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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: T1B6
Facility ID: 00751

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245519**

2. STATE VENDOR OR MEDICAID NO.
(L2) **594243800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ABBOTT NORTHWESTERN COURAGE RESIDENCE**
(L4) **3915 GOLDEN VALLEY ROAD**
(L5) **GOLDEN VALLEY, 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) **06/01/2013**

6. DATE OF SURVEY **02/03/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12. Total Facility Beds **40** (L18)

13. Total Certified Beds **40** (L17)

10. THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Sarah Grebenc, Unit Supervisor — 02/03/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 03/13/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/21/2014
(L33)

DETERMINATION APPROVAL

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

Page 2
Provider Number: 24-5519
Item 16 Continuation for CMS-1539

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective January 31, 2014, the facility is certified for 40 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245519

February 23, 2014

Mr. Matthew Kinne, Administrator
Abbott Northwestern Courage
Residence 3915 Golden Valley Road
Golden Valley, Minnesota 55422

Dear Mr. Kinne:

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 January 31,2014, the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

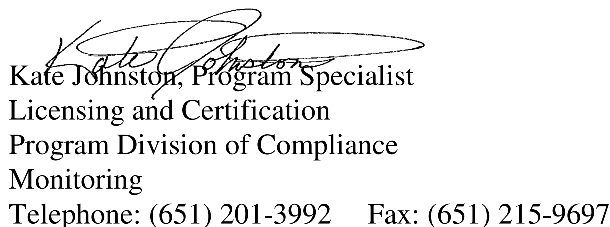
Your facility's Medicare approved area consists of all 40 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,



Kate Johnston, Program Specialist
Licensing and Certification
Program Division of Compliance
Monitoring
Telephone: (651) 201-3992   Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

February 3, 2014

Mr. Matthew Kinne, Administrator
Abbott Northwestern Courage Residence
3915 Golden Valley Road
Golden Valley, MN 55422

RE: Project Number 00751

Dear Mr. Kinne:

On November 14, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 25, 2013. 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 December 17, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 3, 2014, 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 October 25, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 31, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 25, 2013, and therefore remedies outlined in our letter to you dated November 14, 2013, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Grebenc, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 320-223-7365 Fax: 320-223-7348

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245519	A. Building B. Wing	12/17/2013

Name of Facility	Street Address, City, State, Zip Code
ABBOTT NORTHWESTERN COURAGE RESIDENCE	3915 GOLDEN VALLEY ROAD GOLDEN VALLEY, MN 55422

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0166 Reg. # 483.10(f)(2) LSC	12/02/2013	ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - LSC	12/02/2013	ID Prefix F0226 Reg. # 483.13(c) LSC	12/02/2013
ID Prefix F0241 Reg. # 483.15(a) LSC	12/02/2013	ID Prefix F0242 Reg. # 483.15(b) LSC	12/02/2013	ID Prefix F0309 Reg. # 483.25 LSC	12/02/2013
ID Prefix F0314 Reg. # 483.25(c) LSC	12/02/2013	ID Prefix F0315 Reg. # 483.25(d) LSC	12/02/2013	ID Prefix F0323 Reg. # 483.25(h) LSC	12/02/2013
ID Prefix F0325 Reg. # 483.25(i) LSC	12/02/2013	ID Prefix F0353 Reg. # 483.30(a) LSC	12/02/2013	ID Prefix F0356 Reg. # 483.30(e) LSC	12/02/2013
ID Prefix F0371 Reg. # 483.35(i) LSC	12/02/2013	ID Prefix F0441 Reg. # 483.65 LSC	12/02/2013	ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By ✓ State Agency	10562	2/3/14	10562	2/3/14
Reviewed By CMS RO				

Followup to Survey Completed on:
10/25/2013

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245519	A. Building B. Wing 01 - MAIN BUILDING 01	2/3/2014

Name of Facility	Street Address, City, State, Zip Code
ABBOTT NORTHWESTERN COURAGE RESIDENCE	3915 GOLDEN VALLEY ROAD GOLDEN VALLEY, MN 55422

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0011	Correction Completed **01/31/2014**	ID Prefix Reg. # **NFPA 101** LSC K0017	Correction Completed **12/20/2013**	ID Prefix Reg. # **NFPA 101** LSC K0018	Correction Completed **11/01/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency ✓	Reviewed By 10562	Date: 2/3/14	Signature of Surveyor: 10562	Date: 2-3-14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/23/2013

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245519	A. Building 01 - MAIN BUILDING 01 B. Wing	2/3/2014

Name of Facility	Street Address, City, State, Zip Code
ABBOTT NORTHWESTERN COURAGE RESIDENCE	3915 GOLDEN VALLEY ROAD GOLDEN VALLEY, MN 55422

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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency ✓	Reviewed By 10562	Date: 2/3/14	Signature of Surveyor: 10562	Date: 2-3-14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
10/23/2013

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245519	A. Building B. Wing	12/17/2013

Name of Facility	Street Address, City, State, Zip Code
ABBOTT NORTHWESTERN COURAGE RESIDENCE	3915 GOLDEN VALLEY ROAD GOLDEN VALLEY, 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).

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ID Prefix F0241 Reg. # 483.15(a) LSC	12/02/2013	ID Prefix F0242 Reg. # 483.15(b) LSC	12/02/2013	ID Prefix F0309 Reg. # 483.25 LSC	12/02/2013
ID Prefix F0314 Reg. # 483.25(c) LSC	12/02/2013	ID Prefix F0315 Reg. # 483.25(d) LSC	12/02/2013	ID Prefix F0323 Reg. # 483.25(h) LSC	12/02/2013
ID Prefix F0325 Reg. # 483.25(i) LSC	12/02/2013	ID Prefix F0353 Reg. # 483.30(a) LSC	12/02/2013	ID Prefix F0356 Reg. # 483.30(e) LSC	12/02/2013
ID Prefix F0371 Reg. # 483.35(i) LSC	12/02/2013	ID Prefix F0441 Reg. # 483.65 LSC	12/02/2013	ID Prefix Reg. # LSC	

Reviewed By State Agency ✓	Reviewed By 10562	Date: 2/3/14	Signature of Surveyor: 10562	Date: 2/3/14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
10/25/2013

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
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: T1B6
Facility ID: 00751

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245519**

2. STATE VENDOR OR MEDICAID NO. (L2) **594243800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ABBOTT NORTHWESTERN COURAGE RESIDENCE**
(L4) **3915 GOLDEN VALLEY ROAD**
(L5) **GOLDEN VALLEY, 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) **06/01/2013**

6. DATE OF SURVEY **10/25/2013** (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 **40** (L18)

13. Total Certified Beds **40** (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)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Marilyn Kaelke, HFE NE II 12/16/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 01/17/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/01/1988** (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. **00000** (L31)

30. REMARKS
Posted 1/21/2014 ML T1B6

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: T1B6

Facility ID: 00751

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

CCN-245519

At the time of the standard survey completed December 25, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to bewidespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7555

November 14, 2013

Ms. Martha Swenson, Administrator
Abbott Northwestern Courage Residence
3915 Golden Valley Road
Golden Valley, Minnesota 55422

RE: Project Number S5519024

Dear Ms. Swenson:

On October 25, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

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

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

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320) 223-7365
Fax: (320) 223-7348

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 December 4, 2013, 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 December 4, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 25, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 25, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure
cc: Licensing and Certification File

RECEIVED

DEC 0 2 2013

MN Dept of Health
St.Cloud

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

PRINTED: 11/13/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING ____ B. WING ____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTT NORTHWESTERN COURAGE RESIDENCE	3915 GOLDEN VALLEY ROAD GOLDEN VALLEY, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	This plan of correction and response to the survey findings and allegations is written solely to maintain certification in Medicare and Medical Assistance programs. These written responses do not constitute admission of non-compliance with any requirement nor an agreement with any of the findings. The facility wishes to preserve the right to dispute these findings in their entirety at any time and in any legal action.	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure prompt efforts were made to resolve grievances for 1 of 1 resident (R75), reviewed in the sample who voiced a concern related to noise levels and strangers who walked into her room. Findings include: R75 was interviewed on 10/22/13, at 10:11 a.m. and stated her room was next to the kitchenette and she had a problem with the noise level in that area. R75 also voiced concerns about strange people who had entered her room, and stated she woke one night to a strange male using her	F 166	F 166 Resident# 75 was interviewed and stated that her concern had been addressed. Clients are being interviewed to identify potential grievances that have not been brought to the attention of the administrator or Director of Nursing. Issues will be addressed at the time if identified.	12-16-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE ADMINISTRATOR (X6) DATE 12/2/13

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

DEC 0 2 2013

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	245519	A. BUILDING ______ B. WING ______ MN Dept of Health St.Cloud	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	This plan of correction and response to the survey findings and allegations is written solely to maintain certification in Medicare and Medical Assistance programs. These written responses do not constitute admission of non-compliance with any requirement nor an agreement with any of the findings. The facility wishes to preserve the right to dispute these findings in their entirety at any time and in any legal action.	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure prompt efforts were made to resolve grievances for 1 of 1 resident (R75), reviewed in the sample who voiced a concern related to noise levels and strangers who walked into her room. Findings include: R75 was interviewed on 10/22/13, at 10:11 a.m. and stated her room was next to the kitchenette and she had a problem with the noise level in that area. R75 also voiced concerns about strange people who had entered her room, and stated she woke one night to a strange male using her	F 166	F 166 Resident# 75 was interviewed and stated that her concern had been addressed. Clients are being interviewed to identify potential grievances that have not been brought to the attention of the administrator or Director of Nursing. Issues will be addressed at the time if identified.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: ADMINISTRATOR (X6) DATE: 12/2/13

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

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F 166	Continued From page 1 bathroom. R75 stated she reported this to staff and was first told she could get a different room, but then was told, "no, that was just the way it was" and she couldn't change rooms. An admission Minimum Data Set (MDS), dated 10/17/13, identified R75 as cognitively intact. During a follow up interview on 10/24/13, at 3:30 p.m. R75 stated, "It's noisy out there," referring to the kitchenette area outside of her room. R75 stated, "One night there was a man in my room." R75 reported, "On Sundays, residents sit in the kitchenette area and drink coffee and read the paper, and they are just obnoxious." R75 stated when residents have complained to the staff, "pretty much everyone gets told that is just the way it is, and that they are not that loud." R75 reported, "First they said I can change rooms, then they said no to the room change." No reason was given as to the decline of her request. During an interview on 10/24/13, at 4:02 p.m. registered nurse (RN)-C reported, "last week sometime" she overheard R75 voice her complaints to the health unit coordinator (HUC)-A. RN-C assumed the HUC-A was going to "bring it up" to registered nurse care manager (RN)-A. On 10/24/13, at 4:07 p.m. RN-A was interviewed and reported he knew R75 well and talked to her at least once a day, in her room or in the hallway. RN-A stated R75 has never informed him of men coming into her room or discussion about a room change. RN-A verified there are no signs in the kitchenette area to designate quiet hours. RN-A indicated, when a resident voices a concern, his expectation for the staff would be to send him an	F 166	A Client Advisory meeting was held on 11/11/18/13. There were no serious concerns expressed by clients. The Grievance Policy and Procedure has been reviewed and revised. Staff are being educated about the Allina revised Grievance Policy and Procedure. Education will be completed by 12/2/13. Client interviews will be conducted weekly or four weeks with the results reported to the Quality Assurance and Performance Improvement Committee. The Committee will determine further action needed. Correction will be complete by 12/2/13. The Administrator will be responsible for compliance.	12/2/13

