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: T2F1
Facility ID: 00803

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245235**
2. STATE VENDOR OR MEDICAID NO. (L2) **662675000**

3. NAME AND ADDRESS OF FACILITY
(L3) **WOODBURY HEALTH CARE CENTER**
(L4) **7012 LAKE ROAD**
(L5) **WOODBURY, MN** (L6) **55125**

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) **05/01/2007**
6. DATE OF SURVEY **03/23/2016** (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) **09/30**

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

12. Total Facility Beds **175** (L18)
13. Total Certified Beds **175** (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
	175			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Cynthia Wentkiewicz, HFE NE II 03/23/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 04/15/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **06/01/1981** (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
Posted 05/11/2016 Co.

31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE **03/10/2016** (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245235
April 15, 2016

Mr. Michael Karel, Administrator
Woodbury Health Care Center
7012 Lake Road
Woodbury, Minnesota 55125

Dear Mr. Karel:

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

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

Effective April 13, 2016 the above facility is certified for or recommended for:

165 Skilled Nursing Facility/Nursing Facility Beds

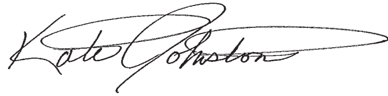
Your facility's Medicare approved area consists of all 165 skilled nursing facility beds.

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
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 5, 2016

Mr Michael Karel, Administrator
Woodbury Health Care Center
7012 Lake Road
Woodbury, Minnesota 55125

RE: Project Number S5235027

Dear Mr. Karel:

On February 16, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 4, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 23, 2016, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 4, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies. Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on February 4, 2016.

However, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the February 4, 2016 standard survey has not yet been verified. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective May 4, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective May 4, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 4, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Woodbury Health Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 4, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.

Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 4, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

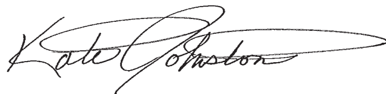
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992   Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 15, 2016

Mr. Michael Karel, Administrator
Woodbury Health Care Center
7012 Lake Road
Woodbury, Minnesota 55125

RE: Project Number F5235026

Dear Mr. Karel:

On April 5, 2016, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 4, 2016. (42 CFR 488.417 (b))

Also, we notified you in our letter of April 5, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 5, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on February 4, 2016, and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our April 5, 2016 notice. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 13, 2016, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 4, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 13, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 4, 2016, as of April 13, 2016.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and

Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of April 5, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 4, 2016, be rescinded. (42 CFR 488.417 (b))

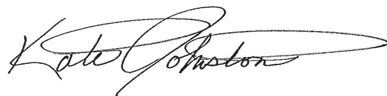
The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective May 4, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective May 4, 2016, is to be rescinded.

In our letter of April 5, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 4, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on April 13, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,



Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
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P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245235		3/23/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	7012 LAKE ROAD WOODBURY, MN 55125

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0154 Reg. # 483.10(b)(3), 483.10(d)(2) LSC	Correction Completed 03/15/2016	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 03/15/2016	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 03/15/2016
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 03/15/2016	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 03/15/2016	ID Prefix F0412 Reg. # 483.55(b) LSC	Correction Completed 03/15/2016
ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 03/15/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 03/15/2016	ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 03/15/2016
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 (INITIALS) SR/KJ	DATE 03/31/2016	SIGNATURE OF SURVEYOR 34986	DATE 03/23/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/4/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245235 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	4/13/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	7012 LAKE ROAD WOODBURY, MN 55125

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 04/13/2016	ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 02/22/2016	ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 02/19/2016
ID Prefix Reg. # NFPA 101 LSC K0054	Correction Completed 02/24/2016	ID Prefix Reg. # NFPA 101 LSC K0067	Correction Completed 03/04/2016	ID Prefix Reg. # NFPA 101 LSC K0071	Correction Completed 02/05/2016
ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 02/22/2016	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 (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/4/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
00803		3/23/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	7012 LAKE ROAD WOODBURY, MN 55125

