a hard time not providing when a resident's sats were low. "I look at a resident's ability to talk as part of an assessment of their respiratory status. Too much oxygen can cause confusion, fatigue and inability to do things for

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F 328	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.	F 328		
F 332 SS=D	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 by: Based on observation, interview and document review, the facility failed to ensure an insulin pen was primed to ensure accurate dosing for 1 of 2 residents (R125) observed for insulin administration. This resulted in a medication error rate of 8 percent, and had the potential to affect six residents residing on the unit who received insulin. In addition, the facility failed to ensure dosages were not exceeded per medical doctor (MD) orders for 1 of 2 residents (R151) who received medications containing acetaminophen (mild analgesic).	F 332	The submission of this plan of correction is not an admission by the provider of any fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted because it is required by law. However, evidencing Robbinsdale Rehabilitation and Care Center good faith, the facility offers the following plan of correction and has achieved substantial compliance in each of the areas addressed by February 21, 2017	2/21/17

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F 332	Continued From page 21 Findings include: R125's insulin was prepared on 1/9/17, at 6:27 p.m. by licensed practical nurse (LPN)-D. She cleaned her hands, donned gloves and drew up 5 units of Novolog insulin per FlexPen. She stated R125 received 3 units per his medication schedule and 2 units per sliding scale due to an accucheck (measures blood glucose) reading of 232. LPN-D approached R125 in his room, explained the procedure, cleaned the cite with alcohol, administered the 5 units subqutaneously (just beneath the skin), held the needle in the skin for greater than five seconds, removed the needle, checked the cite, disposed of the needle in the sharps container, removed the gloves and washed her hands. LPN-D verified she had not primed (removed air bubbles) the insulin needle prior to use. She explained that she only primed the insulin needles when used with a new pen, "That's the way we did it when I worked in the hospital." On 1/10/17, at 12:16 p.m. LPN-E explained the facility had not received the manufacturer's package inserts when the flexpens when delivered from the pharmacy. However, she was able to provide manufacturer's instructions for use of the BD [Becton Dickenson] Auto Shield Safety Pen Needle. The instruction pamphlet directed staff to "Always check the flow in the Pen, Needle before each injection by priming the device with an airshot. Dial 2 units, point the pen up and press the button. A drop or stream of liquid should appear at the needle tip. If NOT, repeat as recommended by the pen's instructions. If the pen still does not prime, change the Needle and repeat the priming steps."	F 332	1. R151 no longer resides at Robbinsdale Rehab and Care Center. R125 insulin pen was not primed, a call was placed to the Nurse Practitioner who gave an order to give the 2 units of insulin that was potentially missed due to not priming the pen. Verbal education was provided to LPN-D on 1/9/2017 regarding priming insulin pen and holding for 10 seconds. A Medication error was completed and Physician updated regarding exceeding the 4000mg Tylenol/ Acetaminophen dosage for R151. 2. Residents who have orders for Tylenol/ Acetaminophen or medications that contain Tylenol/ Acetaminophen have the potential to be affected by this practice. Residents who have Physician orders for insulin via pen have the potential to be affected by this practice. Chart reviews were completed on residents with Physician orders for Tylenol/ Acetaminophen or medications containing Tylenol/ Acetaminophen and residents with Physician orders for insulin and updated as appropriate. 3. LN staff were given education on insulin administration via pen and Tylenol/ Acetaminophen perameters. Education regarding insulin via pen included a return demonstration. 4. Audits will be completed by the Director of Nursing or designee monitoring insulin pen administration 3x per week for 2 weeks then twice per week for 2 weeks then 3x per month for 2	

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ROBBINSDALE REHAB & CARE CENTER	**3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 22 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...." R151's one caplet of acetaminophen (Tylenol) 500 milligrams (mg) and diazepam (for anxiety) 5 mg was set up for administration on 1/9/17, at 5:33 p.m. by registered nurse (RN)-B. R151's discharge orders and information dated 1/3/17, indicated R151 had diagnoses of chronic low back pain, acute kidney injury and mantle cell lymphoma. The discharge orders instructed staff	F 332	months. Audit will be completed by Director of Nursing or designee monitoring for exceeding the maximum dose of Tylenol/ Acetaminophen 3x per week for 2 weeks then twice per week for 2 weeks, then 3x per month for 2 months. 5. Audits will be reviewed at Quality Assurance Meeting (QAPI) monthly for 3 months to determine if any trends are identified and recommendations for continued audits or monitoring. 6. Completion date 2/21/2017	

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to give acetaminophen 500 mg every six hours as needed for mild pain. Request for CII (control substance category II) Continuance of Therapy Prescription form dated 1/6/17, instructed staff to give two Percocet 5/325 (oxycodone 5 mg/acetaminophen 325 mg) every four hours as need for pain not to exceed 4000 mg of acetaminophen per 24 hours.

A pain management care plan dated 1/17, indicated R151 had diagnoses of acute pain and alteration in comfort related to cervical spine abnormality. Staff were directed to administer pain medication as ordered and monitor and record effectiveness, and side effects.

R151's 1/17, Medication Administration Record (MAR) revealed the resident had received acetaminophen 500 mg on 1/9/17, at 9:10 a.m. and 5:35 p.m.; Percocet 5/325 (oxycodone 5 mg/acetaminophen 325 mg) two tablets on 1/8/17, at 8:00 p.m., and on 1/9/17, at 12:15 a.m., 6:50 a.m. 11:07 a.m. and 3:30 p.m. This amount exceeded the maximum ordered by the physician when the resident received 4250 mg in 24 hours.

During an interview on 1/12/17, at 9:50 a.m. the facility's consulting pharmacist stated "I would expect that they [nurses] would not exceed 4000 mg in a 24 hour period, because the limit is there as a cautionary warning. Some people have no adverse effects and someone could get 2000 mg and have a problem. It really depends on the person."

RN-A stated 1/12/17, at 2:53 p.m. "The nurses should ensure that the acetaminophen dose that they are giving in the 24 hour period does not exceed that 4000 mg limit."

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F 332	Continued From page 24 In an interview on 1/12/17, at 4:14 p.m. the nurse practitioner (NP)-A said, "The standard of nursing is not more than 4000 mg of Tylenol a day. [R151] does not have liver disease...The 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."	F 332		
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an insulin pen was primed to ensure accurate dosing for 1 of 2 residents (R125) observed for insulin administration. This practice had the potential to affect 6 residents residing on the unit who received insulin. This practice resulted in a significant medication error. In addition, the facility failed to ensure that 1 of 1 resident (R154) received Coumadin (a blood thinner used to	F 333	The submission of this plan of correction is not an admission by the provider of any fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted because it is required by law. However, evidencing Robbinsdale Rehabilitation and Care Center good faith, the facility offers the following plan of correction and has achieved substantial compliance in each	2/21/17

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F 333	Continued From page 25 prevent clotting) as ordered Findings include: R125's insulin was prepared on 1/9/17, at 6:27 p.m. by licensed practical nurse (LPN)-D. She cleaned her hands, donned gloves and drew up 5 units of Novolog insulin per FlexPen. She stated R125 received 3 units per his medication schedule and 2 units per sliding scale due to an accucheck (measures blood glucose) reading of 232. LPN-D approached R125 in his room, explained the procedure, cleaned the cite with alcohol, administered the 5 units subqutaneously (just beneath the skin), held the needle in the skin for greater than five seconds, removed the needle, checked the cite, disposed of the needle in the sharps container, removed the gloves and washed her hands. LPN-D verified she had not primed (removed air bubbles) the insulin needle prior to use. She explained that she only primed the insulin needles when used with a new pen, "That's the way we did it when I worked in the hospital." On 1/10/17, at 12:16 p.m. LPN-E explained the facility had not received the manufacturer's package inserts when the flexpens when delivered from the pharmacy. However, she was able to provide manufacturer's instructions for use of the BD [Becton Dickenson] Auto Shield Safety Pen Needle. The instruction pamphlet directed staff to "Always check the flow in the Pen, Needle before each injection by priming the device with an airshot. Dial 2 units, point the pen up and press the button. A drop or stream of liquid should appear at the needle tip. If NOT, repeat as recommended by the pen's instructions. If the pen still does not prime,	F 333	of the areas addressed by February 21, 2017 1. R125 had no adverse effects related to medication error. Nurse Practitioner was updated and new orders received. R154 no longer resides at the facility. 2. Residents that have orders for any of the following have the potential to be affected by this practice: Insulin administration via pen, Coumadin, and Pain medications. Residents receiving insulin via pen have had a chart review with Care plans and Medication Administration Record (MAR) updated as appropriate to include instructions related to priming insulin pen prior to administration. Educational instructions have also been included in the MAR regarding insulin pen administration. Policy and procedure regarding Coumadin administration has been reviewed and residents receiving Coumadin have had a chart and MAR review with updates as appropriate. Residents receiving pain medications have had a chart and MAR review to include updates as appropriate. 3. Education was provided to LPN-D on 1/9/2017 regarding priming insulin pen and holding for 10 seconds. On 1/18/2017 formal education was provided to LPN-D and on 1/24/2017 a return demonstration was completed. LN staff have been educated on policy and procedures regarding Coumadin administration. LN staff have been educated on procedure and manufactures	

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F 333	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 aortic valve replacement, on chronic Coumadin	F 333	guidlines as it relates to insulin administration via pen. LN staff have been educated on administration of pain medications as ordered by the Physician and ensuring there are clear directions regarding perameters for administration. 4. Audit will be complete by Director of Nursing or designee monitoring insulin pen administration 3x per week for 2 weeks then twice per week for 2 weeks then 3x per month for 2 months. 5. Audits will be reviewed during Quality Assurance Meetings (QAPI) to determine if any trends are indentified and recommendations for continued audits or monitoring. 6. Completion date 2/21/2017	

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therapy, acute on chronic respiratory failure and chronic back pain.