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F 166	Continued From page 2 email, call him, come to his office and inform him, or inform the nurse. He would expect the nurse to inform him, "Then I would go and interview the client." RN-A stated, R75 "has no cognitive deficits in the way of expressing her needs." During an interview on 10/25/13, at 8:26 a.m. HUC stated, "Actually, [R75] did talk to me last week about it being extremely noisy at times, mostly when she sleeps." HUC denied R75 reported a strange man had entered her room. When asked what she does when a resident voices a complaint, HUC stated she "passed it on to the nurses." HUC indicated she thought she had told licensed practical nurse (LPN)-B, but she wasn't sure. A review of R75's progress notes, indicated a note written on 10/14/13, at 23:08 by RN-D. The note included, "It was reported to writer that client was stating that people are randomly coming into her room, using her bathroom and feels that the halls need to be patrolled. Client was given clonazepam and Percocet at 2020. Writer tried to reiterate [sic] with client that there is a security [sic] officer, that the staff is in the halls multiple times and that there was no one in the cafe this evening. Client was very distraught about this and writer did try to re- direct and was unable to." During an interview on 10/25/13, at 8:40 a.m. RN-E stated if a resident voiced a complaint to her, she would, "deal with the issue." When asked what she would do with a complaint about the noise level in an area, RN-E stated, "I would ask the people to quiet down." During an interview on 10/25/13, at 11:45 a.m. licensed social worker (LSW)-A reported she was	F 166		

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F 166	Continued From page 3 new to the facility, but knew there was a formal complaint process and "if we know about them, we can work to resolve them." LSW-A stated she didn't know if every complaint needed to be formally written. LSW-A stated she was not aware of any complaints from R75, or any complaints of noise levels. LSW-A added, "If I knew of any, I would address it." A review of the Grievance Procedure policy, last revised 3/22/10, indicated, residents had the right to voice grievances and prompt efforts by the facility to resolve your grievances under the facility's written grievance procedure. Also included, under procedure, 2. Any staff person having received a concern from a client should complete a "Grievance Form"...The staff person will then document the concern being addressed...3...If the staff is not able to resolve the concern with the client, the staff will ask for assistance from other appropriate staff such as Social Service Liaison, Clinical Nurse Manager, etc...4. If the client's concern is not resolved to his/her satisfaction through Step 2, he/she will be reminded of additional staff members, including the Director of Nursing and Administrator, that he/she can set up an appointment with to discuss the issue further, if so desired.	F 166		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property;	F 225		

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F 225	Continued From page 4 and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of mistreatment or neglect were reported to the administrator or his designee immediately and thoroughly investigated for 1 of 1 resident (R88), who reported an allegation of abuse.	F 225	F225 For resident #88, a vulnerable adult report was made on 10/24/13 when the Administrator and Director of Nursing were made aware of the client's concern. The staff involved was suspended during the investigation. An investigation was completed and the investigation report was made to the State. The State concluded that no further action was required. The staff received appropriate education. The client stated that she was comfortable having the staff member provide care for her. Clients are being interviewed to identify potential issues that may not have been brought to the attention of the administrator or Director of Nursing. Reports will be made per policy if issues are identified The Vulnerable Adult policy and procedure was reviewed and revised.	

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

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F 225	Continued From page 5 Findings include: R88 reported on 10/21/13, at 6:55 p.m., she felt a staff person during the night shift had made disrespectful statements to her and was verbally abusive. She further reported the nurse had told she was using her call light at night too much and she was being selfish, as her use of the call light was interfering with staff meeting the needs of other residents. R88 reported she and the nurse got into an argument regarding her statements of R88 abusing the call light and reported the nurse "yelled at me." R88 reported she felt "unimportant" as a result of the nurse accusing her of abusing her call light. She also reported she felt the nurse tried to push medications onto her and stated "I feel that she (the nurse) wanted to dope me up so I would sleep and she would not have to deal with me." R88 also reported she had talked to registered nurse clinical manager (RN)-A on two occasions about the night nurse's behavior. She indicated she was unaware if this was addressed with the alleged staff member and the staff member continued to work with her during the night. She stated "I only have problems with her when I can't sleep." R88's admission Minimum Data Set (MDS) completed on 9/6/13, indicated R88 was considered to be cognitively intact. She had no communication barriers and was able to verbalize her concerns. The MDS also indicated R88 was totally dependent on staff to complete all of her activities of daily living and had loss of functional ability of her both sides of her upper and lower extremities. The MDS identified R88 had diagnoses that included closed fracture of the cervical spine (C1-C4) with residual quadriplegia.	F 225	Staff is receiving education about the revised Vulnerable Adult policy and procedure. Education will be completed by 12/2/13. Client interviews about staff behaviors and potential abuse will be conducted weekly for four weeks with the results reported to the Quality Assurance and Performance Improvement Committee. The Committee will determine further action needed. Correction will be complete by 12/2/13. The Administrator will be responsible for compliance.	12/2/13

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F 225	Continued From page 6 A second interview with R88 was completed 10/23/13, at 8:55 a.m. and R88 validated the statements made on 10/21/13. An interview with RN-A was completed on 10/23/13, at 12:07 p.m. He reported R88 talked to him "a couple weeks ago regarding a night nurse." He reported she complained of the treatment provided during the night and told him a nurse complained of her using the call light too frequently during the night. He reported he had talked to the night nurse about resident report and the registered nurse had reported that R88 was not sleeping well at night and frequently used her call light for various things including repositioning, pain and medication administration. He indicated he routinely talks to R88, about every two to three days and she made no further complaints of the night nurse, so he assumed the "issue had resolved itself." He acknowledged he had not informed the administrator or the director of nurses of R88's report and had not done any further investigation other than talk to identified registered nurse. An interview with the director of nurses (DON) was completed on 10/24/13, at 10:00 a.m. She reported RN-A had not informed her or the administrator of the resident's allegations. She indicated they should have been informed and a report should have been filed with the regulatory agency. DON also reported an investigation was not completed and should have been done. A review of the facility's policy Program Abuse Prevention Plan, revised 10/25/12, defined one area of abuse as conduct which was not an accident or therapeutic conduct which produced or could reasonably be expected to produce	F 225		

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F 225	Continued From page 7 emotional distress included use of repeated malicious oral, written or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing or threatening. The policy Reporting of Abuse and Neglect, revised 12/14/12, directed staff to report immediately any suspicion, allegation or incident of maltreatment to the administrator and DON.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed implement written policies to ensure alleged abuse or mistreatment were immediately reported to the administrator and state agency and investigated for 1 of 1 resident (R88), who reported an allegation of abuse. Findings include: The facility's policy Program Abuse Prevention Plan, revised 10/25/12, defined Abuse to include conduct which was not an accident or therapeutic conduct which produced or could reasonably be expected to produce emotional distress included use of repeated malicious oral, written or gestured language toward a vulnerable adult or	F 226	F 226 For Resident #88 vulnerable adult report was made on 10/24/13 when the Administrator and Director of Nursing were made aware of the client's concern. The staff involved was suspended during the investigation. An investigation was completed and the investigation report was made to the State. The State concluded that no further action was required. The staff received appropriate education. The client stated that she was comfortable having the staff member provide care for her.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING ______ B. WING ______	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTT NORTHWESTERN COURAGE RESIDENCE	3915 GOLDEN VALLEY ROAD GOLDEN VALLEY, MN 55422

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F 226	Continued From page 8 the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing or threatening. The policy Reporting of Abuse and Neglect, revised 12/14/12, directed staff to report immediately any suspicion, allegation or incident of maltreatment to the Administrator and the DON. The Administrator would immediately report suspicions of maltreatment to the state regulatory agency and then an investigation of the allegation would be conducted. The policy specified that all efforts would be taken to protect, assure the safety and comfort of the vulnerable adult. The policy specified that if the alleged perpetrator was a staff person, they "may be reassigned" or placed on suspension until the investigation was completed. R88 reported on 10/21/13 at 6:55 p.m., she felt a staff person during the night shift had made disrespectful statements to her and was verbally abusive to her. She further reported the nurse had told she was using her call light at night too much and she was being selfish, as her use of the call light was interfering with staff meeting the needs of other residents. R88 reported she and the nurse got into an argument regarding her statements of R88 abusing the call light and reported the nurse "yelled at me." R88 reported she felt "unimportant" as a result of the nurse accusing her of abusing her call light. She also reported she felt the nurse tried to push medications onto her and stated "I feel that she (the nurse) wanted to dope me up so I would sleep and she would not have to deal with me." R88 also reported she had talked to registered nurse clinical manager (RN)-A on two occasions	F 226	Clients are being interviewed to identify potential issues that may not have been brought to the attention of the administrator or Director of Nursing. Reports will be made per policy if issues are identified The Vulnerable Adult policy and procedure was reviewed and revised. Staff is receiving education about the revised Vulnerable Adult policy and procedure. Education will be completed by 12/2/13. Client interviews about staff behaviors and potential abuse will be conducted weekly for four weeks with the results reported to the Quality Assurance and Performance Improvement Committee. The Committee will determine further action needed. Correction will be complete by 12/2/13. The Administrator will be responsible for compliance.	12/2/13

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F 226	Continued From page 9 about the night nurses behavior. She indicated she was unaware if this was addressed with the alleged staff member and the staff member continued to work with her during the night. She stated I only have problems with her when I can't sleep." An admission Minimum Data Set (MDS) completed on 9/6/13, indicated R88 was considered to be cognitively intact. She had no communication barriers and was able to verbalize her concerns. The MDS also indicated R88 was totally dependent on staff to complete all of her activities of daily living and had loss of functional ability of her both sides of her upper and lower extremities. The MDS identified R88 had diagnoses that included closed fracture of the cervical spine (C1-C4) with residual quadriplegia. A second interview with R88 was completed 10/23/13, at 8:55 a.m. and R88 validated the statements made on 10/21/13. An interview with RN-A was completed on 10/23/13, at 12:07 p.m. He reported R88 talked to him "a couple weeks ago regarding a night nurse." He reported she complained of the treatment that was provided during the night and told him a nurse complained of her using the call light too frequently during the night. He reported he had talked to the night nurse about resident report and the registered nurse had reported that R88 was not sleeping well at night and frequently used her call light for various things including repositioning, pain and medication administration. He indicated he routinely talks to R88 every two to three days and she made no further complaints of the night nurse, so he assumed the "issue had	F 226		

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F 226	Continued From page 10 resolved itself ." He acknowledged he had not informed the administrator or the director of nurses of R88's report and had not done any further investigation other than talk to identified registered nurse. An interview with the director of nurses (DON) was completed on 10/24/13, at 10:00 a.m. She reported RN-A had not informed her or the administrator of the resident's allegations. She indicated they should have been informed and a report should have been filed with the regulatory agency. DON reported an investigation was not completed and should have been done.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal cares were provide in a dignified manner for 1 of 4 residents (R100) reviewed for dignity. Findings include: R100's family member (FM)-A was interviewed on 10/22/13, at 10:41 a.m. FM-A reported she was very upset about an incident which occurred with her family member on 10/18/13. She indicated R100 needed to use the bathroom and a nursing assistant (NA) transferred him from the bed onto	F 241	F 241 Resident #100's family member was interviewed on 10/24/13 as soon as the Administrator was made aware of the issue. A Vulnerable Adult Incident report was made on 10/24/13. An investigation was conducted and the Investigation report was sent to the Department of Health on 10/24/13. The staff identified as involved in the issue received education on 10/24/13.	