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix 20560 Reg. # MN Rule 4658.0405 Subp. 2 LSC	Correction Completed 03/15/2016	ID Prefix 20565 Reg. # MN Rule 4658.0405 Subp. 3 LSC	Correction Completed 03/15/2016	ID Prefix 20570 Reg. # MN Rule 4658.0405 Subp. 4 LSC	Correction Completed 03/15/2016
ID Prefix 20920 Reg. # MN Rule 4658.0525 Subp. 6 B LSC	Correction Completed 03/15/2016	ID Prefix 21325 Reg. # MN Rule 4658.0725 Subp. 1 LSC	Correction Completed 03/15/2016	ID Prefix 21375 Reg. # MN Rule 4658.0800 Subp. 1 LSC	Correction Completed 03/15/2016
ID Prefix 21426 Reg. # MN St. Statute 144A.04 Subd. 3 LSC	Correction Completed 03/15/2016	ID Prefix 21620 Reg. # MN Rule 4658.1345 LSC	Correction Completed 03/15/2016	ID Prefix 21685 Reg. # MN Rule 4658.1415 Subp. 2 LSC	Correction Completed 03/15/2016
ID Prefix 21695 Reg. # MN Rule 4658.1415 Subp. 4 LSC	Correction Completed 03/15/2016	ID Prefix 21710 Reg. # MN Rule 4658.1415 Subp. 7 LSC	Correction Completed 03/15/2016	ID Prefix 21825 Reg. # MN St. Statute 144.651 Subd. 9 LSC	Correction Completed 03/15/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) SR/KJ	DATE 03/31/2016	SIGNATURE OF SURVEYOR 34986	DATE 03/23/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/4/2016	☐ 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: T2F1
Facility ID: 00803

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245235**

2.STATE VENDOR OR MEDICAID NO.
(L2) **662675000**

3. NAME AND ADDRESS OF FACILITY
(L3) **WOODBURY HEALTH CARE CENTER**
(L4) **7012 LAKE ROAD**
(L5) **WOODBURY, MN** (L6) **55125**

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) **05/01/2007**

6. DATE OF SURVEY **02/04/2016** (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)
09/30

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

12.Total Facility Beds **175** (L18)

13.Total Certified Beds **175** (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
	175			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Cynthia Wentkiewicz, HFE NE II 03/02/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 03/08/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/01/1981
(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

Posted 03/10/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 16, 2016

Mr. Allan Barr, Administrator
Woodbury Health Care Center
7012 Lake Road
Woodbury, Minnesota 55125

RE: Project Number S5235027

Dear Mr. Barr:

On February 4, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

<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:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 15, 2016, 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 March 15, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 4, 2016 (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 August 4, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

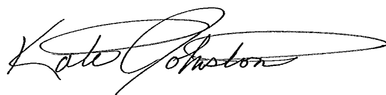
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992   Fax: (651) 215-9697
Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245235	A. BUILDING ______ B. WING ______	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	**7012 LAKE ROAD WOODBURY, MN 55125**

(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		
F 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain informed consent from R161's family decision makers, (F)-A, prior to the initiation of occupational therapy for 1 of 1 resident reviewed for informed consent, (R161). Findings include: Review of R161's most recent annual minimum data set (MDS), dated 10/21/15, revealed R161	F 154	F154 The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions	3/15/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 02/25/2016

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 154	Continued From page 1	F 154		

was significantly cognitively impaired.

During interview on 2/1/16, at 7:04 p.m., F-A reported he was a designated decision maker for health and financial matters for R161. F-A reported he received an explanation of benefit form which indicated he owed over $90 for occupational therapy (OT) for the month of November. F-A then reported he found out he would get similar statements for December and January. F-A reported he was not aware R161 was receiving occupational therapy until he was told by the facility to come down and sign a form that it was ending and received a form in the mail stating R161 would owe over $90 for OT in November . F-A reported he had heard R161 was getting new silverware from OT, but had no idea the extent of services R161 was receiving or that it would be several sessions of OT during November, December and January. F-A reported he would want to be fully informed in advance of any rehabilitation services prior to initiation and had told the facility this after a similar incident occurred about a year prior. F-A reported if R161 needed rehabilitation therapy, he wanted her to have it, but he wanted enough information to make that determination.