Review of R154's Medication Administration Records (MARs) from February through June 2016, revealed R154 did not receive the Coumadin ordered to minimize the risk for blood clot development related to aortic valve replacement Coumadin 5 mg on 2/26/16, and 2/28/16, 3/23/16, 4/15/16, 6/24/16, and Coumadin 7.5 mg on 5/30/16.

R154 had an order dated 4/8/16, for an INR blood test to determine effectiveness of Coumadin dosing. R154's desired INR range was 2.0-2.5. R154 had an order for an INR on 4/15/16, which was not completed until 4/18/16 (three days later). On 4/18/16, INR was drawn. Result was 1.9, which was lower than the desired physician ordered range. A hand written order on 4/18/16, lab result was to increase Coumadin to 10 mg today and to alternate with Coumadin 5 mg. Repeat INR on 4/25/16.

R154 had an order dated 5/4/16, for an INR on 5/11/16, which was not done until 5/12/16. On 5/12/16, the INR was drawn. The result was 3.0, which was higher than the desired range. An order written on 5/12/16, directed to repeat the INR on 5/23/16.

An complaint allegation dated 5/31/16, indicated R154 was not receiving the Coumadin medication which affected the blood levels. The allegation went onto to state that R154 experienced headaches when the blood level was high. It could not be determined if R154 received the Coumadin as ordered as the MARs were void of any documentation and the Coumadin levels

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were not drawn as ordered by the physician.

Pain medication:
R154 had an order for scheduled Morphine Sulfate ER (extended release-long acting) 15 mg twice a day for chronic back pain dated 2/24/16. R154 had a physician order dated 3/17/16, for Percocet 5/325 mg 1 tablet by mouth every four hours as needed for pain max of five tablets in 24 hours. Not to exceed 4000 mg acetaminophen in 24 hours.

Review of R154's MARs from February 2016 through June 2016, revealed R154 did not receive the Morphine Sulfate ER on 2/26/16, 2/28/16, 3/27/16, 4/16/16, 5/26/16, and 5/29/16.

The Progress Note of 2/26/16, indicated R154 had a pain level of 8 out of ten, with ten being the highest rating of pain. The note dated 4/16/16, indicated R154's pain level to be 7.

The May Analgesic Record dated 5/26/16, noted R154's pain to be rated 7 out of ten. R154 received Percocet (a narcotic) however, R154's scheduled long acting Morphine Sulfate medication box was void of any entry. The record lacked evidence for any explanation as to why the Percocet was given instead of Morphine. On 5/29/16, R154's pain level at 8:00 a.m. the level was seven out of ten, at noon the level was eight out of ten, at 4:00 p.m. eight out of ten, at 8:20 p.m. the pain was rated at a level seven out of ten. The record indicated R154 was given the as needed Percocet (which was not long acting) and the scheduled long acting Morphine was void of any documentation as to why Percocet was given versus the Morphine. In addition, the medical record lacked evidence of any justification for

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when the staff was to administer the Percocet versus the long acting Morphine. The Analgesic Record for February, March, and April 2016 were reviewed./ There were no as needed (PRN) medications were administered on the days that the long acting Morphine was void of documentation.

An allegation of a complaint dated 5/31/16, indicated R154 was not receiving the correct medication.

R154's discharge Minimum Data Set (MDS) dated 7/27/16, indicated R154 was cognitively intact with no rejection of cares. R154's MDS indicated R154 had diagnoses of chronic obstructive pulmonary disease, heart failure, edema, polyarthritis, and anemia. The pain section indicated R154 to be in pain occasionally and the rating was 5.

During interview on 1/12/17, at 12:51 p.m. the DON reviewed the Routine Medication, PRN Analgesic Record/pain Flow sheets, Coumadin, Neb and unlabeled MARs dated February 2016, through June 2016, for R154. DON verified identified medications were not signed as being administered. The DON said, "If the nurse cannot give the medication, they are to circle their initials and document on the back of the medication administration record why the medication was not given. DON said, "I cannot tell if this resident [R154] received the medications that were not signed for. The possibility of her medications being missed, is unknown. The missing Coumadin is a significant medication error. When asked if there had been any medication errors reported for (R154), DON said, "I would have to look up the medication errors." Medication error

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F 333	Continued From page 30 reports for R154 from 2/1/16, until date of discharge were requested but not provided. The 8/10, Morphine Sulfate ER Manufacturer's Insert by Watson Laboratories ING indicated "Morphine Sulfate Extended-Release Tablets is an extended-release oral formulation of morphine sulfate indicated for the management of moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time. Morphine Sulfate Extended-Release Tablets is not intended for use as a prn analgesic." The 2016, Percocet Manufacturer's Insert by Endo Pharmaceuticals, Inc. indicated "PERCOCET is indicated for the management of moderate to moderately severe pain, severe enough to require an opioid analgesic and for which alternative treatments are inadequate." The Medication Administration procedure revised March 2016, instructed staff that, "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."	F 333		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 425		2/21/17

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F 425	Continued From page 31 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-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications were available and administered timely and administered as prescribed by the physician, for 1 of 1 resident (R153) whose medications were unavailable. Findings include: R153 was admitted to the facility on 6/1/16, 5:30 p.m. and discharged on 6/2/16. According to a Medication Profile Report dated 6/1/16, the resident had diagnoses including anoxic brain damage, seizures and respiratory failure. In addition, the report noted R153 had an order for Keppra 100 milligram (mg)/milliliter (ml) 1250 mg twice daily for seizure disorder with special instructions "DAW per md [Dispense As Written Per Medical Doctor]." The 6/16, Medication Administration Record (MAR) for R153 revealed two scheduled doses of Keppra had been missed on 6/1/16, 8:00 p.m. and again on 6/2/16, 8:00 a.m. Although a nurse had circled and initialed the MAR on 6/1/16, it was not circled and initialed on 6/2/16. R153's Interdisciplinary Progress Notes from	F 425	The submission of this plan of correction is not an admission by the provider of any fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted because it is required by law. However, evidencing Robbinsdale Rehabilitation and Care Center good faith, the facility offers the following plan of correction and has achieved substantial compliance in each of the areas addressed by February 21, 2017 1. R153 no longer resides at Robbinsdale Rehab and Care Center. 2. Resident who receive orders for "DAW" orders at Robbinsdale Rehab and Care Center have the potential to be affected by this practice. Facility to obtain orders from the hospitals for incoming admissions prior to resident arrival. Medications should be reviewed and medication clarification should occur timely as needed to include "DAW". Resident's orders containing "DAW" should be clarified with the pharmacy to ensure medication is available as written.	

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F 425	Continued From page 32 6/1/16 to 6/2/16, were reviewed. On 6/1/16, a nurse had indicated bedtime [HS] Keppra had not been administered "Because pharmacy currently has no supply of Keppra Brand name as per doctor recommendations...." The writer indicated the doctor who wrote the discharge order was called, but was "unable to give ok [okay] for generic name Keppra until Brand name came...." A fax dated 6/1/16, sent by the facility Transitional Care Unit (TCU) nurse clarified the diagnosis for the medication Keppra was for seizures. A Situation Background Assessment Recommendation (SBAR) Communication Form dated 6/2/16, indicated "Pt [patient] has high respirations, high pulse. Pt has missed 2 doses of Keppra. Family reported swollen arm. Eye twitching. Patients family concerned about latex allergy...." On 1/10/17, at 1:05 p.m. a phone call was made to R153's discharging hospital. The hospital licensed social worker (LSW) explained when any patient who discharged, a Medication Profile Report with all the medications they were taking was faxed over to the admitting facility. It was the facility's responsibility to obtain the medication for the admitting resident. The hospital LSW stated "To my understanding, I found out the facility did not have what they needed for the patient later." When asked the meaning of "DAW PER MD" as noted on R153's discharge Medication Profile Report, the hospital LSW stated she would inquire with the discharging doctor. At 1:38 p.m. the LSW stated the physician explained he had indicated on page 1 of the medication record Keppra was to be dispensed as written, as that	F 425	If pharmacy is unable to accommodate, facility to make arrangements through a pharmacy other that Omnicare. 3. Education provided to nursing staff and admission staff who receive orders from discharging facility to contact pharmacy to ensure medication will be available; if medication is unavailable, concern to be elevated to the Director of Nursing or designee. 4. Audits will be completed on all new admission orders and admission process for obtaining medication orders weekly for 4 weeks, then 4 charts per month for 3 months. 5. Audits will be reviewed during Quality Assurance Meeting (QAPI) to determine if any trends are identified and recommendations for continued audits or monitoring. 6. Completion date 2/21/2017	

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F 425	Continued From page 33	F 425		

was what the patient was being given at the hospital. The physician's intention was "DAW PER MD " meant the resident was to be administered Keppra and not the generic form. The physician had not received a call clarifying the order.