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F 241	Continued From page 11 a commode and wheeled him into the bathroom with his pants and incontinent products below his knees. She reported that her husband's roommate had visitors at the time and they would have been able to view her husband partially clothed. She reported her husband "looked very frustrated" regarding the incident. She voiced that the incident bothered her and felt it bothered her husband. She reported, "if he (R100) could have said anything, he would have." She went on to express fear that her husband (R100) would "hate me from not protecting him from situations like that." R100's admission nursing assessment completed on 10/15/13, identified R100 was admitted to the facility on 10/15/13, for rehabilitation due to hemiplegia affecting unspecified side due to cerebrovascular disease, cerebral infarction, aphasia, and dysphagia. The assessment also indicted R100 was nonverbal but had the ability to express ideas and wants. R100 was totally dependent with activities of daily living, including transfers, locomotion, dressing and toilet use. An observation was made on 10/23/13, at 8:20 a.m. of R100's personal cares. It was observed at this time NA-A put his incontinence product on and his pants while R100 was lying on his bed. She did not pull these items up but instead, left them below his knees. She and NA-B assisted R100 to stand on the edge of the bed and pivot into the resident's wheelchair. The clothing items were below the resident's knees. NA-A started to push the resident to the bathroom, at which time, NA-B stopped NA-A and reminded her to cover the resident's lap with a towel. R100 was interviewed on 10/23/13, at 8:45 a.m.	F 241	Clients are being interviewed to identify potential issues that may not have been brought to the attention of the administrator or Director of Nursing. The Resident Rights pamphlet given to clients at admission has been reviewed to ensure that the information is up to date. The up to date Resident Rights document was obtained from the Minnesota Department of Health and staff is receiving education about Resident Rights, specifically, dignity and privacy. Education will be completed by 12/2/13 Client interviews about being treated with dignity and having privacy will be conducted weekly for four weeks with the results reported to the Quality Assurance and Performance Improvement Committee. The Committee will determine further action needed.	

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F 241	Continued From page 12 Resident was nonverbal and was able to shake his head for yes/no and shrug for maybe. He was able to understand questions and responded appropriately. R100 acknowledged he remembered the incident his wife described on 10/22/13. He shook his head up and down rapidly when asked if the incident bothered him and R100's eye brows became furrowed. He acknowledged his roommate had company and he was pushed to the bathroom by a nursing assistant, uncovered, with his pants and incontinent product below his knees. He indicated he did not know if the visitors had witnessed the incident. An interview with the administrator on 10/25/13, at 1:05 p.m. was completed and verified the resident should not have been transported to the bathroom in this manner. The facility's policy Residents Rights, revised 8/20/00, indicated every resident had the right to dignity and private medical and personal care including activities of personal hygiene like toileting or bathing.	F 241	Correction will be complete by 12/2/13. The Administrator will be responsible for compliance.	12/2/13
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced	F 242	F242 Resident #100's wife was interviewed about his bedtime preference on 10/24/13 and the nursing assistant care sheet was updated to reflect his preference.	

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F 242	Continued From page 13 by: Based on interview and document review, the facility failed to ensure that 1 of 3 residents (R100) reviewed for choices were honored. Findings include: R100's family member (FM)-A reported on 10/22/13, at 10:34 a.m. that R100 had no choice as to when he went to bed at night or when he got up in the morning. She stated "they just put him to bed." She further stated she did not feel it was so much of an issue regarding morning arising as he needed to be got up and prepared for his therapy sessions but felt R100 should have more choices regarding bedtime. R100 was interviewed on 10/23/13, at 8:45 a.m. Resident was nonverbal and was able to shake his head for yes/no and shrug his shoulders for maybe. He understood questions and responded appropriately. He shook his head side to side, when asked if he was given choices regarding bedtime or morning arising. He shook his head up and down, when asked if he would like to have the choice for bedtime. An interview with nursing assistant (NA)-A was completed on 10/23/13, at 8:20 a.m. NA-A reported she gets resident up and puts him to bed according to her care sheet. She produced the care sheet which specified resident was to be gotten up at 9:00 a.m. and put to bed at 8:00 p.m. NA-A indicated she also checks the resident's therapy schedule in the morning to ensure his personal cares are done before these are scheduled. She reported the lead nursing assistant makes the determination as to resident's schedule.	F 242	Current residents were interviewed about their bed time preferences. Interviews were completed by 11/22/13 and care sheets were update to reflect their preferences. New admissions have been interviewed about their bed time preferences and the care sheets reflect their preferences. The procedure for obtaining information about individual preferences was reviewed and revised. Staff is receiving education about Resident Rights, specifically, accommodation to resident preferences. Education will be completed by 12/2/13 Client interviews about bedtime preferences will be conducted weekly for four weeks with the results reported to the Quality Assurance and Performance Improvement Committee. The Committee will determine further action needed.	

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F 242	Continued From page 14 An interview with NA-B was completed on 10/23/13 at 8:45 a.m. NA-B was identified as the lead nursing assistant and the staff person, who created the Client Care Sheet. She reports that upon admission residents and family are asked about their preferences regarding arising and going to bed. They try to accommodate the requests but if they request times that are not available, they are put into other time slots. NA-B indicated she puts resident morning cares and evening bedtime, wherever there is an opening in the schedule. An interview with registered nurse care manager (RN)-A was done on 10/23/13 at 2:14 p.m. RN-A reported that upon admission, residents and family members are asked of their personal preferences for arising and going to bed. They attempt to accommodate this but if there request cannot be accommodated, they will negotiate with residents and families. A second interview was completed with R100 on 10/24/13 at 8:45 a.m. He again verified the information he reported on 10/23/13. He also shook his head up and down vigorously when asked if he had ever tried to refuse his scheduled bedtime. He shook his head from side to side when asked if his personal preference for bedtime had been considered. The facility policy Rights to freedom of Choice, revised 8/20/01 specified residents had the right to reside and receive services in the facility with reasonable accommodations of their needs and preferences.	F 242	Correction will be complete by 12/2/13. The Director of Nursing will be responsible for compliance.	12/2/13
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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F 309 SS=D	Continued From page 15 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to reassess pain, identify non medication interventions and monitor pain management effectiveness for 2 of 2 residents (R100, R55), who were reviewed for pain. Findings include: R100's family member (FM)-A reported on 10/21/13, at 5:09 p.m. that she did not feel the facility was managing the resident's pain issues. She reported he had intermittent pain to the right side of his body and the pain will significantly worsen when staff "move him wrong." She was tearful when discussing this and also reported she was afraid her family member "would get mad at her for not protecting him from the pain." She reported R100 had developed a DVT (deep vein thrombosis-blood clot) since his admission to the facility and since then has had an increase in his pain to the right side of his body. FM-A reported she had an incident when she had requested pain medication for her family member and the staff did not respond for over 30 minutes. She reported she approached an unidentified the	F 309	F309 Resident #100 has a pain assessment completed on 10/30/13 and his care plan was updated. He was discharged. Resident # 55 was discharged. Clients' pain assessments are being reviewed. Missing assessments are being completed. Weekly pain assessments are being conducted for the first four weeks after admission to ensure that clients' pain is managed. The Pain Assessment policy and procedure was reviewed and revised. Staff is receiving education about Pain assessment and management. Education will be completed by 12/2/13. Audits of pain assessment and pain medication use will be conducted weekly for four weeks and reported to the Quality Assurance and Performance Improvement Committee. The Committee will determine further action needed.	

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F 309	Continued From page 16 staff and again requested pain medication for her family member and was told by the staff person, that it was the facility policy that staff have an hour to administer pain medication. She voiced she did not feel that this was acceptable. FM-A reported she was fearful of leaving her husband alone at the facility and feels that she needs to be at the facility as much as possible to ensure that resident gets the care that she feels he needs or that is ordered by physician. R100 was admitted to the facility on 10/15/13. The admission nursing assessment completed on 10/15/13, identified R100 had diagnoses that included hemiplegia affecting unspecified side due to cerebrovascular disease, cerebral infarction, aphasia, and dysphagia. R100 was also diagnosed with a DVT (deep vein thrombosis-blood clot) on 10/18/13. The admission nursing assessment completed on 10/15/13, also noted resident was nonverbal but did have the ability to express ideas and wants. R100 was totally dependent with activities of daily living, including transfers, locomotion, dressing and toilet use. R100 reported that he had pain frequently, which interfered with his sleep and limited his day to day activities. During the interview, R100 denied any pain and felt his current medication regime was effective and non-medication interventions were noted but none were listed. The resident identified head pain and his pain goals was for him to have no pain. A pain assessment was completed on 10/15/13, and documented the pain assessment interview was not done as the resident was not able to	F 309	Correction will be complete by 12/2/13. The Director of Nursing will be responsible for compliance.	12/2/13

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F 309	Continued From page 17 communicate appropriately. The assessment did note that non-verbal sounds and facial expression would be an indicator of resident's pain and PRN (as needed) medications (Tylenol and Percocet) were effective at the time. The assessment also identified non-medication interventions were effective for pain but did not identify what they were. No further pain assessments were found in the medical record. The resident's care plan, established on 10/16/13, identified pain as a problem and the established goal was for the resident's pain to be managed to a level that did not impair his ability to participate in daily life and therapy and the reduction of pain. Interventions included monitoring pain, offer non-drug interventions, administer pain medications per physician order and notify the physician if the pain is not relieved or appears to be betting worse. In addition, the staff were directed to allow resident to express feelings about pain (even thought R100 was nonverbal), assess and document if pain referral is needed to pain clinic, assessment pain for interventions that increase/decrease, educate R100 on pain interventions, encourage PRN pain management one hour prior to therapy or activity acknowledge presence of pains and discomfort and listen to resident's concerns (R100 nonverbal), documents and report complaints and non-verbal signs of pain and implement relaxation techniques to assist with pain control. A review of the physician orders noted as of 10/15/13, R100 could receive Tylenol 650 mg (milligrams) every four hours if needed or Percocet 5-325 mg one tablet every four hours if needed for pain.	F 309		

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F 309	Continued From page 18 A second interview with FM-A was completed on 10/23/13, at 9:10 a.m. She verified her concerns regarding the management of R100's pain. A review of the medication administration record (MAR) revealed that R100 received Tylenol 650 mg once on 10/15/13, at 4:43 p.m. and then Percocet one tablet at 11:15 p.m. on the same date, which were effective. He did not receive any medication for pain again until 10/18/13, at 10:31 p.m., when he received Percocet. He received Percocet three times on 10/19/13, (12:44 a.m., 1:00 p.m. and 6:00 p.m.) which were effective. On 10/20/13, he received Percocet four times (12:30 a.m., 8:00 a.m., 1:00 p.m., and 10:41 p.m.) which also were effective. He received Percocet twice on 10/21/13 and 10/22/13. Personal cares were given by nursing assistant (NA)-A on 10/23/1,3 at 8:20 a.m. NA-A started with range of motion (ROM) to the lower extremities (legs). R100 did not report any pain during this and NA-A frequently checked with the resident to ensure that ROM was not causing any pain. R100 did complain of pain when NA-A attempted to move his right arm laterally and she stopped. His right hand was clenched and NA-A attempted to do ROM to the hand, which caused the resident pain which he verbalized. R100 was transferred from the bed to a wheelchair by NA-A and NA-B without any complaints of pain. An interview with registered nurse (RN)-C on 10/24/13, at 3:15 p.m. was completed. RN-C reported that R100 does have occasional pain issues. She indicated that staff generally check with him at least once per shift and ask if he was having any pain. She reported R100 generally	F 309		

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ABBOTT NORTHWESTERN COURAGE RESIDENCE	3915 GOLDEN VALLEY ROAD GOLDEN VALLEY, MN 55422

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F 309	Continued From page 19	F 309		

complains of pain on his right side of his body. She also reported the staff should try to ensure R100 is given pain medication prior to his therapy sessions, however the MAR did not reflect scheduling of this.