On 2/3/16, at 12:48 p.m. the director of rehabilitation therapy (DRT) explained she was just informed after R161's care conference a day or so ago that F-A had expressed concerns about not being fully informed about R161's receiving OT. DRT reported R161 received OT services to improve self feeding ability in November, December and January. DRT confirmed the rehabilitation therapy staff had not obtained informed consent for OT prior to initiation of services. DRT reported she would expect staff to

of State of Law. Without waiving the forgoing statement, the facility states that:
1. With respect to resident #161, the resident decision maker has been informed of the Occupational Therapy services provided. Facility has offered to refund costs incurred to the family.
2. All residents currently receiving rehab therapies have been reviewed to assure informed consents have been completed with appropriate decision maker.
3. All licensed staff receiving physician orders for rehab therapies will notify resident decision maker of new orders and rationale. All licensed nursing staff will be re-educated by March 15, 2016 regarding the process for notification when receiving new orders.
4. The Director of Nursing and/or designee will audit 3 therapy referrals each week for one month and two therapy referrals each week for two months to assure informed consent has been received on new therapy orders as long as new orders for therapy services have been obtained.
5. The data collected will be presented at QAPI by the Director of Nursing. The data will be reviewed/discussed and decision/recommendations made regarding any necessary follow up studies.

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F 154	Continued From page 2	F 154		

obtain informed consent from the resident or the resident decision makers prior to the start of rehabilitation therapy services. DRT reported she had recently discussed this with her staff after learning of F-A's concern. However, this was not documented. DRT reported she discovered rehabilitation therapy staff were not routinely getting informed consent prior to starting services. There was no formal process in place to ensure informed consent was obtained prior to the start of rehabilitation services. DRT reported, to her knowledge, F-A still needed to use R161's funds to pay the co-pay of over $90 for R161's OT services, even though informed consent was not obtained. A policy on obtaining informed consent prior to initiating rehabilitation therapy services was requested but not provided.

Review of R161's admission record, printed 2/4/16, revealed F-A was the primary decision maker for R161's financial and care decisions. Another family member was noted as an emergency contact, but not a decision maker.

Review of R161's OT Plan of Care, Therapist Progress and Updated Plan of Care and Therapist Progress and Discharge Summary, dated 11/10/15 to 1/18/16 revealed R161 received OT services to improve self feeding ability between those dates.

Review of a Concern and/or Questions Form, undated revealed a hand written note: "Therapy: See attached therapy charge understand there will be more for Dec and Jan-Please let me know when therapy is provided in the future. This is a surprise! [F-A-phone number]. Attached was an Explanation of Benefits, dated 1/9/16 with 10 claims for OT services between 11/10/15 and

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F 154	Continued From page 3 11/23/15. R161 was responsible for paying $94.75 for these services. A handwritten note read "Surprise! 2 months later." On 2/11/16, the facility sent an email and attachment with an OT care plan, dated 11/10/15, effective 11/10/15 until 12/7/15. The OT care plan noted "Treatment Plan, including benefits, risks and alternatives discussed with patient and/or family, who agree to treatment." However, the note did not indicate the individual that gave informed consent and the date and time it was received. The note did not indicate OT obtained informed consent from R161's designated decision maker for healthcare and financial matters, (F)-A. The note did not indicate how F-A was informed of the treatment plan, risks, benefits and alternatives and what plan, risks, benefits and alternatives were discussed to ensure it was in a manner F-A could understand. There was no documentation indicating F-A was given updates on updated plans of care, dated 12/8/15, 12/28/15 and 1/18/16 since initiation on 11/10/15 and ending 1/18/16.	F 154		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		3/15/16

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F 279	Continued From page 4 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify the presence of hand contractures in the care plan for 1 of 2 residents reviewed for range of motion, (R181). Findings include: R181's most recent comprehensive minimum data set [MDS], a significant change assessment completed on 9/16/15, revealed R181 had functional impairment in range of motion (ROM) in both upper extremities. The 12/9/15, quarterly MDS revealed no functional impairment in range of motion in the upper extremities. The 12/9/15, MDS revealed R181 had short and long term memory problems and significant impairment in decision making ability. On 2/2/16, at 11:19 a.m. the registered nurse unit manager, (RN)-B, reported R181 had a contracture in her hand and was not receiving range of motion services and did not have a splint device in place. On 2/3/16, at 1:43 p.m. surveyor made observations of R181 with RN-B. RN-B gently	F 279	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that: 1. With respect to resident R181 the care plan was revised regarding the resident's contractures and interventions as indicated. 2. All residents with contractures will have there care plans reviewed to assure the contractures have been addressed along with the appropriate intervention. 3. All licensed nursing staff will be re-educated by March 15, 2016 regarding revisions to care plans when a change of condition occurs. 4. The Director of Nursing and/or designee will audit 5 resident care plans each week for one month and then 3	