On 1/10/16, at 3:28 p.m. the director of nursing (DON) was interviewed. The DON stated, "From my understanding pharmacy sent the generic not the brand." The DON said the physician at the hospital then stated R153 should not receive the generic form of Keppra. The medical director then instructed the staff to administer the generic Keppra, however, the family did not want it given. The DON stated, "Mom was very intense as she had taken care of daughter and wanted her sent out and facility to the hospital. Mom thought the resident was seizing." When asked if the ordered had been reviewed, the DON stated orders had been reviewed and were sent to the pharmacy, however, they did not realize and had not been informed by the pharmacy staff they did not have the medication available. The DON said the nurse did not find out the medication was unavailable until late on 6/1/16, when medications were delivered. The DON was unsure whether the facility had a back up plan such as contacting another pharmacy to obtain the medication. The DON stated the pharmacist had not communicated they did not have the medication available, which led to the problem. She did not believe R153's swollen arm and eye twitching was related to the two missed doses of Keppra, however, the resident had been sent to the hospital on 6/2/16, at approximately noon, right after the correct medication had been delivered.

On 1/12/17, at 3:40 p.m. the consultant

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F 425	Continued From page 34 pharmacist (CP) with the DON were interviewed. The CP stated the order should have been written as either "dispense as written" or should have indicated the brand name. The CP stated she would have expected the medication to have indicated dispensed as written, and would have expected the pharmacy to communicate with the facility to inform them the medication was unavailable. The facility's 11/21/16, Receipt of Interim/Stat/Emergency Deliveries policy directed the following: "1. Facility should immediately notify Pharmacy when Facility receives from a Physician/Prescriber a medication order that may require an interim/stat/emergency delivery. 2. If a necessary medication is not contained within Facility's interim/stat/emergency supply, and Facility determines that an interim/stat/emergency delivery is necessary, Facility should arrange with Pharmacy for one of the following actions: 2.1 For Pharmacy to include the interim/stat/emergency medication(s) in an earlier scheduled delivery or a special delivery, as required, or 2.2 For Pharmacy delivery by contract courier, or 2.3 For Pharmacy to arrange for the medication to be dispensed and delivered by a Third Party Pharmacy to ensure timely receipt...."	F 425		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 431		2/21/17

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F 431	Continued From page 35 (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 Schedule II of the Comprehensive Drug Abuse Prevention and	F 431		

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F 431	Continued From page 36 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications in 1 of 3 medication rooms were only accessible to authorized personnel to minimize the risk of diversion. This had the potential to affect 4 of 4 residents (R60, R59, R106, R154) whose medications was handled by unauthorized personnel without supervision. Findings include: On 1/12/17, at 7:09 a.m. the maintenance supervisor (MS) was observed in the Transitional Care Unit (TCU) without supervision by a licensed nurse. The MS was moving medications from one refrigerator to another. When asked if he was a nurse or a trained medication aide (TMA), the maintenance supervisor replied, "No." When asked if he was supposed to be allowed in the medication room without a nurse present he replied, "No--the nurse was here when I started." The MS verified there was no nurse in the area. 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.	F 431	The submission of this plan of correction is not an admission by the provider of any fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted because it is required by law. However, evidencing Robbinsdale Rehabilitation and Care Center good faith, the facility offers the following plan of correction and has achieved substantial compliance in each of the areas addressed by February 21, 2017 1. R60, R59, R106 and R154's medications were counted promptly after incident occured in medication room by the Director of Nursing and Assistant Director of Nursing to confirm all medications accounted for. R154 no longer resides at the facility. 2. Resident who reside at Robbinsdale Rehab and Care Center and receive medications that at any time are stored in the medication room have the potential to be affected by this practice. 3. Education was immedicately provided to the Maintenance Supervisor and RN-A on who is able to access medication rooms. Staff both clinical and non clinical have been educated on who is authorized	

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F 431	Continued From page 37 The contents of the refrigerator that the MS handled without supervision were verified by RN-A: Three vials 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 Influenza 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 and the MS should not have been 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.	F 431	to be in the medication rooms in effort to minimize the risk for diversion. 4. Audits will be conducted by Director of Nursing or designee to monitor that non authorized personnel do not have access to medication rooms weekly for 4 weeks then monthly for 2 months. 5. Audits will be brought to Quality Assurance Meeting (QAPI) for 3 months for continued opportunities for quality improvement. 6. Completion date 2/21/2017	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 441		2/21/17

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F 441	Continued From page 38 (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 441		

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F 441	Continued From page 39 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene and peri-care was provided in a manner that minimized infection for 1 of 3 residents (R13) reviewed for activity of daily living (ADLs). Findings include: R13's morning cares were observed on 1/11/17, at 7:12 a.m. by nursing assistant (NA)-K. NA-K while wearing gloves, NA-K removed R13's wet incontinence brief and washed the resident. Although NA-K then changed her soiled gloves, she did not wash her hands or utilize hand sanitizer. NA-K proceeded to apply lotion to R12's chest and back. NA-K placed a clean sheet and incontinent pad under R13. NA-K removed the gloves and applied new gloves, then applied barrier cream to R13's bottom. NA-K applied	F 441	The submission of this plan of correction is not an admission by the provider of any fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted because it is required by law. However, evidencing Robbinsdale Rehabilitation and Care Center good faith, the facility offers the following plan of correction and has achieved substantial compliance in each of the areas addressed by February 21, 2017 1. R13 plan of care was reviewed and remains current. A resident choice form in relation to how she prefers to be cleansed was completed and resident was educated on female hygeine and interventions to prevent UTI's. Residents	

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F 441	Continued From page 40 Nystatin Powder (for fungus) to abdomen folds and under the resident's breasts. R13 requested NA-K to get perfume out of her drawer. NA-K did so without changing gloves. NA-K washed R13's peri area from front to back and then brought the wash cloth from back to front. NA-K repeated action three times. Without changing the soiled gloves NA-K applied a gown on R13 and then put a clean top sheet over R13. NA-K then changed gloves and washed hands. R13's urinary incontinence care plan dated 9/23/16, indicated the resident was frequently incontinent and instructed staff to change incontinent pad as needed and clean perineum from front to back. Previous physician orders dated 12/27/16, instructed staff to administer the antibiotic Macrobid 100 milligrams twice daily for seven days for treatment of a urinary tract infection (UTI). R13's quarterly Minimum Data Set (MDS) dated 1/1/17, noted the resident was cognitively intact and required assistance with toileting, dressing, personal hygiene and bed mobility, and was frequently incontinent of bladder. R13's MDS indicated diagnoses including urinary tract infections. A Physician Telephone Order for R13 dated 1/8/17, instructed staff to administer Macrobid 100 milligrams twice daily for three days for treatment of a UTI. R13 was being treated for a UTI at the time of the observation on 1/11/17. During an interview on 1/11/17, at 7:42 a.m. NA-K verified not washing hands or using sanitizer	F 441	that reside at Robbinsdale Rehab and Care Center who receive assist with perineal care have the potential to be affected by this practice. Policy and Procedure in relation to the Bowel and Bladder program were reviewed as well as procedure regarding perineal care. 2. Education was provided to NA-K on 1/13/2017 related to perineal care, Personal Protective Equipment (PPE) and and hand Hygeine. Education provided to nursing staff related to perineal care, policy and procedures related to PPE, hand hygeine including use of sanitizer and infection prevention standards of practice. 3. Audits wil be completed by Director of Nursing or designee monitoring for proper perineal care, use of gloves, and hand hygeine 3x per week for 2 weeks, then twice per week for 2 weeks, then 3x per month for 2 months. 4. Audits will be reviewed during Quality Assurance Meeting (QAPI) monthly for 3 months to determine if any trends are identified and recommendations for continued audits or monitoring. 5. Completion date 2/21/2017	

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during R13's cares except at the start of cares. NA-K said, "I got distracted." NA-K explained washing the peri area last because the resident wanted staff "to put so much soap down there and scrub around really hard." NA-K did acknowledge going front to back and then pulling the cloth, back to the front. NA-K said, "I could have just left it down there until I was done and then removed it without coming back over the clean area."