An interview with RN-D on 10/24/13, at 3:30 p.m. was completed. RN-D verified R100 had issues with pain and the locations were generally his head or the right side of his body (the location of the DVT). She indicated the resident's pain was increased by movement such as when he was transferred from bed. She reported she was aware that R100's family was concerned about his pain and as a result, she had requested R100 be asked every four hour if he had pain. She indicated she told the staff of the family's request but did not know if this request was being complied with. RN-D reported that a pain assessment was to be completed upon admission and then repeated weekly for the first four weeks. She reviewed the electronic medical record and reported the only pain assessment completed had been the one done on admission and the second pain assessment had not been completed and was overdue.

An interview with physical therapist (PT)-A was completed on 10/25/13, at 9:15 a.m. She reported R100 did have right sided arm and leg pain which she understood was related to the DVT, head pain and knee pain related to twisting his knee during a pivot transfer .

An interview with registered nurse care manager (RN)-A was completed on 10/25/13, at 9:40 a.m. He reported he expected nurses to inquire of R100 every time they gave him medication, if he had any pain but acknowledged that could not

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F 309	Continued From page 20 verify that this was being done. He indicated nurses are to complete an admission pain assessment and then this assessment should be done quarterly, unless there were no issues of pain. He verified R100 did have new issues of pain related to the DVT and therefore, a new pain assessment and plan should have been completed but had not been done. A review of the facilities policy Pain Assessment, last revised on 3/19/10 was completed. The policy specified pain should be assessed and documented on admission, with each new complaint of pain and then minimally quarterly. The facility did not identify causative factors related to R55's back pain, failed to assess probable side effects of narcotics, and assess bowel functioning. R55's admission Minimum Data Set (MDS) date 8/16/13 identified diagnoses that included traumatic brain injury (TBI). R55 required extensive assistance with toileting and his cognition was severely impaired. An undated client care sheet indicted R55 had a bowel program. A care plan dated 8/29/13 directed staff to monitor bowel movements. A progress note dated 8/26/13, directed staff to visualize/assess R55's buttocks due to discomfort from sitting during the day and every evening shift. A progress noted dated 8/28/13, indicated R55 had complaints of lower back pain on 8/27/13. A progress noted dated 8/31/13, at 7:50 a.m. indicated that R55's abdomen was distended and bowel sounds (made by the movement of the intestines as they push food through) sluggish. A progress noted dated 8/31/13, at 11:09 a.m. indicated that bowel sounds were absent. An x-ray was ordered. A radiology report dated 8/31/13, indicated	F 309		

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F 309	Continued From page 21 increased fecal material throughout the colon. A progress note dated 9/1/13, indicated to hold narcotics until further notice. The facility's complex alert documentation report dated 8/26/13 through 8/31/13 indicated that R55 did not have a bowel movement for 6 days. A physician order dated 8/27/13, for Norco (narcotic pain medication) 5/325 mg (milligram) orally 2 times a day and as needed was ordered for pain 1-5 out of 10 scale, 1 tablet and 6-10 out of 10 scale for pain 2 tablets. On 8/28/13, a physician order for a one time use of oxycodone was given to R55 and a bowel program was initiated. On 8/29/13, the physician order sheet indicated Norco 5/325 mg orally 4 times a day and as needed for pain was ordered. A medication administration record dated 8/2013 indicated that R55 had 3 doses of Oxycontin 10 mg, 2 doses of Norco 5/325 mg (1 tablet each time), 6 doses of Norco 5/325 mg (2 tablets each time), 2 doses of oxycodone 5 mg, and 1 dose of oxycodone 10 mg from 8/27/13 through 9/1/13. Progress notes dated 8/29/13, indicated R55 was on a daily bowel program that was changed on 8/22/13, to an as needed program and R55 had no pain medication available on 8/22/13 but standing orders for Tylenol. A progress notes dated 8/29/13, at 10:39 a.m. indicated that R55 remains yelling out at times, and the narcotic was ineffective. Later in the day the progress notes indicated that the narcotic pain medication was effective for R55. Progress notes indicated R55 was having leg pain, left knee pain, and lower back pain. Progress notes dated 8/27/13 through 8/30/13, indicated R55 was yelling out in pain. An interview on 10/24/13, at 11:40 with registered nurse (RN)-B indicated that R55 was yelling out in discomfort on 8/27/13, and pain medication was	F 309		

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F 309	Continued From page 22 given to R55 for the pain. R55 continued to have pain and narcotic medication was given as ordered. On 8/31/13, R55's abdomen was distended and R55 felt uncomfortable. R55 had an x-ray and an enema and magnesium citrate (a saline laxative) was given as ordered with no results. R55 received another enema on 9/2/13, had large results. R55's abdomen was softer and bowel sounds were present. RN-B stated that the physician ordered the narcotic to be held on 9/1/13. RN-B indicated that narcotics can cause constipation. RN-B stated that no formal bowel assessment was done for R55 the staff charts in the progress notes. RN-B stated that if there is no documentation then an assessment was not done of R55's bowels. An interview on 10/25/13, at 11:13 a.m. with RN-G revealed that staff responds to residents with the pain and the increase fecal material in the bowel. RN-G stated that a formal bowel assessment would not be done for an acute (sudden onset) problem and that dietary would not be involved for an acute problem. RN-G verified that no pain assessment or bowel assessment had been completed. The facility's pain assessment policy revised date 3/19/10 indicated the purpose of the pain assessment is to assess the client's level of pain, and identify the factors that exacerbate or relieve the client's pain. The policy directs the nurse to use the Initial Pain Assessment Tool any time there is a new or a significant change in the level of pain.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		

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F 314	Continued From page 23 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed provide additional interventions after a resident developed a Stage I pressure ulcer to minimize the risk of developing a Stage II pressure ulcer for 1 of 2 residents (R88) who were reviewed for pressure ulcers. Findings include: R88's admission Minimum Data Set (MDS) completed on 9/6/13 identified R88 had diagnoses that included closed fracture of the cervical spine (C-1 to C-4) with residual quadriplegia (paralysis of the limbs) and quadripartite (weakness of the limbs). The MDS indicated R88 was considered to be cognitively intact. She had no communication barriers and was able to verbalize her concerns. The MDS also indicated R88 was totally dependent on staff to complete all of her activities of daily living and had loss of functional ability of her both sides of her upper and lower extremities. The MDS also indicated she had no pressure ulcer but was at risk for the development of one. It noted that the facility was currently using a pressure reducing devise for the chair and bed and had a repositioning program in place.	F 314	F314 Resident #88's plan of care was reviewed and revised to ensure that up to date interventions were documented for pressure ulcer prevention. Her open skin area was examined by the facility's certified wound care nurse on 11/13/13, 11/20/13 and 11/27/13. The area is improving with current treatment. The client has been given written education material about preventing pressure ulcers to take home on her frequent leaves of absence. There are no other residents with facility acquired pressure areas as of 11/27/13. The policy and procedure for prevention of pressure ulcers was reviewed and revised. Staff is receiving education about pressure ulcer risk assessment. Education will be completed by 12/2/13.	

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F 314	Continued From page 24 The Care Area Assessment (CAA) for pressure ulcer completed on 9/6/13, noted R88 had potential problems due to decreased mobility secondary to tetraparesis (weakness) secondary to SCI (spinal cord injury). The assessment noted R88 was incontinent of bowel and bladder, wore a cervical collar and bilateral wrist/hand splints. It noted R88's skin was intact and she needed assistance with all personal cares. Her skin was to be kept clean and dry. Staff were to complete skin checks and to continue to use a pressure re-distribution mattress and wheelchair cushion. A tissue tolerance assessment was completed on 8/30/13, which indicated redness did not occur after two hours and therefore, a two hour repositioning plan would be implemented. A Braden, used to aid in predicting the risk for the development of pressure sore ulcers was completed on 8/30/13, and identified R88 was at moderate risk for the development of pressure ulcers. The Braden was redone on 9/4/13, and R88 was assessed as being at low risk for pressure ulcer development. A nutritional assessment competed by consultant dietician on 9/10/13, indicated R88 did not require any nutritional interventions as she had a good appetite, was eating 75 to 100% of her meals and had no skin breakdown. No nutritional reassessment was completed after the development of the pressure ulcer. The care plan dated 9/6/13, identified R88 was at risk for pressure ulcer development due to decreased mobility, incontinence of bowel and bladder, wearing a cervical collar and bilateral	F 314	Audits of care plans will be conducted for clients with a high risk Braden score to ensure that appropriate intervene are in place. Results of audits will be reported to the Quality Assurance and Performance Improvement Committee. The Committee will determine further action needed. Correction will be complete by 12/2/13. The Director of Nursing will be responsible for compliance.	12/2/13

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F 314	Continued From page 25 wrist/hand splints. Staff were instructed to assess R88's skin during cares and notify the nurse of any problems or concerns. Staff were also to keep her skin clean and dry and maintain the pressure re-distribution mattress and wheelchair cushion. The nurse's progress notes reflected no problems with her skin until 9/16/13, when a nurse noted a non-blanchable area, measuring 1 centimeter (cm) x 1.5 cm near coccyx. On 9/17/13, R88 voiced concern about the need to get turned every two hours due to concern of her skin but no reddened area was observed. R88 was seen by the facility nurse practitioner on 9/18/13, who had been told of a non-blanchable redness on her coccyx earlier and the resident was currently on an alternating air mattress, pressure redistribution cushion in her wheelchair and was repositioned every two hours during the night. The nurse practitioner documented "Stage I pressure ulcer (Intact skin with non-blanchable redness of a localized area usually over a bony prominence.) coccyx, healed ..." A progress note written on 10/4/13, noted "...noted to have skin shearing to coccyx, cream applied and client informed to make sure when on LOA (leave of absence) that cream is applied." A progress note was written on 10/7/13, "..noted to have open area on coccyx, Areas appear to be shearing of the skin. Cream applied ...." A nurse documented on 10/8/13, that resident had "skin shearing abrasion on coccyx, 1.5 cm long and 4 cm wide toward left side ...."	F 314		

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F 314	Continued From page 26 R88 was seen by a nurse practitioner on 10/8/13, who diagnosed Stage 2 pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough) on the resident coccyx. The area was midline and open lateral to the right at 5 o'clock measuring 2 x 3 cm and smaller wound to the right 0.3 cm x 0.5 cm. The wound bed was 100% granulation tissue and the wound was pink, blanchable and moist. The nurse practitioner ordered specific wound care instructions, recommended continue with repositioning, Hoyer lift, group I pressure redistribution mattress, foam pressure redistribution cushion and education on proper nutrition, hydration and pressure redistribution measures. An interview with registered nurse care manager (RN)-A was completed on 10/21/13, at 2:41 p.m. He reported R88 had developed a Stage II pressure ulcer on her coccyx. He indicated she went home on a pass on 10/5/13, and upon return to the facility, she had a pressure ulcer. He identified that she was not admitted with any pressure ulcers or any open areas. Observation of the affected area on the coccyx was completed on 10/23/13, at 7:25 a.m. A white thick ointment covered the open area. A butterfly shaped deep reddened discoloration around the open areas, measuring approximately 3 inches x 2 inches. A request was made on 10/23/13, at 8:55 a.m. of RN-A to be present during the weekly measurement and assessment of the area. The wound was assessed by RN-A on 10/23/13, at unknown time. The open area measured 1.3 cm x 0.3 cm. No other descriptors were documented.	F 314		