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F 279	Continued From page 5 attempted to uncurl R181's left hand, which was contracted with fingers in toward the palm. R181 said "ouch" and RN-B stopped attempting to uncurl R181's hand. On 2/3/16, at 1:43 p.m. RN-B and RN-C, who was responsible for completion of the MDS and care plan reviewed R181's care plan and reported R181's contractures were not addressed. RN-B reported it was determined R181 would not benefit from range of motion services or a splint device due to it not causing her pain or impairing her significantly at this point since staff provided almost all cares for R181. RN-B reported R181 developed the contracture in August after a fall at the facility. RN-B and RN-C were unable to find any documentation in the medical record related to the facility's interdisciplinary team decision making process to not pursue range of motion or splint services for R181 and what were appropriate goals and interventions related to R181's left hand contracture. RN-C reported she was unsure if the most recent quarterly MDS, dated 12/9/15, should have indicated no functional impairment in ROM. A review of R181's care plan, last revised 12/15/15, revealed no indication R181's left hand contracture was addressed in the plan of care The Care Plan Completion Policy, last revised 8/2013 directed staff to include "Functional Limitations in ROM" in the care plan.	F 279	resident care plans a week for two months to assure care plans are accurate and reflect resident conditions. 5. The data collected will be presented at QAPI by the Director of Nursing. The data will be reviewed/discussed and decision/recommendations made regarding any necessary follow up studies.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280		3/15/16

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F 280	Continued From page 6 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the care plan was revised for 1 of 3 residents (R105) with a limited range of motion. Findings include: On 2/2/16, at 9:26 a.m. R105 was observed sitting in a Broda chair with both hands lightly clenched together in a fist. No splints or other devices were noted in the resident's hands or nearby. On 2/3/16, at 8:26 a.m. R105 was observed holding a glass in the right hand and independently drank from the glass. R105 was also observed to use the left hand, pointer finger to scratch left ear. However, R105 did not entirely open the hand. There was no splint or cloth in	F 280	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that: 1. With respect to R105, the care plan was revised regarding the residents limited ROM and interventions as indicated. 2. All residents with contractures will have	

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F 280

Continued From page 7

R105's left hand.

On 2/2/16, at 9:14 a.m. registered nurse (RN)-B stated the facility has tried hand splints for R105 in the past and R105 would remove them right away.

On 2/3/16, at 3:32 p.m. RN-B stated staff would put cloths in R105's hands. RN-B was informed at this time there were no cloths in R105's hands, and was asked about range of motion (ROM) to R105's left hand. RN-B stated R105 had been on hospice at one time and the hospice staff did not want ROM or anything which would cause R105 pain; and ROM to R105's hand was "very painful."

On 2/4/16, at 8:57 a.m. nursing assistant (NA)-Z stated R105 would allow staff to wash R105's hands, and did not complain of pain when the hands were washed. NA-Z stated that gentle ROM to the left hand during cares if R105 would allow it. NA-Z stated R105 would not allow a cloth to remain in the hand, as staff had tried that and R105 would remove the cloth.

The most recent care plan dated/revised on 4/11/14, indicated R105 would hold both hands tight, didn't extend all digits consistently or purposefully; had received occupational therapy (OT) services; refused to wear splints, as they caused increased agitation; and nursing staff were to complete recommendations from OT, which according to the care plan had been provided on 1/17/14.

When the care plan was reviewed with RN-B on 2/3/16, at 3:32 p.m. and RN-B was asked why the care plan did not address putting a cloth in R105's left hand or that the resident would take

F 280

there care plans reviewed to assure the contractures have been addressed along with the appropriate intervention.
3. All licensed staff will be re-educated by March 15, 2016 regarding revisions to care plans with any change in status and orders.
4. The Director of Nursing and/or designee will audit 5 resident care plans each week for one month and 3 resident care plans each week for 2 months to assure care plans have been revised to reflect any resident changes.
5. The data collected will be presented at QAPI by the Director of Nursing. The data will be reviewed/discussed and decision/recommendations made regarding any necessary follow up studies.