Registered nurse (RN)-A stated on 1/12/17, at 11:24 a.m. "Staff are to clean [the perineum] from front to back and then not come back to the front."

During an interview on 1/12/17 at 12:26 p.m. the director of nurses explained, "Pericare should be done front to back. If a resident wanted the area cleaned several times the staff should have changed the cloth. There is a possibility of urinary tract infection if staff wipe back to front."

The facility's 1/17, Hand Hygiene--Plain Soap and Water Procedure instructed staff, "Hand hygiene is the most important procedure for preventing Healthcare Associated 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 also instructed staff that plain soap and water or an alcohol hand rub may be used. "During resident care if moving from a contaminated--body site to a clean body site, after removing gloves."

The facility provided an 11/11/16, Lippincott Procedures--Perineal care of the female resident

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F 441	Continued From page 42 that instructed staff: "Perineal care, which includes care of the external genitalia and the anal area, should be performed during the daily bath and if the patient is incontinent after urination and bowel movements. The procedure promotes cleanliness and prevents infection...For using a washcloth: Wet a washcloth with warm water from a spigot (or from a clean and disinfected bath basin) and apply mild soap. Separate the patient's Labia with one hand. If the patient has an indwelling urinary catheter in place, use the other hand to clean the urethral meatus with the washcloth to reduce the risk for catheter-associated urinary tract infection. Don't aggressively clean the meatal area; aggressive cleaning can lead to meatal irritation increasing the risk for infection. Using gentle downward strokes, clean the perineal area from the front to the back of the perineum to prevent intestinal organisms form contaminating the urethra or vagina. Avoid the area around the anus and use a clean section of washcloth for each stroke by folding each used section inward to prevent contamination with secretions or discharge."	F 441		
F 465 SS=F	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (h) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account	F 465		2/21/17

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F 465	Continued From page 43 non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a tub was in working order for resident use. This had the potential to affect the 65 residents in the facility. Findings include: The executive director (ED) explained on 1/12/17, at 7:36 a.m. they had bathtubs approximately 20 years prior, but there was no desire on the part of the residents to take a bath versus a shower. Although the bathtubs were not in use, they had not been removed and the room was changed to a storage room. The ED said residents were shown the facility prior to their admission and if they said they preferred a bath, they would admit them to a sister facility instead. Current residents were offered a choice of a shower or a bed bath. The ED felt there was still no desire on the residents' part to have a tub bath. "I can't lie. We had tubs. We can't get parts--it is very expensive." The director of nursing (DON) confirmed in an interview on 1/12/17, at 12:11 p.m. the facility bathtubs were not currently available for use. The DON said she could not explain why the bath tubs were not in use, and if a resident wanted a bath they should not have been admitted to the facility. The maintenance supervisor (MS) stated on 1/12/17, at 12:44 p.m. although he had worked at the facility for many years, he did not recall the bathtubs being in use. He did not know why the tubs had never been replaced, nor had it been discussed. He explained that the old tub rooms	F 465	The submission of this plan of correction is not an admission by the provider of any fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted because it is required by law. However, evidencing Robbinsdale Rehabilitation and Care Center good faith, the facility offers the following plan of correction and has achieved substantial compliance in each of the areas addressed by February 21, 2017 1. R95 is currently not at the facility and R101 stated that he knows that the facility does not have a tub bath and he does not want to transfer to a facility with a tub bath. 2 Residents that reside at Robbinsdale Rehab and Care Center have the potential to be affected by this practice. Social Service will meet with all residents that reside at the facility and review preferences. Also newly admitted residents to Robbinsdale Rehab and Care Center will be notified that the faclity does not have a tub bath and if they wish to have a tub bath the facility will assist with locating a facility with a tub bath. 3. Education provided to the Activity department that addresses the need to ensure newly admitted residents plan of care and annual/ quarterly plan of care are reviewed for choices and if a resident	

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F 465	Continued From page 44 were currently used for storage. The ED stated on 1/12/17, at 12:58 p.m. "I cannot answer why they [bathtubs] were not replaced. I don't know what the thought process was." The ED stated they had no written information related to the tubs. The maintenance director (M)-A was interviewed on 1/12/17, at 4:15 p.m. stated the facility did not have any bath tubs. However, floor plans submitted to the Minnesota Department of Health dated 5/13/16, revealed the presence of five tubs on three floors in the facility. Based on observation, interview and document review, the facility failed to ensure a tub was in working order for resident use. This had the potential to affect the 65 residents in the facility. Findings include: R101 was interviewed on 1/9/17, at 3:12 p.m. When asked about bathing choices the resident stated she stated she did not have a choice as, "There is no bath in this facility. I wish there was. I would like a bath. I'm sure a lot of people would." In a follow up interview with R101 on 1/11/17, at 8:33 a.m. he stated, "I do not remember them telling me there was no bath in the place. If they would have I would've bitched about it. It's important to me to have a bath instead of a shower...The older I get the more I would like a bath to soak. I have arthritis." R95 was interviewed on 1/9/17, at 4:10 p.m. R95 stated that they would enjoy an Epson salt bath and soaking in the bath tub. R95 then stated the facility did not have a bathtub on any of the floors.	F 465	would like a tub bath. Activities will notify Social Services so they can meet with the resident and assist with locating a facility with a tub bath. 4. Audits will be completed by the Director of Social Services or designee that will monitor next business day for newly admitted residents for proper bathing choice for 3 weeks and then weekly audits for 4 weeks. 5. Audits will be reviewed at Quality Assurance Meeting (QAPI) monthly for 3 months to determine if trends are identified and recommendations for continued audits and monitoring needs. 6. Completion date 2/21/2017	

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

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F 465	Continued From page 45	F 465		

When asked if they informed staff of their request for a tub bath and R95 stated, "Yes, on admission I was asked what type of bathing I preferred, I then told a nursing assistant (NA) and a nurse. I do not remember who else I told." In a follow up interview with R95 on 1/12/17, at 3:41 p.m. he stated he had not been informed prior to his admission in 8/16, that a tub was unavailable, and no one else would been informed on his behalf. R95 stated, "I would not have come to this facility if I would have known they did not have bathtubs. I like taking Epson [salt] baths and soaking in the tub." At 3:44 p.m. R95 added that he was never offered a choice of going instead to a sister facility that had a tub.

The executive director (ED) explained on 1/12/17, at 7:36 a.m. they had bathtubs approximately 20 years prior, but there was no desire on the part of the residents to take a bath versus a shower. Although the bathtubs were not in use, they had not been removed and the room was changed to a storage room. The ED said residents were shown the facility prior to their admission and if they said they preferred a bath, they would admit them to a sister facility instead. Current residents were offered a choice of a shower or a bed bath. The ED felt there was still no desire on the residents' part to have a tub bath. "I can't lie. We had tubs. We can't get parts--it is very expensive."

The director of nursing (DON) confirmed in an interview on 1/12/17, at 12:11 p.m. the facility bathtubs were not currently available for use. The DON said she could not explain why the bath tubs were not in use, and if a resident wanted a bath they should not have been admitted to the facility.

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The maintenance supervisor (MS) stated on 1/12/17, at 12:44 p.m. although he had worked at the facility for many years, he did not recall the bathtubs being in use. He did not know why the tubs had never been replaced, nor had it been discussed. He explained that the old tub rooms were currently used for storage.

The ED stated on 1/12/17, at 12:58 p.m. "I cannot answer why they [bathtubs] were not replaced. I don't know what the thought process was." The ED stated they had no written information related to the tubs.

The director of social services (LSW)-A was interviewed on 1/12/17, at 3:44 p.m. at which time a copy of the Admission Packet was provided. LSW-A explained that she informed prospective residents and/or representatives that the facility was old and they only had a bathtub at either end of the halls.

The maintenance director (M)-A was interviewed on 1/12/17, at 4:15 p.m. stated the facility did not have any bath tubs. However, floor plans submitted to the Minnesota Department of Health dated 5/13/16, revealed the presence of five tubs on three floors in the facility.

The Admission Packet, undated which was provided to all residents at the time of their admission did not indicate the facility did not have a bath tub. Based on observation, interview and document review, the facility failed to ensure a tub was in working order for resident use. This had the potential to affect the 65 residents in the facility.

Findings include:

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R101 was interviewed on 1/9/17, at 3:12 p.m. When asked about bathing choices the resident stated she stated she did not have a choice as, "There is no bath in this facility. I wish there was. I would like a bath. I'm sure a lot of people would." In a follow up interview with R101 on 1/11/17, at 8:33 a.m. he stated, "I do not remember them telling me there was no bath in the place. If they would have I would've bitched about it. It's important to me to have a bath instead of a shower...The older I get the more I would like a bath to soak. I have arthritis."