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F 314	Continued From page 27 An interview with nursing assistant (NA)-A was completed on 10/23/13, at 7: 55 a.m., who reported the staff are instructed to reposition the resident every two hours. NA-A indicated that during the day, R88 is so busy and she is on and off her buttock a lot with therapy and then resting in her bed, no special repositioning schedule is needed. During the evening and night, staff attempt to reposition her at least every two hours. R88 was interviewed on 10/23/13, at 8:55 a.m. She reported she was aware she had a "sore on her bottom" and she was unaware of any special repositioning plan. She also reported she left the facility on pass from 10/5/13, and returned on 10/7/13. She did not remember being given any special instructions regarding repositioning or any special care instructions regarding the open area on her coccyx, when she was on leave. An interview with RN-A was completed on 10/23/13, at 11:34 a.m. RN-A indicated R88 was admitted to the facility with no open areas and was assessment on 8/30/13, to be moderate risk for the development of pressure ulcers. She was reassessed on 9/4/13, to be at low risk for pressure ulcer development. He indicated that nursing assistants are to do daily skin checks during cares and there were no problems until 10/4/13, when R88 developed a reddened area on her coccyx, He indicated physical therapy did do pressure mapping of her seated position on 9/6/13, and as result she was given a Roho cushion. He reported that was unsure when R88 was given the pressure distribution mattress. An interview with the director of nurses (DON) was completed on 10/24/13, at 9:00 a.m. She	F 314		

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F 314	Continued From page 28 reported was aware of the open area on the resident coccyx, which was felt to be from shearing initially. She reported this probably occurred during transfers. The facility's policy, Wound Prevention/Treatment Guidelines, last revised on 12/10/12, identified that prevention interventions would be identified in the plan of care based on the resident's individualized comprehensive assessment. Prevention interventions could include education, regular skin assessments/checks, repositioning, wheelchair cushions, bed mattress, keeping heels elevated while in bed, use of positioning devices, keeping skin free of urinary and fecal incontinence, adequate nutrition, adequate hydration, assessing tissue tolerance, keeping skin clean, adding moisture to the skin, checking postural alignment, prevention shearing and friction, pain management, discharge planning, referral to specialist and other interventions individualized to client need, nutritional support, and therapy prevention/interventions.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	F 315 Client #55 was discharged. An assessment of bladder function was completed for other clients who had indwelling urinary catheters removed. Care plan were updated as needed to minimize incontinence.	

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F 315	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess bladder function after the removal of a Foley catheter for 1 of 4 (R55) residents assessed for urinary incontinence. Findings include: R55's admission Minimum Data Set (MDS) date 8/16/13, indicated R55 required extensive assistance with toileting and his cognition was severely impaired. The MDS indicated R55 had an indwelling catheter. A undated client care sheet indicted R55 was occasionally incontinent and used a urinal. The care sheet directed staff to offer R55 the urinal every 2 hours. A progress noted dated 8/22/13, at 6:35 a.m. indicated that R55's Foley catheter was removed and R55 was instructed to use the urinal and call for assistance as needed. A physicians order, dated 8/31/13, directed staff to scan R55's bladder every six hours every shift and straight catheterize for post void residual (PVR) of greater than 400 centimeters(cc) every shift. The progress notes, dated 8/31/13 through 9/25/13, indicated R55 did have PVR but did not require straight catheterization. A progress note dated 8/25/13, at 4:27 a.m. indicated R55 had symptoms of infection, urinary urgency, frequency, odor, and dysuria (painful urination). The resident was diagnosed with an urinary tract infection and treated with Cipro (an antibiotic) 500 milligram (mg) twice a day for 7 days. The resident was treated a second time on 9/11/13 with Macrobid (an antibiotic) 100 mg twice a day for 10 days. On 10/23/13, at 7:23 a.m., nursing assistant (NA)-H was observed giving R55 personal cares. According to NA-H, R55 was incontinent of urine	F 315	Staff is receiving education about urinary bladder assessment and management. Education will be completed by 12/2/13. Audits of bladder assessments and care plans will be conducted for clients who have an indwelling catheter removed to ensure that appropriate interventions are in place. Results of audits will be reported to the Quality Assurance and Performance Improvement Committee. The Committee will determine further action needed. Correction will be complete by 12/2/13. The Director of Nursing will be responsible for compliance.	12/2/13

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F 315	Continued From page 30 as evidenced by urine in his incontinence product. NA-H indicated R55 would let staff know if a urinal was needed at times. An interview on 10/24/13, at 2:14 p.m., with NA-K revealed R55 was offered the use of a urinal or the bathroom every 2 hours. NA-K indicated R55 used an incontinent product as he was incontinent of urine. An interview on 10/24/13, at 3:45 p.m. with registered nurse (RN)-F revealed R55's bladder assessment was done 8/11/13, and no further assessment was completed after the Foley catheter was removed on 8/21/13. An interview on 10/25/13, at 10:15 a.m. with RN-G revealed after a Foley catheter is discontinued, the staff does a bladder scan as ordered by the physician. RN-G indicated if R55's bladder scan revealed there was urine in the bladder, staff were to straight catheterize R55 to remove the urine from R55's bladder. RN-G verified that no re-assessment of R55's bladder was completed. RN-G indicated after having the Foley discontinued for a few days residents should have another bladder assessment. An interview on 10/25/13, at 11:13 a.m. with registered nurse care manager (RN)-A indicated staff do not do a bladder assessment after a resident had a Foley catheter removed. RN-A verified that no bladder assessment was completed after R55 had the Foley catheter was removed and it was an expectation this be done.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		

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	245519	A. BUILDING ______ B. WING ______	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTT NORTHWESTERN COURAGE RESIDENCE	3915 GOLDEN VALLEY ROAD GOLDEN VALLEY, MN 55422

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F 323	Continued From page 31 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate supervision to minimize the risk of falls for 1 of 3 residents (R92) reviewed for accidents and failed to investigate the cause of the fall. Findings include: R92's admission Minimum Data Set (MDS) dated 9/17/13, identified R92 had diagnoses that included abnormality of gait and muscle weakness. R92 fell on on 9/15/13 while he attempted to self transfer in the bathroom. The MDS also indicated R92 required extensive assistance of one staff to physically assist him to the bathroom and to transfer on and off the toilet. The MDS indicated R92 was occasionally incontinent of bowel and bladder. The care area assessment (CAA) dated 9/17/13, indicated "Potential for falls d/t [due to] cerebrovascular accident or stroke (CVA) with (l) hemiparesis with impulsivity. Client is not ambulating with nursing at this time but is working with therapy and able to pivot transfer with A1 [assist of 1] at this time. Has had 2 falls since admission, 9/15 & 9/11/13." It also noted R92 to have impaired balance during transitions. The care plan created 9/30/13, noted R92 as non-ambulatory. The care plan also noted R92 required assistance with toileting and was occasionally incontinent. Interventions included	F 323	F323 The fall risk assessment and care plan for Resident #92 was reviewed and revised as needed to ensure that appropriate interventions are in place to minimize the risk for falling. The Fall Risk assessments for other clients were reviewed and care plans were revised as needed to ensure that appropriate interventions are in place to minimize the risk for falling. The policy and procedure for Fall Prevention was reviewed and revised. A policy and procedure for post-fall assessment was implemented. Post fall assessments are conducted after each resident's fall to ensure that appropriate interventions are added to the plan of care to minimize the risks for falling or injury. Staff is receiving education about fall risk, prevention and post-fall assessment. Education will be completed by 12/2/13.	

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F 323	Continued From page 32 assisting with toileting as needed or requested. The care plan also indicated R92 had the potential for falls and the plan directed staff to assist with toileting and transfers and analyze previous falls. The Client Care Sheet indicated R92 required assist of one staff for transfers, and was continent of bowel and bladder. The Care Sheet also indicated R92 was not safe to be alone in the bathroom. It directed staff to offer toileting assist every two hours when R92 was up. The Care Sheet informed staff R92 was continent of bowel and bladder with urgency and to do hourly checks of resident as he was a fall risk. Nursing progress note dated 9/16/13, at 0041 noted "Per day shift report client sustained a fall in the bathroom this AM [morning] and did strike his head. Per day shift an order was obtained from on-call NP [nurse practitioner] for VS [vital signs] and Neuros [neurological assessment] Q4H [every four hours]. VS and Neruos x2 [twice] this shift, WNL [within normal limits]. Seat alarm placed in w/c [wheelchair]. Per day shift report client had loose stools in the bathroom at the time of the fall..." The Interdisciplinary Rehab Consult progress note dated 9/17/13, made no mention of falls. The Incident report dated 9/15/13, indicated "Writer was told that client had fallen in the bathroom when he was trying to get off the toilet. He slipped and sat down on the floor. While he was lying on the floor, he was rolling around trying to get himself up. It was while he was rolling that he was hitting his head on the wall. He said he didn't hit anything hard, but bumped it a few times when he was rolling. RA [resident aide] came into the room to answer the light and found him. It is	F 323	Audits of fall risk assessments, post fall assessments and care plan interventions will be conducted for clients to ensure that appropriate interventions are in place. Results of audits will be reported to the Quality Assurance and Performance Improvement Committee. The Committee will determine further action needed. Correction will be complete by 12/2/13. The Director of Nursing will be responsible for compliance.	12/2/13

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F 323	Continued From page 33 not known if she got help to get him up or not. " When interviewed on 10/22/13, at 10:52 a.m., R92 indicated he has waited up to 30 minutes to receive assistance from staff, and has been incontinent due to the wait time. He also noted he was incontinent while in bed, with the bowel leaking down his leg and stool got onto the floor in the bathroom, where he slipped and fell. When interviewed on 10/25/13, at 10:52 a.m. director of nursing (DON) reported when a resident falls, it would be noted in the next interdisciplinary progress note from their weekly meeting. She verified that there is no mention of the fall from 9/15/13 in the 9/17/13 interdisciplinary note. She also reported typically the nurse would write a progress note including why the fall happened and what changes would be made in the care plan for safety. She verified this did not occur related to the 9/15/13 fall. She reported it would be her expectation that a progress note be made in a resident's chart after a fall, and it would be discussed in the weekly interdisciplinary team meetings and documented. Facility policy titled Fall Prevention effective date August 2006, revised date March 2010, indicated "Every fall incident will be reviewed by the multidisciplinary rehabilitation team to review current interventions and revise as needed."	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional	F 325		

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F 325	Continued From page 34 status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R88) with a significant weight loss and the development of a pressure ulcer was provided reassessment of nutritional needs. Findings include: R88' admission Minimum Data Set (MDS) completed on 9/6/13, identified R88 was admitted to the facility on 8/30/13, for rehabilitation related to a closed fracture of the cervical spine (C-1 to C-4) with residual quadriplegia (paralysis of the limbs) and quadriparesis (weakness of the limbs). R88's admit weight was on 8/30/13, was 158 and the next weight taken on 10/19/13, was 124, a weight loss of 34 pounds. The MDS also indicated R88 was considered to be cognitively intact. She had no communication barriers and was able to verbalize her concerns. The MDS also indicated R88 was totally dependent on staff to complete all of her activities of daily living and had loss of functional ability of her both sides of her upper and lower extremities. The MDS also indicated she had no pressure ulcer but was at risk for the development of this. It noted that the facility was currently using a	F 325	F325 Resident #88's nutrition assessment was reviewed and revised to reflect her current weight and risks for weight loss. Her plan of care was updated to ensure that interventions are in place to halt her weight loss. She was counseled by the registered dietician about nutrition, weight loss and skin breakdown on 11/21/13. A revised weight procedure for nursing staff was implemented on 11/15/13. The dietician will check weights twice per week for high risk clients and update their care plans as needed. The Nutrition management policy and procedure was reviewed and revised as needed. Staff is receiving education about weights and reporting weight loss. Education will be completed by 12/2/13. Audits of nutrition assessments and care plans for clients at high nutritional risk will be conducted to	