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F 280	Continued From page 8 the cloths out. RN-B stated the hospice care plan had indicated ROM was not to be completed. The hospice care plan dated 12/8/14, was reviewed and indicated passive ROM was to be done to all extremities, except the right arm, which had a fractured ulna. The facility's policy titled Care Plan Completion and revised 8/13, indicated a resident's care plan was to be updated/revised as changes occur.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for the provision of activities of daily living for 1 of 3 residents (R105) dependent on staff for completion of ADL's. Findings include: The care plan revised on 4/11/14, revealed R105 had cognitive loss, with deficits in memory, judgement, decision making, and thought processes. The care plan directed staff R105 could be resistive with cares and required one staff to assist with completing grooming needs. The care plan did not indicate R105 did not mind chin whiskers.	F 282	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that: 1. With respect to R105, the Nurse Manager is working with the staff to develop a routine for shaving the resident, re-approaching or obtaining the	3/15/16

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F 282	Continued From page 9 On 2/1/16, at 5:45 p.m. approximately 1/8-1/4th inch long hairs were noted on the resident's chin and corners of the mouth. The chin hairs were still present on 2/2/16, at 8:26 a.m.; on 2/3/16, at 8:26 a.m.; and on 2/4/16, at 8:34 a.m. On 2/4/16, at 8:59 a.m. nursing assistant (NA)-Z stated R105 had a bath on Saturday evenings, but NA-Z had not given R105 a bath that evening. NA-Z stated R105 had been on NA-Z's assignment list for 2/3 and 2/4/16, and had not attempted to remove R105's chin hairs on these dates. NA-Z stated R105 would "fight" when shaved but would try to remove the chin hairs today if the resident would allow it. NA-Z verified the presence of the chin hairs at this time. The facility's policy titled Functional Maintenance Program, dated 4/15, indicated functional maintenance programs were to be initiated to assist to maintain a resident's highest practicable level of function and well-being. The policy included the provision of grooming for residents.	F 282	assistance of the nurse when resident refuses. The resident care plan and nursing assistant assignment sheet have been updated accordingly. 2. All residents have been reviewed for refusal of shaving and a plan of care established for approaches to promote a routine for shaving that best meets the residents needs. The NAR assignment sheet and resident care plan have been revised as indicated. 3. All nursing staff will receive education by March 15, 2016 regarding managing challenges during grooming and interventions/approaches to ensure each individuals needs are met. 4. The Director of Nursing and/or designee will complete 5 resident audits each week for one month and 3 resident audits each week for two months to assure care of the individual resident is being completed according to the individual plan of care. 5. The data collected will be presented at QAPI by the Director of Nursing. The data will be reviewed/discussed and decision/recommendations made regarding any necessary follow up studies.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		3/15/16

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F 312	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate grooming to 1 of 3 residents (R105) dependent on staff for completion of activities of daily living (ADL.) Findings include: On 2/1/16, at 5:45 p.m. approximately 1/8-1/4th inch long hairs were noted on the resident's chin and corners of the mouth. The facial hairs were still present on 2/2/16, at 8:26 a.m.; on 2/3/16, at 8:26 a.m.; and on 2/4/16, at 8:34 a.m. On 2/4/16, at 8:59 a.m. nursing assistant (NA)-Z stated R105 had a bath on Saturday evenings, but NA-Z had not given R105 a bath that evening. NA-Z stated R105 had been on NA-Z's assignment list for 2/3 and 2/4/16, and had not attempted to remove R105's chin hairs on these dates. NA-Z stated R105 would "fight" when shaved but would try to remove the chin hairs today if the resident would allow it. NA-Z verified the presence of the chin hairs at this time. On 2/3/16, at 3:40 p.m. a family member stated not being able to provide information as to whether or not the facial hair would bother R105. On 2/3/16, at 3:47 p.m. a message was left for R105's conservator to determine if the facial hair would bother R105, however, the conservator was unable to be interviewed. The facility's policy titled Functional Maintenance Program, dated 4/15, indicated functional maintenance programs were to be initiated to	F 312	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that: 1. With respect to R105, the Nurse Manager is working with the staff to develop a routine for grooming the resident, re-approaching or obtaining the assistance of the nurse when resident refuses. The resident care plan and nursing assistant assignment sheet have been updated accordingly. 2. All residents have been reviewed for refusal of grooming and a plan of care established for approaches to promote a routine for shaving that best meets the residents needs. The NAR assignment sheet and resident care plan have been revised as indicated. 3. All nursing staff will receive education by March 15, 2016 regarding managing challenges during grooming and interventions/approaches to ensure each individuals needs are met. 4. The Director of Nursing and/or designee will complete 5 resident audits each week for one month and 3 resident audits each week for two months to	