R95 was interviewed on 1/9/17, at 4:10 p.m. R95 stated that they would enjoy an Epson salt bath and soaking in the bath tub. R95 then stated the facility did not have a bathtub on any of the floors. When asked if they informed staff of their request for a tub bath and R95 stated, "Yes, on admission I was asked what type of bathing I preferred, I then told a nursing assistant (NA) and a nurse. I do not remember who else I told." In a follow up interview with R95 on 1/12/17, at 3:41 p.m. he stated he had not been informed prior to his admission in 8/16, that a tub was unavailable, and no one else would been informed on his behalf. R95 stated, "I would not have come to this facility if I would have known they did not have bathtubs. I like taking Epson [salt] baths and soaking in the tub." At 3:44 p.m. R95 added that he was never offered a choice of going instead to a sister facility that had a tub.

The executive director (ED) explained on 1/12/17, at 7:36 a.m. they had bathtubs approximately 20 years prior, but there was no desire on the part of the residents to take a bath versus a shower. Although the bathtubs were not in use, they had

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F 465	Continued From page 48	F 465		

not been removed and the room was changed to a storage room. The ED said residents were shown the facility prior to their admission and if they said they preferred a bath, they would admit them to a sister facility instead. Current residents were offered a choice of a shower or a bed bath. The ED felt there was still no desire on the residents' part to have a tub bath. "I can't lie. We had tubs. We can't get parts--it is very expensive."

The director of nursing (DON) confirmed in an interview on 1/12/17, at 12:11 p.m. the facility bathtubs were not currently available for use. The DON said she could not explain why the bath tubs were not in use, and if a resident wanted a bath they should not have been admitted to the facility.

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The ED stated on 1/12/17, at 12:58 p.m. "I cannot answer why they [bathtubs] were not replaced. I don't know what the thought process was." The ED stated they had no written information related to the tubs.

The director of social services (LSW)-A was interviewed on 1/12/17, at 3:44 p.m. at which time a copy of the Admission Packet was provided. LSW-A explained that she informed prospective residents and/or representatives that the facility was old and they only had a bathtub at either end of the halls.

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F 465	Continued From page 49 The maintenance director (M)-A was interviewed on 1/12/17, at 4:15 p.m. stated the facility did not have any bath tubs. However, floor plans submitted to the Minnesota Department of Health dated 5/13/16, revealed the presence of five tubs on three floors in the facility. The Admission Packet, undated which was provided to all residents at the time of their admission did not indicate the facility did not have a working bath tub.	F 465		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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	K 000	EPOC	

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

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K 000	Continued From page 1 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:	K 000		
K 321 SS=D	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING	K 321		2/21/17

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K 321	Continued From page 2 Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not properly separate and protect hazardous areas. 19.3.2.1. This deficient practice could affect all residents within the smoke compartment. Findings include: On a facility tour between the hours of 0930 and 1730 on January 11, 2017, observation revealed	K 321	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. K 321 door to storage propped open The one door to the office/ storage area	

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K 321	Continued From page 3 that the Central Supply Room door was wedged open and unable to self-close. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 321	that was held open and prevented the mechanical device from closing correctly. The staff were educated on January 17, 2017 that the doors can not be held open by any non-approved device. The maintenance director will be responsible to prevent a reoccurance by monitoring storage.office areas. To ensure the deficient practice will not reoccure, the maintenance director will monitor on daily rounds.	
K 351 SS=F	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and approved automatic sprinkler system in accordance with the NFPA 13, Standard for Installation of Sprinkler Systems. LSC 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4,	K 351	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the	2/21/17

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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. This deficient practice was verified by the Director of Maintenance at the time of discovery.	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	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not inspect and maintain portable fire extinguishers in accordance with NFPA 10. 19.3.5.12. This deficient practice could affect all residents within the smoke compartment. Findings include: On a facility tour between the hours of 0930 and 1730 on January 11, 2017, observation revealed that the fire extinguishers in Room 111 and the Elevator Equipment Room were missing required	K 355	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. K355 Fire extinguishers The two fire extinguishers that were missed for their monthly inspection and dated with the time of inspection was	2/21/17

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K 355	Continued From page 5 monthly checks. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 355	completed on 1/16/2017. The maintenance director will be responsible to prevent reoccurance by monitoring maintenance inspection monthly. To ensure the deficient practice will not reoccur an audit tool has been developed of all locations of fire extinguishers and the maintenance director will randomly audit the fire extinguisher inspections to ensure the deficient practice will not reoccur.	
K 372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not properly provide smoke barrier walls free of penetrations. 19.3.7.3, 8.6.7.1(1). This deficient practice could affect all residents in the smoke compartment. Findings include: On a facility tour between the hours of 0930 and	K 372	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. K372 Smoke Barriers	2/21/17

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K 372	Continued From page 6 1730 on January 11, 2017, observation revealed that there were penetrations in the smoke barrier walls above the doors on the 1st and 4th floors, on the North end. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 372	The two smoke barrier penetrations above the ceiling were fire stopped on 1/16/2017. The maintenance director wil be responsible to prevent a reoccurance by monitoring maintenance work bt theire department and/ or vendors that if they have to penetrate the smoke barriers walls that the penetration is corrected immediately. The maintenance director will inspect smoke barriers to ensure no fire stop becomes loose. To ensure the deficient practice will not reoccur and audit tool has been put into place. This audit will be completed twice per year.	
K 521 SS=F	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility's heating, ventilation, and air conditioning in not in compliance with the 2012 LSC NFPA 101 9.2, 19.5.2.1 and NFPA 90A. This deficient practice could effect all 68 residents. Findings include: On a facility tour between the hours of 0930 and	K 521	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. K521 Waiver	2/21/17

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ROBBINSDALE REHAB & CARE CENTER	**3130 GRIMES AVENUE NORTH** **ROBBINSDALE, MN 55422**

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K 521	Continued From page 7 1730 on January 11, 2017, observation revealed that the facility was using their egress corridors as an exhaust plenum. This deficiency need not be corrected with the approval of an annual waiver. This deficient practice was verified by the Director of Maintenance at the time of inspection.	K 521	A request for an annual waiver was submitted. See waiver request and documentation. Waiver will be faxed and or e mailed.	
K 920 SS=D	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the	K 920	This plan of correction constitutes this	2/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245417	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/11/2017**

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

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K 920	Continued From page 8 facility did not use power cords and extension cords in a manner that exercises general precautions. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA99), 400.8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5. This deficient practice could affect all residents within the room. Findings include: On a facility tour between the hours of 0930 and 1730 on January 11, 2017, observation revealed that there were daisy changed power-strips in Room 120. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 920	facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. K920 The relocatable power strip that was being used improperly was removed 1/11/2017. Other office areas were audited to ensure compliance. Office staff was educated on the proper usage of relocatable power strips. The maintenance director will be responsible to prevent reoccurance by monitoring office space monthly.	
K 926 SS=F	NFPA 101 Gas Equipment - Qualifications and Training Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not maintain a training program for staff on the proper handing, storage, and maintenance of medical gas equipment. 11.5.2.1 (NFPA 99). This deficient practice could affect all 68 residents.	K 926	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report.	2/21/17

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	245417	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/11/2017**

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K 926	Continued From page 9 Findings include: On a facility tour between the hours of 0930 and 1730 on January 11, 2017, observation revealed that the facility did not have a documented training program for staff that are involved in the handling of medical gas appliances. This deficient practice was verified by the Administrator at the time of discovery.	K 926	K 926 The nursing staff has been trained on the proper usage, storage, and maintenance of oxygen. Staff education will be completed by February 20, 2017. The Director of Maintenance with the Director of Nursing will ensure training and audits will be completed on an annual basis.	

Name of Facility

ROBBINSDALE REHABILITATION AND CARE CENTER ROBBINSDALE, MINNESOTA

2012 LIFE SAFETY CODE

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 cited. 6. This annual/continuing waiver has been approved in the past.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* Thomas Linhoff 12424	Title Fire Safety Supervisor	Office State Fire Marshal Division	Date 02-09-2017

March 17, 2015

Mr. Tom 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^{th}) of the month on all invoices issued by the first (1^{st}) 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,

Ronald M. Gundershaug
V.P. Service Division

AGREED BY: EXTENDICARE

SIGNED BY:_____

DATE:_____

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

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

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00122	A. BUILDING: _____ B. WING _____	C 01/12/2017

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

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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 REQUIREMENT 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 statute after the statement,	2 000		

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2 000	Continued From page 2 "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period for Correction.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide physician ordered treatments as ordered for 1 of 1 resident (R154) who allegedly did not receive care as ordered. Findings include: R154's Interagency Transfer Orders dated 2/24/16, indicated diagnoses of diabetes aortic valve replacement, acute on chronic respiratory failure and chronic back pain, as well as the use of the blood thinner Coumadin. The orders instructed staff to weigh R154 every morning and keep a record related to heart failure and edema (fluid in the tissues). If R154's weight increased	2 830	Corrected	2/21/17

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2 830	Continued From page 3	2 830		

two pounds over night or four pounds in one week staff was instructed to contact primary care provider or cardiologist related to acute on chronic respiratory failure. R154's Treatment Administration Record (TAR) record lacked evidence of the weights were recorded as ordered. In April 14 of 30 days were missing, May 27 out of 31 days, and June 23 of 30 days. Therefore, it could not be determined if the resident had gained weight, as the weights were not consistently documented.