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F 325	Continued From page 35 pressure reducing devise for the chair and bed and had a repositioning program in place. The admission MDS indicated R88 had no swallowing difficulty or any issues with weight loss or weight gain. A nutritional assessment competed by consultant dietician on 9/10/13, indicated R88 did not require any nutritional interventions as she had a good appetite, was eating 75 to 100% of her meals and had no noted skin breakdown. R88 developed a Stage II pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough.) on 10/7/13, and there was no nutritional re-assessment found in the medical record. The nutritional Care Area Assessment (CAA) completed on 9/12/13, indicated R88 was eating well with assistance, generally eating 75 to 100% of meals serviced and was not receiving any supplements. No nutritional diagnosis was noted and currently required no interventions. The registered dietician was to monitor oral intakes, weight trends and laboratory results when available. The care plan developed on 9/6/13, noted R88 had adequate weight for her height and needed good nutritional and hydration. The goal was for the resident to maintain her weight. Staff were directed to monitor her food and fluid intake and weigh her monthly. An interview with R88 was completed on 10/22/13, at 8:55 a.m. She reported she had lost about 13 pounds while she was previously hospitalized and felt that she had lost a "couple pounds" since she has been at the facility. She	F 325	ensure that appropriate interventions are in place. Results of audits will be reported to the Quality Assurance and Performance Improvement Committee. The Committee will determine further action needed. Correction will be complete by 12/2/13. The Registered Dietician will be responsible for compliance.	12/21/13

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F 325	Continued From page 36 indicated that she is trying to regain some weight and reported she had been taking a nutritional supplement (Ensure) as she knew she needed to ensure adequate nutrition as she "had a sore on her bottom". She indicated that a nutritional supplement was ordered for her in the recent past but it was discontinued as she was not using it. She reported the staff would give it (nutritional supplement) to her at meal time and she just could not eat her meal and drink the supplement at the same time. She indicated she was weighed at the facility once a month. An interview with registered nurse case manager (RN)-A was competed on 10/23/13, at 9:14 a.m. He reported was not aware that R88 had lost any weight until this morning, when the consultant dietician had emailed him a request for a re-weight as the resident had lost 20 pounds. He reported the resident was not on any dietary supplements and the nursing assistants are reporting the resident is generally eating well. He indicated the resident is generally eating 50% of food served and at times, 75% to 100% of the meals served. He indicated when R88 was weighed on 10/19/13, the nursing assistant should have noticed the weight loss and should have told the nurse about it, who would have informed him. He reported this had not happened. An interview with consultant dietician on 10/23/13, at 9:30 a.m. She reported that she was not notified of R88's significant weight loss by nursing staff. She noted the weight loss on 10/22/13, when she audited the resident's weights. She questioned if the resident's admission weight was accurate, but also reported that she should have been informed of the resident's weight loss. She	F 325		

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F 325	Continued From page 37 also reported that she was unaware that R88 had developed a Stage II pressure ulcer and should have been informed.	F 325		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure sufficient nursing staff was available to provide services in accordance with each resident's needs for 9 of 11 residents (R65, R88, R100, R96, R92, R95, R105, R60, and R89) reviewed in the sample for sufficient staffing. This had the potential to affect all residents residing in	F 353	F353 The nursing staffing pattern for the facility was reviewed. A root cause analysis of staff response to call lights was conducted and nursing assistant work flow was noted to be disorganized. Nursing assistant care sheets were reviewed and revised to reflect clients' preferences for getting up in the morning and bed times. Nursing assistant assignments were reviewed and revised to reflect assignment of clients with roughly equal care needs to each nursing assistant. Nursing assistant work flow patterns were reviewed and assignments for break times and dining room assistance were revised to make more staff available to assist client after meals. Nursing staff have been coached to anticipate clients' needs. An additional nursing assistant position has been added to the night shift. A proposal for increased staff has been made to administration.	

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F 353	Continued From page 38 the facility. Findings include: R65 reported on 10/22/13, at 9:07 a.m. he did not feel that during the night there are not enough staff. He indicated at times had to wait a long time for staff assistance He reported an incident that occurred during the night when he had been incontinent and had to wait 2 ½ hours to 3 hours for help. He described lying in his urine and being unable to reach the call light and no staff had checked on him. He reported his call light had fallen on the floor and he was unable to reach it. He indicated he got really frustrated and finally started to call out for help. He indicated he felt very vulnerable when this happened and "very alone." He reported he had talked to a couple of nursing assistants about this incident but had not talked to any administrative staff. He reported other episodes of urinary incontinent that had occurred as the staff did not respond to him quickly enough. R65's admission Minimum Data Set (MDS), completed on 9/18/13, indicated R65 was totally dependent on two staff for all transfers and needed extensive assistance of two staff with bed mobility. He needed extensive assistance of one staff with dressing, toileting and personal hygiene. The MDS indicated R65 was cognitively intact. A second interview with R65 was completed on 10/23/13, who verified what he had reported on 10/22/13. R88 reported on 10/21/13 at 6:55 p.m. she felt the facility was very short staffed. She reported	F 353	Clients are being interviewed to identify potential issues with staff responsiveness that may not have been brought to the attention of the administrator or Director of Nursing. Issues will be addressed at the time they are identified. A Client Advisory meeting was held on 11/18/13. There were no concerns about staff responsiveness expressed by clients. Health Unit Coordinators have been educated to seek information about when staff will be available to assist a client who has called for assistance and to communicate that information to the client via intercom. Client interviews about staff responsiveness will be conducted weekly for four weeks with the results reported to the Quality Assurance and Performance Improvement Committee. The Committee will determine further action needed. Correction will be complete by 12/2/13.	

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F 353	Continued From page 39 the facility used agency staff and "they don't know how to care for me and so I have to tell them. She indicated "this morning the agency staff did not wake me in time to get me ready for therapy and get my breakfast. I missed my therapy session and also did not get my shower that I was scheduled to have." She also reported "agency staff will ask me how to do my range of motion and I don't feel real confident in their ability." She indicated at times, she will have to wait for over a half an hour for someone to answer her call light and reported that was upset about the long call light waits. R88's admission MDS, completed on 9/16/13 indicated R88 was totally dependent with bed mobility, transfers, locomotion on/off the unit, dressing, eating, toilet use and personal hygiene. She was cognitively intact. A second interview with R88 was completed on 10/24/13, at 12:30 p.m. She verified the information she had provided on 10/21/13 was accurate. She also reported that on 10/22/13, she was gotten up late again by nursing staff as they were busy with other residents and did not get to her on time, She indicated that she almost missed her therapy again but was sent without breakfast. She indicated a therapy staff person made and fed her some toast in the therapy room. R100's family member (FM)-A reported on 10/21/13, at 2:41 p.m., that she did not feel there were enough nursing assistant to care for her husband. She reported that when he was admitted to the facility, they sat in his room for three hours until the staff had time to meet with him. She reported that it takes a long time for	F 353	Correction will be complete by 12/2/13. The Director of Nursing will be responsible for compliance	12/2/13

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F 353	Continued From page 40 staff to respond to his call light. She reported they generally respond via the intercom and ask her husband what he wants. She reported being frustrated about this as her husband is unable to respond due to his stroke. The nurse assistants will respond in person, generally within 15 to 30 minutes and by this time, her husband had "wet himself", which she reported was "embarrassing to him." She reported that she was afraid to leave him at time, as "no one checks on him." She went on to report that she felt that the therapy department was excellent but did not feel there were enough nursing staff to give her husband the care she felt he needed. She indicated that she had talked to the care manager about her concerns and hoped it got better. R100's admission nursing assessment completed on 10/15/13, noted resident was nonverbal but did have the ability to express ideas and wants. R100 was totally dependent with activities of daily living, including transfers, locomotion, dressing and toilet use. A second interview with FM-A was completed on 10/22/13, at 9:05 a.m. FM-A stated, "it happened again." She went on to explain the nursing assistants got her husband up late as they were busy with other residents. As result, they are really pushing him to eat fast as "therapy is waiting for him and he might miss therapy if he does not get there in time." She went on to report her husband had a swallowing problem and "should not be rushed when he is eating." She reported being very angry regarding the rushed care of her husband (R100). R96's MDS, dated 10/1/13, noted R96 required	F 353		

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F 353	Continued From page 41 extensive assist (resident involved in activity, and staff provide weight-bearing support) of two staff for transfers, and extensive assist of one staff for toileting. It also noted R96 to be occasionally incontinent of bladder, and always continent of bowel. R96 was considered to be cognitively intact. When interviewed on 10/22/13, at 9:13 a.m. R96 reported he felt the facility was short staffed "around the clock" and often waited 30-45 minutes for staff to come to his room to assist him; and at times had "given up" and stopped asking for help. He reported he has been incontinent due to waiting a long time for help, which makes him feel "very embarrassed." When re-interviewed on 10/24/13, at 10:43 a.m. R96 verified the initial interview statements, and reported he had talked with multiple staff about this and feels at times registered nurse clinical manager (RN)-A gets tired of seeing him. R92's admission MDS, dated 9/17/13, indicated R92 required extensive assistance of staff with bed mobility, transfers, locomotion on and off the unit, dressing, toileting and personal hygiene. R92 was considered to be cognitively intact. When interviewed on 10/22/13, at 10:52 a.m. R92 reported he felt staff was short, mostly first thing in the morning. He sometimes had to put on his call light three times to get help, and he had waited up to 30 minutes for help. R92 also reported he had been incontinent due to the wait time, and on one occasion while in bed, he became incontinent of stool that "leaked" down his leg and got onto the floor in the bathroom. He	F 353		

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F 353	Continued From page 42 reported he slipped in the bathroom and fell in the fecal matter. See F323. When re-interviewed on 10/24/13, at 10:38 a.m. R92 verified his statements from the initial interview. He indicated it made him feel bad when he was incontinent and reported some of the incontinence was due to the wait time for help from staff. He reported he talked with someone about having to wait so long for assistance, but unable to state who or when. R95's admission MDS, dated 9/27/13, indicated R95 required extensive assist of one staff for transfers and toileting. R95 was considered to be cognitively intact. He had no communication barriers. When interviewed 10/22/13, at 11:43 a.m. R95 reported incontinence due to the wait, and "this didn't feel good, but what do you do." He did not feel there was sufficient staff available. He reported the overnights and weekends seem the worst. R95 reported he had waited an hour for help when putting on the call light and had been When re-interviewed 10/24/13, at 10:52 a.m. R95 verified his statements from the interview on 10/22/13, at 11:43 a.m. R105's admission MDS dated 10/23/13, noted R105 required extensive assistance of one staff to physically assist in toilet use. This included using the bathroom and to transfer on and off the toilet. R105 also required extensive assist of one staff with transfers. She was considered to be	F 353		

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F 353	Continued From page 43 cognitively intact. When interviewed on 10/22/13, at 10:21 a.m. R105 reported staff were not efficient. She indicated it took 20-25 minutes to get assistance after putting her call light on. When re-interviewed on 10/24/13, at 8:44 a.m. R105 verified her statements from the interview on 10/22/13, at 10:21 a.m., and reported she feels there is not enough staff. R105 reported she had been incontinent due to the long response time, and this made her feel "terrible." She reported "staff say they will return in 'a little bit ' and then don't return, so she has to put her call light on again." R105 reported she felt she was inconveniencing staff when she uses the call light. R105 also reported she has talked with a nurse about her concerns. R60's quarterly MDS dated 9/24/13, noted R60 required extensive assist of two staff with bed mobility, and extensive assist of one staff with transfers and toileting. R60 is noted to be occasionally incontinent of urine, and frequently incontinent of bowel. She was considered to be cognitively intact. When interviewed on 10/21/13, at 6:48 p.m. R60 reported at times night staff are so short they aren't very timely, and she had waited 30-45 minutes for staff. R60 reported she required catheterization every four hours. She reported she woke 10/20/13, and had been incontinent of urine. She also reported when staff answered her call light, she informed them of this, and it still took 30-45 minutes before they provided assistance to change her. She noted she has	F 353		