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F 312	Continued From page 11 assist ot maintain a resident's highest practicable level of function and well-being.	F 312	assure care of the individual resident is being completed according to the individual plan of care. 5. The data collected will be presented at QAPI by the Director of Nursing. The data will be reviewed/discussed and decision/recommendations made regarding any necessary follow up studies.	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure routine dental services were provided to 1 of 3 residents (R105) on an annual basis to ensure there were no dental issues. Findings include: On 2/2/16, at 9:33 a.m. R105 was observed to have several lower front teeth missing. On 2/3/16, at 8:39 a.m. R105 was observed to feed self bite size pieces of an omelet and toast. There were	F 412	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that:	3/15/16

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F 412	Continued From page 12	F 412		

no problems noted with chewing or swallowing.

The care plan revised on 1/17/14, indicated R105 was to be referred to the dentist as needed; the resident would grind their teeth; and staff were to assess/observe for mouth and tooth issues. Another portion of the care plan revised on 9/21/15, noted R105 had some natural teeth missing, staff performed oral care, as R105 did not participate, but was cooperative; and refer to dentist as needed. However, the care plan did not indicate R105 was not to see the dentist for annual oral exams.

A dental agreement with the facility's contract dental service revealed the conservator had signed the form on 10/11/12, which authorized the consulting dental service to provide comprehensive and periodic oral evaluation. There was no indication on the form that the conservator did not want the resident to see the dentist.

A review of the consult section of the medical record did not indicate R105 had seen a dentist since the dental agreement had been signed on 10/11/12.

On 2/3/16, at 3:22 p.m. registered nurse (RN)-C stated they would check the thinned medical record for any documentation regarding dental visits. By 2/4/16, at 1:00 p.m. RN-C had not been able to find any documentation of a dental visit.

On 2/4/16, at 11:30 a.m. health unit coordinator (HUC)-A stated there had been a dental screening of R105 at the time the dental agreement had been signed, and the facility was trying to find the screening. HUC-A stated the

Provider's Plan of Correction (F 412):

1. With respect to R105, an oral screen was completed and dental recommendations presented to the family for making determination for treatment.
2. All resident records have been audited by Health Information to ensure they have been offered dental care/services within the past 12 months.
3. All Health Information staff will be re-educated by March 15, 2016 regarding the guidelines and process for dental visits and other ancillary services.
4. The Director of Nursing and/or designee will complete 2 resident chart audits each week for one month and then one resident chart audit each week for two months to assure dental services are offered and obtained as requested.
5. The data collected will be presented at QAPI by the Director of Nursing. The data will be reviewed/recommendations made regarding any necessary follow up studies.

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F 412	Continued From page 13 contracting dental service did not keep dental screenings, but provided the documentation to the facility. HUC-A stated R105 had not had any dental issues that they were aware of. On 2/4/16, at 8:59 a.m. nursing assistant (NA)-Z stated R105 was resistive with oral cares, but was not having any problems with chewing or swallowing. The facility's Dental Services policy, revised 8/13, indicated annual dental services and dental services as indicated were to be provided to residents.	F 412		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		3/15/16

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F 431	Continued From page 14 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were stored and labeled properly for 3 of 45 residents (R332, R123 and R234) reviewed for medication storage. Findings include: During observations of multiple medication storage areas throughout the facility, medications for R332, R123 and R234, which included eye drops, ear drop and insulins, lacked dates to indicate when they were opened. During the medication storage tour on 2/3/16, at 9:10 a.m. with registered nurse (RN)-A, in the transition care unit team 3 medication cart, multiple opened, used and undated medication bottles were stored in medication carts. Observations included the following: R332's Azelastine (redness of eye) eye drop bottle was opened, used and was undated. R332's Ciprodex (for infection) ear drop bottle was opened, used and was undated.	F 431	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that: 1. With respect to residents R332,R123,R234; medications were removed from the storage areas and disposed of properly. 2. All medication storage areas have been inspected for proper compliance with handling, storage and dating of opened medications. All medications not in compliance have been disposed of according to facility protocol. 3. Processes have been developed for periodic inspection of the medication storage areas for cleanliness, proper	