Copies of R154's weights for February to June 2016 were requested but was not provided.

An allegation of cares not being completed dated 5/31/16, noted R154 did not receive treatments per physician's orders. It was alleged ace bandages (elastic bandages) for R154's legs were not being applied for two days as the staff "was busy." The allegation indicated R154 had a diagnosis of congestive heart failure.

R154 had an order to wrap both legs dated 2/24/16. The staff were to start at bottom of the feet and work their way up, wrapping the legs. Documentation showing the treatment was completed as ordered was lacking on R154's TARs as follows: No documentation was recorded on 4/25, 4/27, or 4/28/16; nine of 31 days was missing on the May TAR, as well as nine of 31 days. The June 2016 TAR revealed no documentation of treatments being completed on 6/7, 6/25, and 6/29/16.

R154's discharge Minimum Data Set (MDS) dated 7/27/16, indicated R154 was cognitively intact with no rejection of cares. Diagnoses were listed as chronic obstructive pulmonary disease, heart failure, edema, polyarthritis and anemia.

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2 830	Continued From page 4 On 1/12/17, at 12:51 p.m. the director of nursing (DON) reviewed and verified the following information related to R154: routine and as needed medications, analgesic/pain flow sheets, nebulizer treatments for breathing, and unlabeled Medication Administration Records dated February through June 2016 were reviewed. The DON verified the treatments had not been signed off as completed. The DON stated, "If the nurse cannot complete a treatment, they are to circle their initials and document on the back of the treatment administration record why the treatment was not done...I cannot tell if this resident received the treatment, as they were not signed for." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop polices and procedures regarding assessing and monitoring of treatments. The Director of Nursing or her designee could educate staff on the policies and procedures. The Director of Nursing or her designee could develop a monitoring system to ensue residents receive the appropriate care. TIME FRAME FOR CORRECTION: Twenty-one (21) days	2 830		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of	2 915		2/21/17

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2 915	Continued From page 5 the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide eating assistance for 1 of 1 resident (R150) who received a room tray. Findings include: R150 was observed on 1/11/17, at 7:01 a.m. lying in bed on his back. At 8:22 a.m. a nursing assistant (NA) looked into R150's room but did not enter. At 8:25 a.m. a nurse entered and then immediately emerged from the room. At 8:32 a.m. R150's light was on, the head of the bed was elevated 45 degrees. The reported he thought he'd get up for breakfast. At 8:44 a.m. a licensed social worker (LSW)-A asked R150 what he wanted for breakfast. At 8:49 a.m. LSW-A brought R150's breakfast tray and set it on the bedside table. The tray was not prepared in any way, and the food was left covered. At 9:10 a.m. the breakfast tray was untouched and R150 was lying in bed with his eyes closed. At 9:22 a.m. NA-K entered R150's room and washed her hands and indicated she was going to feed R150	2 915	Corrected	

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2 915	Continued From page 6	2 915		

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 well...All 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: "Various disabilities and conditions may prevent a resident from feeding

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 7 herself, including cognitive deficits, neuromuscular disease, cancer obstructive lung disease and traumatic injury. When a resident can't feed herself, she's susceptible to malnutrition." While procedure addressed the mechanics of feeding a resident, it did not address timeliness of providing that assistance. SUGGESTED METHOD FOR CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the need for assistance withADLs. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures and importance of documentation. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely toileting assistance for 1 of 1 resident (R150) reviewed for bowel and bladder incontinence.	2 920	Corrected	2/21/17

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2 920	Continued From page 8 Findings include: R150 was not provided toileting assistance for at least 2 hours, 48 minutes. Continuous observations were conducted on 1/11/17, from 7:41 a.m. until 10:29 a.m. during which time R150 was not provided toileting assistance. At 7:41 a.m. R150 was lying in bed on his back in the dark. At 8:49 a.m. licensed social worker (LSW)-A brought R150's breakfast tray. Nursing assistant (NA)-K entered R150's room and said she was going to assist the resident to eat. Toileting assistance was not provided at that time. At 9:45 a.m. NA-K entered the room at 9:45 and said to see whether R150 was drinking his orange juice, however, toileting was not offered. At 9:51 a.m. NA-K removed a pillow from under R150's right hip and lowered head of bed and adjusted the resident's shirt. R150 reported, "I don't feel well...All over. I don't know what is wrong." R150 informed NA-K he wanted to stay in bed. NA-K verified R150 did not have pants on and his incontinent product was wet. NA-K stated needed two staff to assist the resident. NA-K told R150 she would be back when there was another NA available. Between 10:07 and 10:17 a.m. physical therapy assistant (PTA)-A came and went from R150's room. At 10:24 a.m. licensed practical nurse (LPN)-A entered room and asked R150, "Do you want some pants on? I will have to find some." LPN-A repositioned R150 onto his side. Continuous observation ended at 10:29 a.m. A Progress Note dated 1/7/17, indicated R150 was incontinent of bowel and bladder. The Nursing Comprehensive Admission Data Collection and Assessment dated 1/7/17, indicated R150 was incontinent. Although R150	2 920		

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2 920	Continued From page 9 was assessed as being incontinent, the medical record lacked evidence of sufficient interventions to provide the newly admitted resident with care related to his incontinence. During an interview on 1/11/17, at 11:05 a.m. NA-L said, "I changed him when I was done with the resident I was working with. It was about 10:45 a.m." NA-L verified R150 was wet when incontinence product was changed. NA-L verified R150 should have been changed every two hours, but it had been more than two hours. NA-L said, "I got him washed up and changed first thing this morning--about 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." SUGGESTED METHOD OF CORRECTION:	2 920		

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2 920	Continued From page 10 The director of nursing could monitor personal cares provided to residents to determine resident needs, educate staff, and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390		2/21/17

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21390	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene and peri-care was provided in a manner that minimized infection for 1 of 3 residents (R13) reviewed for activity of daily living (ADLs). Findings include: R13's morning cares were observed on 1/11/17, at 7:12 a.m. by nursing assistant (NA)-K. NA-K while wearing gloves, NA-K removed R13's wet incontinence brief and washed the resident. Although NA-K then changed her soiled gloves, she did not wash her hands or utilize hand sanitizer. NA-K proceeded to apply lotion to R12's chest and back. NA-K placed a clean sheet and incontinent pad under R13. NA-K removed the gloves and applied new gloves, then applied barrier cream to R13's bottom. NA-K applied Nystatin Powder (for fungus) to abdomen folds and under the resident's breasts. R13 requested NA-K to get perfume out of her drawer. NA-K did so without changing gloves. NA-K washed R13's peri area from front to back and then brought the wash cloth from back to front. NA-K repeated action three times. Without changing the soiled gloves NA-K applied a gown on R13 and then put a clean top sheet over R13. NA-K then changed gloves and washed hands. R13's urinary incontinence care plan dated 9/23/16, indicated the resident was frequently incontinent and instructed staff to change incontinent pad as needed and clean perineum from front to back. Previous physician orders dated 12/27/16, instructed staff to administer the antibiotic	21390	Corrected	

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21390	Continued From page 12 Macrobid 100 milligrams twice daily for seven days for treatment of a urinary tract infection (UTI). R13's quarterly Minimum Data Set (MDS) dated 1/1/17, noted the resident was cognitively intact and required assistance with toileting, dressing, personal hygiene and bed mobility, and was frequently incontinent of bladder. R13's MDS indicated diagnoses including urinary tract infections. A Physician Telephone Order for R13 dated 1/8/17, instructed staff to administer Macrobid 100 milligrams twice daily for three days for treatment of a UTI. R13 was being treated for a UTI at the time of the observation on 1/11/17. During an interview on 1/11/17, at 7:42 a.m. NA-K verified not washing hands or using sanitizer during R13's cares except at the start of cares. NA-K said, "I got distracted." NA-K explained washing the peri area last because the resident wanted staff "to put so much soap down there and scrub around really hard." NA-K did acknowledge going front to back and then pulling the cloth, back to the front. NA-K said, "I could have just left it down there until I was done and then removed it without coming back over the clean area." Registered nurse (RN)-A stated on 1/12/17, at 11:24 a.m. "Staff are to clean [the perineum] from front to back and then not come back to the front." During an interview on 1/12/17 at 12:26 p.m. the director of nurses explained, "Pericare should be done front to back. If a resident wanted the area cleaned several times the staff should have	21390		

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changed the cloth. There is a possibility of urinary tract infection if staff wipe back to front."