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F 353	Continued From page 44 talked with the director of nursing (DON) about her concerns with staffing, and the use of agency nurses, but did not talk with anyone about the incident that occurred the night before relating to her incontinence. When re-interviewed on 10/25/13, at 11:40 a.m. R60 verified her previous interview statements, and stated she since had spoken with the DON about the incident relating to her incontinence, and the DON informed her the staff would need either more training or a refresher. R60 indicated it is very random she has the same agency nursing assistant (NA) more than once, and it is more difficult to direct her care with agency staff since they are not familiar with her situation and cares. R60 stated she had became exhausted with working with agency staff, and sometimes with the facility staff also. R89 reported on 10/21/13, at 7:50 p.m. he did not feel there were enough nursing staff. He indicated "when I need to use the bathroom, I can't wait very long " . He then proceeded to report very loudly "when I have to go to the bathroom, I have to go RIGHT now" He reported he had frequently been incontinent and feels really bad about this. R89 needed extensive assistance of one staff for transferring and was not steady moving from seated to standing according to the admission MDS completed on 9/11/13. He needed limited assistance of one staff with locomotion, dressing, toilet use, and personal hygiene. He used a wheelchair for locomotion. He was considered to be cognitively intact.	F 353		

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F 353	Continued From page 45 A second interview was completed with R89 on 10/23/13, at 10:30 am and he verified he did not feel the facility had enough nursing staff to provide him timely assistance with his toileting and he had incidents of urinary incontinence, which he felt bad about. A review of R89 's record, noted a report from his physician from a visit of 9/23/13, when the resident complained to the physician of nursing staff. He reported he needed to call the nursing assistants three or four times in five minutes for them to come to him with his urinal. Staff When interviewed on 10/24/13, at 7:18 a.m. licensed practical nurse (LPN)-A reported it would be nice to have two nursing assistants on each floor during the night shift. Stated the census fluctuates. She skipped her breaks to answer the call lights and explained to residents when they have their call light on that staff will be with them after approximately ten minutes. When interviewed on 10/24/13, at 8:03 a.m. health unit coordinator (HUC)-C reported there was not always enough staff to provide assistance in a reasonable amount of time. She also reported residents had voiced concern about how busy the nursing assistants are. She verbalized the level of care has gotten a bit higher while the staffing number has remained the same. When interviewed on 10/23/13, at 12:53 p.m. registered nurse (RN)-B reported she did not feel there were sufficient staff, and a lot of the heavy	F 353		

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F 353	Continued From page 46 care residents are put on the first floor. She also reported there have been a lot of complaints from residents being late for therapy or appointments due to insufficient staffing. She also reported the nursing assistants are unable to complete tasks for residents at times. She had been told by management more staff was not needed. She indicated recently due to so many staff resignations, the facility had been using agency staff, who are not familiar with the residents. RN-B reported she had brought up her concerns to registered nurse clinical manager (RN)-A and the director of nursing (DON) and told them of the resident's concerns. When interviewed on 10/24/13, at 9:33 a.m. NA-C indicated he did not feel there was enough staff with 20 residents on the floor. Stated he feels the resident needs were not being met, and felt frustrated about this. NA-C indicated the residents have a high level of care and feels he was not able to do all that should be done for the residents. Stated he spoke to the DON about this, who stated there was nothing she could do as her hands were tied. When interviewed on 10/24/13, at 9:51 a.m. RN-C indicated it feels like they need extra help. She indicated residents have expressed concerns with the staffing numbers, which she relayed to the DON. She reported that after her discussion with the DON, no mention has been made of adding any additional staff. When interviewed on 10/24/13, at 9:51 a.m. LPN-B indicated she felt there was not enough staff, stating it was short with both nurses and nursing assistants. She verified the facility used agency nursing assistants, and the agency staff is	F 353		

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F 353	Continued From page 47 not familiar with the clients, which "makes it tough." She stated when there is an admission, the RN will be pulled from the floor, and the LPN will be left to pass medications and provide treatments for the entire floor of residents. She indicated she spoke to the DON about her concerns but did not feel administration was receptive to adding additional staff. She indicated residents express concerns "all the time" about not having enough staff. She also stated she will help the nursing assistants with transfers when she had time. When interviewed on 10/24/13, at 10:23 a.m. NA-B indicated she felt the facility could do much better with staffing, and she did discuss this with management, but unsure who she spoke to. She indicated there are agency staffs at the facility, but felt they don't come back due to the heavy work load, so there is no consistency. She indicated she has asked for help in the morning with getting residents up for the day and ready for their therapies and appointments. She also indicated that residents do express concerns when they are late. When interviewed on 10/24/13, at 4:19 p.m. NA-E noted he felt there was not enough staff and residents do voice this concern to him. He indicated the nursing assistants have been asking for one more staff in their staff meetings which is held with managerial staff. He also indicated the facility used agency staff, but felt they do not provide consistent care as the staff sent do not know the resident well and there is no consistency in sending the same staff. When interviewed on 10/24/13, at 2:45 p.m. DON indicated the staffing patterns are determined	F 353		

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F 353	Continued From page 48 based on census and the acuity, and she looks at case mix index as one measure which tells her the activities of daily living (ADL) levels. She looks at nursing needs. She verified that she is aware people feel sometimes there is not enough staff, but she feels it is not the number of staff but how they are deployed. She also indicated they staff the same numbers per shift, 7 days per week. She indicated that if there is a sick call, they either call in additional staff or use agency staff when needed. She stated there have been concerns expressed by staff and residents about the number of staff. She also indicated there has been a change in the primary conditions of the clients, with more residents now have suffered strokes, and staff on first floor are struggling with how to organize their work to adapt to these changes. No policy was in place related to staffing patterns or scheduling.	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.	F 356	F356 Nursing staff hours posting forms were revised to reflect the shift hours. Nursing staff hours posting forms will be posted daily and reviewed and revised at the beginning of each shift to accurately reflect the staff hours for the coming shift.	

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F 356	Continued From page 49 The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review, the facility failed to post the total hours worked for nursing staff directly responsible for resident care per shift, which has a potential to affect all 39 residents who resided in the facility. Findings include: During the initial tour observation on 10/21/13, at 12:50 p.m. the facility's nurse staffing information was noted to be posted on the bulletin board at the nursing station desk. The posting lacked identification of day, evening, and night shift times. An interview on 10/23/13, 8:45 a.m. with unit coordinator (HUC)-B revealed nursing operation assistant fill out the report of nursing staff directly responsible for resident care. HUC-B indicated she puts the report of nursing staff directly responsible for resident care in the sleeve and puts it on the bulletin board. HUC-B stated she	F 356	F356 Nursing staff hours posting forms were revised to reflect the shift hours. Nursing staff hours posting forms will be posted daily and reviewed and revised at the beginning of each shift to accurately reflect the staff hours for the coming shift. The process was reviewed with the staffing coordinator and nursing staff are being educated about their responsibility to review and revise the posting. Education will be completed by 12/2/13. The posting will be reviewed several days per week for four weeks and the information will be forwarded to the Quality Assurance and Performance Improvement Committee which will determine further action. Correction will be completed by 12/2/13. The Director of Nursing will be responsible for compliance.	12/2/13

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F 356	Continued From page 50 was responsible for changing the report date sheets or the night shift. The report of nursing staff directly responsible for resident care posted on the bulletin board was dated 10/22/13. An interview on 10/23/13, at 1:32 p.m. with nursing operations assistant revealed she was told how to fill the report of nursing staff directly responsible for resident care by the director of nursing (DON). The nursing operations assistant stated the report of nursing staff directly responsible for resident care were filled out on 10/16/13, for the week. An interview on 10/25/13, at 10:37 a.m. with DON revealed that she did instruct the nursing operations assistant how to fill out the report of nursing staff directly responsible for resident care with total number of hours worked by each discipline of nursing, not the actual shift of hours.	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to prepare and distribute food under sanitary conditions and did not utilize gloves when ready to eat foods were touched	F 371	F371 Cook A received education on proper food handling immediately following the surveyor's observations. Longer tongs were ordered for the salad bar. There is an audit system in place for the salad bar. Bread products are individually wrapped and served with tongs. The measuring tool for beverage thickener is stored in a covered container, separate from the thickening agent.	

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F 371	Continued From page 51 with bare hands. This had the potential to affect 37 of 39 residents who received and were served food items. During an observation of the evening meal on 10/21/13, at 5:05 p.m., residents lined up, cafeteria style, to receive their food. As residents went through the line, they had the opportunity to help themselves or have assistance from staff, to salad bar items in plastic containers with tongs. Then, the resident would inform cook-A of their entree choice. This meal consisted of ribs, baked or mashed potatoes and a vegetable. Cook-A would dish up each resident's plate and hand it to them or to the person assisting the resident. The resident would move to the next area on the line, that offered rolls in a large plastic bowl, with tongs to pick the roll out of the bowl. The next area on the line was the beverage area. Residents would obtain their beverage of choice, and then went to a table in the dining room to eat. On 10/21/13, at 5:10 p.m. cook-A was observed to be serve food with bare hands. Cook-A put a scoop of mashed potatoes on a plate. She used a knife to get butter out of a container, and with her bare fingers, pushed the butter down into the potatoes. Cook-A handed the plate to the resident. The next resident asked for a baked potato. Cook-A picked up a baked potato with her bare hands, used the knife from the container of butter to cut the potato, scooped out some butter with the same knife, put the butter into the cut potato, and then pushed the butter into the potato with her bare fingers. While waiting for the next resident, Cook-A pushed her glasses up with her bare hand, and then picked up a baked potato with the same hand, cut the potato, used her bare fingers to wipe the blade of the knife before	F 371	Nutrition staff received education about proper food handling, hand hygiene and glove use on 11/11/13. Nursing staff are receiving education about proper food handling, hand hygiene and glove use. Education will be completed by 12/2/13 Observational audits of food handling, hand hygiene and glove use are being conducted several times per week for four weeks in the cafeteria and client café areas. Audit results will be reported to the Quality Assurance and Performance Improvement Committee. The Committee will determine further action needed. Correction will be complete by 12/2/13. The Director of Nutrition is responsible for compliance	12/2/13

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F 371	Continued From page 52	F 371		

sticking the same knife into the container of butter. She obtained butter onto the knife and, using her bare fingers, pushed the butter into the potato. The next resident asked to have his meat cut up. Using the tongs from the ribs and her bare fingers, Cook-A pulled the meat from the bones on the plate. Cook-A was also noted to readjust her glasses on two more occasions during the meal. At 5:38 p.m., the tongs that Cook-A was using to put ribs onto the plates, fell into the pan of ribs. She removed the tongs, went to the sink and rinsed them off, and then returned the tongs to the pan containing the ribs. Also during the evening meal, several residents, staff, and visitors were noted to use tongs to obtain lettuce and other items from the salad bar. The handle of the tongs fell into the plastic bin containing the lettuce several times, lying on top of the lettuce. Several residents, staff, and visitors were also noted to use tongs to obtain a roll from the large plastic bowl on the service line. The tongs were then placed on top of the rolls remaining in the bowl, with the handle touching the rolls.