The facility's 1/17, Hand Hygiene--Plain Soap and Water Procedure instructed staff, "Hand hygiene is the most important procedure for preventing Healthcare Associated 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 also instructed staff that plain soap and water or an alcohol hand rub may be used. "During resident care if moving from a contaminated--body site to a clean body site, after removing gloves."

The facility provided an 11/11/16, Lippincott Procedures--Perineal care of the female resident that instructed staff: "Perineal care, which includes care of the external genitalia and the anal area, should be performed during the daily bath and if the patient is incontinent after urination and bowel movements. The procedure promotes cleanliness and prevents infection...For using a washcloth: Wet a washcloth with warm water from a spigot (or from a clean and disinfected bath basin) and apply mild soap. Separate the patient's Labia with one hand. If the patient has an indwelling urinary catheter in place, use the other hand to clean the urethral meatus with the washcloth to reduce the risk for catheter-associated urinary tract infection. Don't aggressively clean the meatal area; aggressive cleaning can lead to meatal irritation increasing the risk for infection. Using gentle downward strokes, clean the perineal area from the front to the back of the perineum to prevent intestinal organisms form contaminating the urethra or vagina. Avoid the area around the anus and use a

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21390	Continued From page 14 clean section of washcloth for each stroke by folding each used section inward to prevent contamination with secretions or discharge." SUGGESTED METHOD OF CORRECTION: The facility DON or infection control nurse could review and revise policies and procedures in relation to the facility's infection control program. Education could be provided as appropriate. Audits could be conducted. The director of nursing (DON) or designee could develop, review, and/or revise Infection Control program and ensure that resident and staff infections are monitored and analyzed. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21390		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or	21545		2/21/17

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21545	Continued From page 15 (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an insulin pen was primed to ensure accurate dosing for 1 of 2 residents (R125) observed for insulin administration. This resulted in a medication error rate of 8 percent, and had the potential to affect six residents residing on the unit who received insulin. In addition, the facility failed to ensure dosages were not exceeded per medical doctor (MD) orders for 1 of 2 residents (R151) who received medications containing acetaminophen (mild analgesic).	21545	Corrected	

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21545	Continued From page 16 Findings include: R125's insulin was prepared on 1/9/17, at 6:27 p.m. by licensed practical nurse (LPN)-D. She cleaned her hands, donned gloves and drew up 5 units of Novolog insulin per FlexPen. She stated R125 received 3 units per his medication schedule and 2 units per sliding scale due to an accucheck (measures blood glucose) reading of 232. LPN-D approached R125 in his room, explained the procedure, cleaned the cite with alcohol, administered the 5 units subqutaneously (just beneath the skin), held the needle in the skin for greater than five seconds, removed the needle, checked the cite, disposed of the needle in the sharps container, removed the gloves and washed her hands. LPN-D verified she had not primed (removed air bubbles) the insulin needle prior to use. She explained that she only primed the insulin needles when used with a new pen, "That's the way we did it when I worked in the hospital." On 1/10/17, at 12:16 p.m. LPN-E explained the facility had not received the manufacturer's package inserts when the flexpens when delivered from the pharmacy. However, she was able to provide manufacturer's instructions for use of the BD [Becton Dickenson] Auto Shield Safety Pen Needle. The instruction pamphlet directed staff to "Always check the flow in the Pen, Needle before each injection by priming the device with an airshot. Dial 2 units, point the pen up and press the button. A drop or stream of liquid should appear at the needle tip. If NOT, repeat as recommended by the pen's instructions. If the pen still does not prime, change the Needle and repeat the priming steps."	21545		

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21545	Continued From page 17 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...." R151's one caplet of acetaminophen (Tylenol) 500 milligrams (mg) and diazepam (for anxiety) 5 mg was set up for administration on 1/9/17, at 5:33 p.m. by registered nurse (RN)-B. R151's discharge orders and information dated 1/3/17, indicated R151 had diagnoses of chronic low back pain, acute kidney injury and mantle cell lymphoma. The discharge orders instructed staff to give acetaminophen 500 mg every six hours as	21545		

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needed for mild pain. Request for CII (control substance category II) Continuance of Therapy Prescription form dated 1/6/17, instructed staff to give two Percocet 5/325 (oxycodone 5 mg/acetaminophen 325 mg) every four hours as need for pain not to exceed 4000 mg of acetaminophen per 24 hours.

A pain management care plan dated 1/17, indicated R151 had diagnoses of acute pain and alteration in comfort related to cervical spine abnormality. Staff were directed to administer pain medication as ordered and monitor and record effectiveness, and side effects.

R151's 1/17, Medication Administration Record (MAR) revealed the resident had received acetaminophen 500 mg on 1/9/17, at 9:10 a.m. and 5:35 p.m.; Percocet 5/325 (oxycodone 5 mg/acetaminophen 325 mg) two tablets on 1/8/17, at 8:00 p.m., and on 1/9/17, at 12:15 a.m., 6:50 a.m. 11:07 a.m. and 3:30 p.m. This amount exceeded the maximum ordered by the physician when the resident received 4250 mg in 24 hours.

During an interview on 1/12/17, at 9:50 a.m. the facility's consulting pharmacist stated "I would expect that they [nurses] would not exceed 4000 mg in a 24 hour period, because the limit is there as a cautionary warning. Some people have no adverse effects and someone could get 2000 mg and have a problem. It really depends on the person."

RN-A stated 1/12/17, at 2:53 p.m. "The nurses should ensure that the acetaminophen dose that they are giving in the 24 hour period does not exceed that 4000 mg limit."

In an interview on 1/12/17, at 4:14 p.m. the nurse

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21545	Continued From page 19 practitioner (NP)-A said, "The standard of nursing is not more than 4000 mg of Tylenol a day. [R151] does not have liver disease...The 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." SUGGESTED METHOD OF CORRECTION: The facility administrator and director of nursing (DON) or designee could review facility policies and procedures, educate staff and implement an ongoing monitoring system to ensure all resident orders are correctly transcribed and implemented as directed by physician orders. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21545		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services.	21550		2/21/17

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21550	Continued From page 20 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications were available and administered timely and administered as prescribed by the physician, for 1 of 1 resident (R153) whose medications were unavailable. Findings include: R153 was admitted to the facility on 6/1/16, 5:30 p.m. and discharged on 6/2/16. According to a Medication Profile Report dated 6/1/16, the resident had diagnoses including anoxic brain damage, seizures and respiratory failure. In addition, the report noted R153 had an order for Keppra 100 milligram (mg)/milliliter (ml) 1250 mg twice daily for seizure disorder with special instructions "DAW per md [Dispense As Written Per Medical Doctor]." The 6/16, Medication Administration Record (MAR) for R153 revealed two scheduled doses of Keppra had been missed on 6/1/16, 8:00 p.m. and again on 6/2/16, 8:00 a.m. Although a nurse had circled and initialed the MAR on 6/1/16, it was not circled and initialed on 6/2/16. R153's Interdisciplinary Progress Notes from 6/1/16 to 6/2/16, were reviewed. On 6/1/16, a nurse had indicated bedtime [HS] Keppra had not been administered "Because pharmacy currently has no supply of Keppra Brand name as per doctor recommendations...." The writer indicated the doctor who wrote the discharge order was called, but was "unable to give ok [okay] for generic name Keppra until Brand name came...."	21550	Corrected	

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21550	Continued From page 21 A fax dated 6/1/16, sent by the facility Transitional Care Unit (TCU) nurse clarified the diagnosis for the medication Keppra was for seizures. A Situation Background Assessment Recommendation (SBAR) Communication Form dated 6/2/16, indicated "Pt [patient] has high respirations, high pulse. Pt has missed 2 doses of Keppra. Family reported swollen arm. Eye twitching. Patients family concerned about latex allergy...." On 1/10/17, at 1:05 p.m. a phone call was made to R153's discharging hospital. The hospital licensed social worker (LSW) explained when any patient who discharged, a Medication Profile Report with all the medications they were taking was faxed over to the admitting facility. It was the facility's responsibility to obtain the medication for the admitting resident. The hospital LSW stated "To my understanding, I found out the facility did not have what they needed for the patient later." When asked the meaning of "DAW PER MD" as noted on R153's discharge Medication Profile Report, the hospital LSW stated she would inquire with the discharging doctor. At 1:38 p.m. the LSW stated the physician explained he had indicated on page 1 of the medication record Keppra was to be dispensed as written, as that was what the patient was being given at the hospital. The physician's intention was "DAW PER MD " meant the resident was to be administered Keppra and not the generic form. The physician had not received a call clarifying the order. On 1/10/16, at 3:28 p.m. the director of nursing (DON) was interviewed. The DON stated, "From my understanding pharmacy sent the generic not	21550		

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21550	Continued From page 22	21550		

the brand." The DON said the physician at the hospital then stated R153 should not receive the generic form of Keppra. The medical director then instructed the staff to administer the generic Keppra, however, the family did not want it given. The DON stated, "Mom was very intense as she had taken care of daughter and wanted her sent out and facility to the hospital. Mom thought the resident was seizing." When asked if the ordered had been reviewed, the DON stated orders had been reviewed and were sent to the pharmacy, however, they did not realize and had not been informed by the pharmacy staff they did not have the medication available. The DON said the nurse did not find out the medication was unavailable until late on 6/1/16, when medications were delivered. The DON was unsure whether the facility had a back up plan such as contacting another pharmacy to obtain the medication. The DON stated the pharmacist had not communicated they did not have the medication available, which led to the problem. She did not believe R153's swollen arm and eye twitching was related to the two missed doses of Keppra, however, the resident had been sent to the hospital on 6/2/16, at approximately noon, right after the correct medication had been delivered.