On 10/21/13, at 5:09 p.m., cook-A was observed to put a thickening agent in a beverage for a resident and used bare hands. The evening cook took the scoop that was in the container of thickening agent out of the container, placed the scoop of thickening agent in the beverage and put the scoop back into the container. Cook-A gave the resident the thickened beverage. Cook-A continued to serve the food with bare hands.
An interview on 10/21/13, at 5:56 p.m., with cook-A revealed stored the scoop for the thickening agent in the can.

During an interview on 10/21/13, at 5:55 p.m.

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F 371	Continued From page 53 when asked about glove use when serving food, cook-A stated, "I don't wear them because my hands sweat." When asked if it is okay to touch food with bare hands, cook-A stated,"The policy says if I wash them between every person, it's okay." Cook-A verified that she did not wash her hands between every person and stated, "I only touched the potatoes." During an interview on 10/23/13, at 11:25 a.m., when asked if touching food with bare hands is allowed, certified dietary manger (CDM)-A stated, "No. We have a policy that addresses that. It's not allowed." When asked about the handles of the tongs falling into the containers of food on the service line after being touched by several people, CDM-A verified that this practice has the potential to cause contamination and discussed finding other ways to serve certain items. When asked about the scoop being kept in the container of Thick-It, CDM-A stated, "It should not be left in the container." A review of the facility's policy titled, Nutrition Services...Hand Washing & Glove Use, dated 11/01/11, included, single-use gloves are to be used to create a barrier between food handler's hands and food. All food handlers should use single-use gloves whenever coming in contact with food, no bare hands should come in contact with food. Also noted, gloves are to be worn in all appropriate tasks; during food preparation, meal service, storage and in any other contact with food items. Hand hygiene An observation of nursing assistant (NA)-M preparing toast for R100 without hand hygiene or wearing gloves/or barrier was made on 10/24/13, at 8:45 a.m. NA-M put the bread into the toaster	F 371		

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F 371	Continued From page 54 with her bare hands, pushed the button down and touched the counter. When the bread was browned, she took the toast, along with cut up eggs, slices of cheese and cut up ham put them on the toast and made a sandwich with her bare hands. An observation was made on 10/24/13, at 9:02 a.m. of NA-C who prepared toast for an unidentified resident. NA-C placed the bread into the toaster, pushed the toaster button down and while it toasted, placed his hands on the counter. He removed the toast from the toaster, placed the toast directly on the counter and applied butter. He then gave the toast to the unidentified resident. An interview with the director of nurses was completed on 10/24/13 at 2:00 p.m. She reported that she would expect the nursing assistants to wash their hands or wear gloves prior to preparing food for the residents.	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	F441 The nurse was re-educated about proper sanitizing of bandage scissors immediately after the Director of Nursing was notified by the surveyor. A log of employee illnesses/infections, including illness type, and/or signs and symptoms of illness has been started and will be regularly compared with client illnesses/infections.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING ______ B. WING ______	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTT NORTHWESTERN COURAGE RESIDENCE	3915 GOLDEN VALLEY ROAD GOLDEN VALLEY, MN 55422

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F 441	Continued From page 55 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure the infection control program included surveillance, investigation, and analysis of staff diseases/infections in order to prevent, recognize and control, to the extent possible, the onset and spread of infection within the facility. This practice had the potential to affect all 39 residents who resided in the facility. In addition the facility failed to ensure equipment used for 1 of 1 observed residents (R88) during a dressing change was cleaned appropriately between uses. Findings include: Review of the facility infection control surveillance	F 441	The infection control policy and procedure for surveillance was reviewed and revised as needed. The equipment cleaning policy and procedure was reviewed and revised as needed. Staff that has contact with clients is being educated about absence/illness reporting and equipment cleaning. Education will be completed by 12/2/13. Observational audits of equipment cleaning are being conducted weekly for four weeks. The results will be reported to the Quality Assurance and Performance Committee. . The Committee will determine further action needed. Data about staff illnesses will be reported to the Quality Assurance and Performance Improvement Committee, along with client illness data. The Committee will determine further action needed. Corrections will be complete by 12/2/13. The Director of Nursing is responsible for compliance.	12/2/13

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	245519	A. BUILDING ______ B. WING ______	10/25/2013

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F 441	Continued From page 56 logs revealed the lack of a comprehensive employee illness/disease tracking and trending system. The facility kept track of employee illness/absences however, illness type, signs and symptoms were lacking. Furthermore, the facility lacked trending of employee illnesses and nor comparison to current infection within the resident population. An interview on 10/25/13, at 9:10 a.m. with the director of nursing (DON), who was identified as the infection control coordinator, revealed that employee illness was not tracked at the facility. The facility did not ensure that medical equipment was cleaned between use. During the application of a Tagaderm barrier to the coccyx of R88 on 10/23/13, at 7:33 a.m., registered nurse (RN)-B was observed to take a bandage scissor out of the pocket of her uniform, slice the patch to shape the patch over the buttock. After she cut the patch, she replaced the scissor into her uniform pocket without cleaning the scissor. RN-B was interviewed on 10/23/13, at 8:25 a.m. and verified the observation. RN-B reported she wiped the bandage scissor with an alcohol swab before she used it on another resident and that she should have not put it back into her uniform pocket before she cleaned the scissor. An interview with the director of nurses (DON) was completed on 10/23/13. DON reported the expectation for the bandage scissors, should have been cleansed with a germicidal wipe and indicated super sani-wipes are available for staff to clean their instruments.	F 441		

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F5519022

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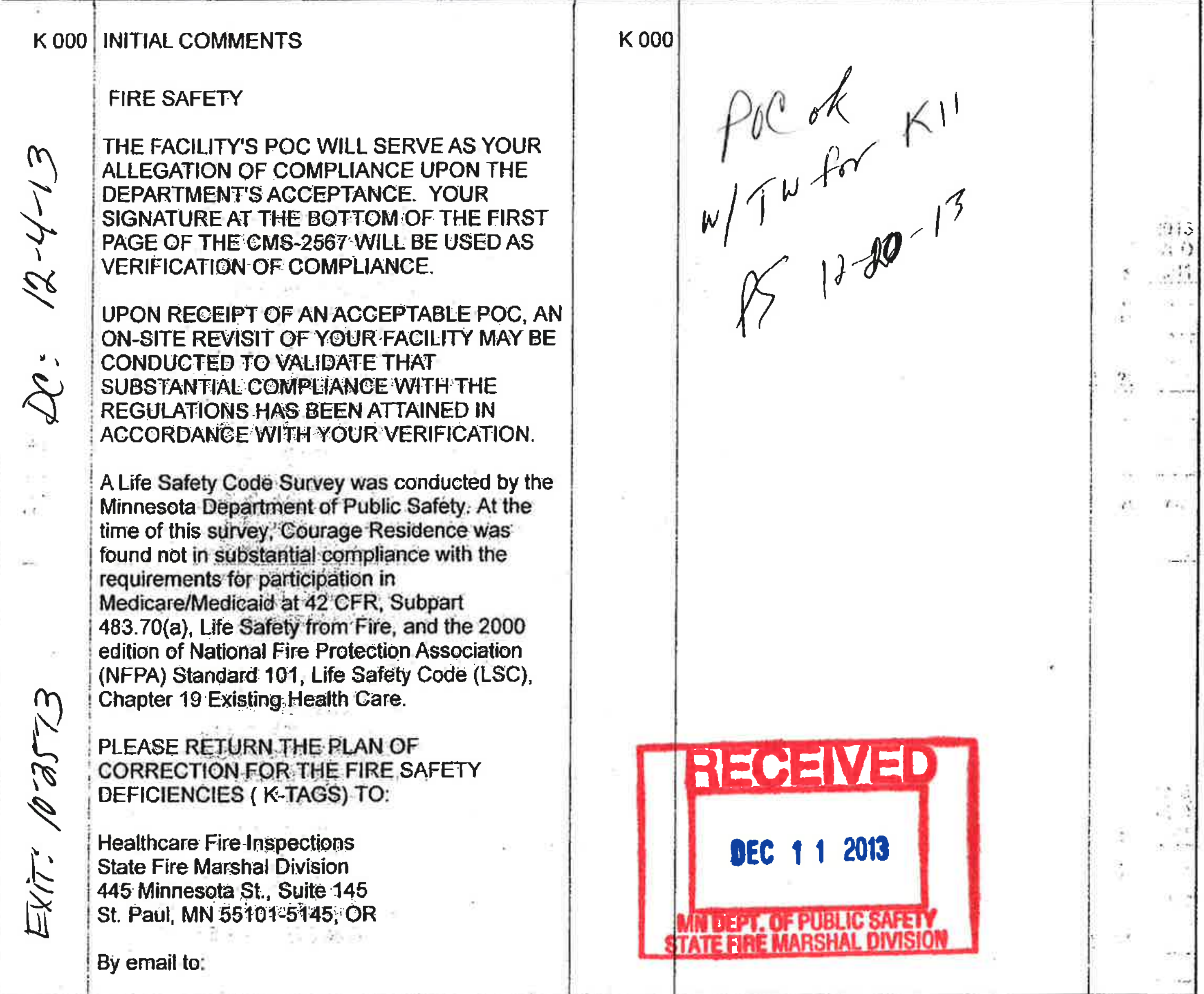
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245519	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Courage Residence was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	POC ok w/ TW for K11 PS 12-20-13 RECEIVED DEC 11 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Exit: 10/23/13 DC: 12-4-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stan Powers	Facilities Supervisor	11/26/13

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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	245519	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	10/23/2013

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K 000	Continued From page 1 Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 3-story building was determined to be of Type II(111) construction. It has no basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 40 beds and had a census of 39 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2	K 011		

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TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245519	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 10/23/2013
NAME OF PROVIDER OR SUPPLIER: ABBOTT NORTHWESTERN COURAGE RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE: 3915 GOLDEN VALLEY ROAD GOLDEN VALLEY, MN 55422	

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K 011	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to separate the non-comforming occupancies in accordance with LCS (2000) Section 19.1.1.4.1. This deficient practice could affect all residents. Findings include: During facility tour between 11:00 Am and 1:00 PM on 10/23/2013, observation revealed that the occupancy separation wall between the garden level PT/OT and dining room is of 1-hour construction and not the required 2-hour fire rated construction. This deficient practice was verified by the Facilities Manager at the time of the inspection.	K 011	TW **K011: Occupancy Separation Wall:** • *BWBR Architectural Firm to develop a construction document with the following information.* • *2 hour gypsum wall assembly to meet occupancy separation code requirements.* • *Abbott Northwestern Courage Kenny Rehabilitation Institute to hire a contractor to perform work stated on construction documents.* • **To Be Completed January 31, 2014**	
K 017 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5	K 017		

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K 017	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has not maintained the corridors in accordance with NFPA 101 (2000 edition), Chapter 19, Section 19.3.6.1. This could affect the residents. Findings include: On facility tour between 11:00 AM and 1:00 PM on 10/23/2013, observation revealed that there are penetrations into the corridors above the ceiling that are not properly firestopped. This deficienct practice was verified by the Facilities Manager at the time of the inspection.	K 017	**K017: Fire Stop Caulking:** • *Abbott Northwestern Courage Kenny Rehabilitation Institute will use Hilti Fire Stop Systems to correct all penetration issues.* • **To be completed** ~~December 31, 2013~~ 12-20-13 per t/c w/ facility	
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	**K018: Door Sequencers:** • *Door sequencers in 2 locations replaced.* • **Completed November 1, 2013**	

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K 018	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility had corridor doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. This deficient practice could affect the residents. Findings include: During facility tour between 11:00 AM and 1:00 PM on 10/23/2013, observation revealed that 2 of the 4 wheelchair storage room double door sequencers failed to properly separate. This deficient practice was verified by the Facilities Manager at the time of the inspection.	K 018		