On 1/12/17, at 3:40 p.m. the consultant pharmacist (CP) with the DON were interviewed. The CP stated the order should have been written as either "dispense as written" or should have indicated the brand name. The CP stated she would have expected the medication to have indicated dispensed as written, and would have expected the pharmacy to communicate with the facility to inform them the medication was unavailable.

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

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21550	Continued From page 23 Interim/Stat/Emergency Deliveries policy directed the following: "1. Facility should immediately notify Pharmacy when Facility receives from a Physician/Prescriber a medication order that may require an interim/stat/emergency delivery. 2. If a necessary medication is not contained within Facility's interim/stat/emergency supply, and Facility determines that an interim/stat/emergency delivery is necessary, Facility should arrange with Pharmacy for one of the following actions: 2.1 For Pharmacy to include the interim/stat/emergency medication(s) in an earlier scheduled delivery or a special delivery, as required, or 2.2 For Pharmacy delivery by contract courier, or 2.3 For Pharmacy to arrange for the medication to be dispensed and delivered by a Third Party Pharmacy to ensure timely receipt...." SUGGESTED METHOD FOR CORRECTION: The DON and/or designee could review with staff the facility's policy and procedure regarding the ordering of medications within a specified time period. A member of the nursing staff could randomly review medication carts and medication rooms to ensure all medications have been and received in a timely manner. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21550		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys.	21610		2/21/17

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21610	Continued From page 24 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications in 1 of 3 medication rooms were only accessible to authorized personnel to minimize the risk of diversion. This had the potential to affect 4 of 4 residents (R60, R59, R106, R154) whose medications was handled by unauthorized personnel without supervision. Findings include: On 1/12/17, at 7:09 a.m. the maintenance supervisor (MS) was observed in the Transitional Care Unit (TCU) without supervision by a licensed nurse. The MS was moving medications from one refrigerator to another. When asked if he was a nurse or a trained medication aide (TMA), the maintenance supervisor replied, "No." When asked if he was supposed to be allowed in the medication room without a nurse present he replied, "No--the nurse was here when I started." The MS verified there was no nurse in the area. 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 vials of Ativan 2 milligram (mg)/milliliter (ml) (anti-anxiety medication) stored	21610	Corrected	

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21610	Continued From page 25 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 Influenza 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 and the MS should not have been 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 DON or designee could develop, review, and/or revise policies and procedures to ensure medications including vaccination solution, are appropriately stored and not expired. In addition, ensure the medication room(s) are safeguarded. The DON could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		

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21810	Continued From page 26	21810		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications in 1 of 3 medication rooms were only accessible to authorized personnel to minimize the risk of diversion. This had the potential to affect 4 of 4 residents (R60, R59, R106, R154) whose medications was handled by unauthorized personnel without supervision. Findings include: On 1/12/17, at 7:09 a.m. the maintenance supervisor (MS) was observed in the Transitional Care Unit (TCU) without supervision by a licensed nurse. The MS was moving medications from one refrigerator to another. When asked if he was a nurse or a trained medication aide (TMA), the maintenance supervisor replied, "No." When asked if he was supposed to be allowed in the medication room without a nurse present he replied, "No--the nurse was here when I started." The MS verified there was no nurse in the area.	21810	Corrected	2/21/17

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21810	Continued From page 27 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 vials 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 Influenza 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 and the MS should not have been 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		

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21810	Continued From page 28 Director of Nursing could review the policies and procedures for accommodation of resident needs, educate the appropriate personnel in any changes and appoint a designee to monitor the procedures to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		
23095	MN Rule 4658.5025 Toilet Rooms & Sanitary Fixtures; Exist.Const A nursing home must have at least one toilet and one sink for eight beds, and at least one shower or tub for 20 beds. When the licensed bed capacity is increased, the requirements under part 4658.4135 apply to the new addition. In resident toilet rooms where grab bars or towel bars are not provided, bars must be installed according to part 4658.4145 to the extent that the room arrangements will permit. A toilet room must have a sink and all sinks must be provided with hot and cold water. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a tub was in working order for resident use. This had the potential to affect the 65 residents residing in the facility. Findings include: R101 was interviewed on 1/9/17, at 3:12 p.m. When asked about bathing choices the resident stated she stated she did not have a choice as, "There is no bath in this facility. I wish there was. I	23095	Corrected	2/21/17

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23095	Continued From page 29	23095		

would like a bath. I'm sure a lot of people would." In a follow up interview with R101 on 1/11/17, at 8:33 a.m. he stated, "I do not remember them telling me there was no bath in the place. If they would have I would've bitched about it. It's important to me to have a bath instead of a shower...The older I get the more I would like a bath to soak. I have arthritis."

R95 was interviewed on 1/9/17, at 4:10 p.m. R95 stated that they would enjoy an Epson salt bath and soaking in the bath tub. R95 then stated the facility did not have a bathtub on any of the floors. When asked if they informed staff of their request for a tub bath and R95 stated, "Yes, on admission I was asked what type of bathing I preferred, I then told a nursing assistant (NA) and a nurse. I do not remember who else I told." In a follow up interview with R95 on 1/12/17, at 3:41 p.m. he stated he had not been informed prior to his admission in 8/16, that a tub was unavailable, and no one else would been informed on his behalf. R95 stated, "I would not have come to this facility if I would have known they did not have bathtubs. I like taking Epson [salt] baths and soaking in the tub." At 3:44 p.m. R95 added that he was never offered a choice of going instead to a sister facility that had a tub.

The executive director (ED) explained on 1/12/17, at 7:36 a.m. they had bathtubs approximately 20 years prior, but there was no desire on the part of the residents to take a bath versus a shower. Although the bathtubs were not in use, they had not been removed and the room was changed to a storage room. The ED said residents were shown the facility prior to their admission and if they said they preferred a bath, they would admit them to a sister facility instead. Current residents were offered a choice of a shower or a bed bath.

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23095	Continued From page 30	23095		

The ED felt there was still no desire on the residents' part to have a tub bath. "I can't lie. We had tubs. We can't get parts--it is very expensive."

The director of nursing (DON) confirmed in an interview on 1/12/17, at 12:11 p.m. the facility bathtubs were not currently available for use. The DON said she could not explain why the bath tubs were not in use, and if a resident wanted a bath they should not have been admitted to the facility.

The maintenance supervisor (MS) stated on 1/12/17, at 12:44 p.m. although he had worked at the facility for many years, he did not recall the bathtubs being in use. He did not know why the tubs had never been replaced, nor had it been discussed. He explained that the old tub rooms were currently used for storage.

The ED stated on 1/12/17, at 12:58 p.m. "I cannot answer why they [bathtubs] were not replaced. I don't know what the thought process was." The ED stated they had no written information related to the tubs.

The director of social services (LSW)-A was interviewed on 1/12/17, at 3:44 p.m. at which time a copy of the Admission Packet was provided. LSW-A explained that she informed prospective residents and/or representatives that the facility was old and they only had a bathtub at either end of the halls.

The maintenance director (M)-A was interviewed on 1/12/17, at 4:15 p.m. stated the facility did not have any bath tubs. However, floor plans submitted to the Minnesota Department of Health dated 5/13/16, revealed the presence of five tubs on three floors in the facility.

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23095	Continued From page 31 The Admission Packet, undated which was provided to all residents at the time of their admission did not indicate the facility did not have a working bath tub. SUGGESTED METHOD OF CORRECTION: The administrator and director of maintenance could ensure one of the existing tubs is either repaired or replaced. Residents could be informed a tub bath is an option in resident council meetings, care conferences, and on their bath day. TIME PERIOD FOR CORRECTION: Thirty (30) days.	23095		