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F 431	Continued From page 15 R123's Lantus (for diabetes) insulin vial was opened, used and was undated. On 2/3/16, at 9:17 a.m. RN-A verified the medications needed to be labeled and stored properly. RN-A added that opened medications should be dated when opened and stated she will remove from medication cart, dispose of properly and reorder them. During the medication administration on 2/3/16, at 9:41 a.m., with LPN-A, the third floor south medication storage cart was reviewed. The following observation was made: R234's Latanoprost (anti-glaucoma) eye drop bottle was opened, used and was undated. On 2/3/16, at 9:41 a.m. LPN-A verified medications should be labeled and stored properly. LPN-A added that opened medications should be dated when opened and will remove and reorder new ones. On 2/3/16, at 10:30 a.m. the director of nursing (DON) explained that staff were supposed to date medication bottles and vials when opened. In addition, the DON indicated that staff should follow policies and pharmacy recommendations. Undated Medication storage and expiration guidelines, directed, "insulin 10 ML (milliliter) vials opened - room temperature, 28 days after 1st use, date when open yes. Xalatan eye drops opened - room temperature, 45 days after 1st use, date when open yes." Policy and procedure titled EXPIRATION AND BEYOND-USE DATING, dated 1/27/15, reads, "D. Certain medications have beyond-use dates	F 431	storage and disposal. All licensed staff/trained medication aides will be re educated regarding medication expiration and storage guidelines by March 15, 2016 4. The Director of Nursing and/or designee will audit 3 medication storage areas each week for one month and 2 medication storage areas each week for 2 months to assure proper storage, dating and disposal of expired medications. 5. The data collected will be presented in QAPI by the Director of Nursing. The data will be reviewed/discussed and decision/recommendations made regarding any follow up studies.	

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F 431	Continued From page 16 specified by the manufacturer that are dependent on storage conditions and/or date of this use. (see chart for example). Nursing staff will write date of first use on the container label for these specified medications."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must 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.	F 441		3/15/16

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(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure hand hygiene was provided for 2 of 4 residents (R161, R96) observed during cares and failed to ensure the mechanical stand lift was sanitized between uses.

Findings include:

On 2/3/16, at 10:21 a.m., nursing assistant, (NA)-E, was observed to don gloves and assist R161 with standing using the mechanical stand lift. R161 grabbed the handles as she stood. NA-E assisted R161 to sit on the toilet after removing the disposable brief. R161 urinated in the toilet. NA-E used disposable wipes to clean R161, assisted R161 with applying a brief and to stand by holding the handles of the mechanical stand lift. NA-E then assisted R161 to sit down in her wheelchair. NA-E removed gloves, and without washing or sanitizing hands, opened the door to R161's room, took the mechanical stand lift to the storage room and opened the door with unwashed hands, and pushed the mechanical stand lift into the storage room. NA-E then proceeded to open the door to R96's room, using unwashed hands, and began to make R96's bed by straightening out the linens and blankets. NA-E did not sanitize the mechanical stand lift after assisting R161 with using the toilet. Sanitizing wipes were attached to the mechanical

The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that:
1. Staff immediately sanitized the mechanical standing device and residents hands.
2. With respect to identified employee, education was provided to ensure proper hand washing and cleaning of equipment was provided between resident cares on February 3, 2016.
3. All nursing staff will be re educated regarding hand washing and disinfecting resident equipment between resident use by March 15, 2016
4. The Director of Nursing and/or designee will audit 5 resident cares each week for one month and 3 resident cares each week for 2 months to assure proper hand washing and disinfection of equipment is occurring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245235	A. BUILDING ______ B. WING ______	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	7012 LAKE ROAD WOODBURY, MN 55125

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 18 stand lift. When asked at this time when NA-E had last washed or sanitized his hands, NA-E reported he performed hand hygiene prior to assisting R161 with using the toilet. NA-E then continued to straighten out R96's bed linens with unwashed hands. NA-E reported he did not sanitize the mechanical stand lift after use and prior to putting in storage. On 2/3/16, at 10:36 a.m. the registered nurse floor manager, (RN)-B, reported staff should perform hand hygiene after assisting a resident with using the toilet and should clean and sanitize the mechanical stand prior to returning it to storage as someone might need to use it right away. The Hand Washing Policy, last revised 8/2013, directed staff "Handwashing involves five simple and effective steps (Wet, Lather, Scrub, Rinse, Dry) to reduce the spread of diarrheal and respiratory illness. Regular handwashing, particularly before and after certain activities, is one of the best ways to remove germs, avoid getting sick, and prevent the spread of germs to others." The policy also directed staff that hand sanitizer may be used if hands were not visibly soiled. The Mechanical Lift Policy, last revised 12/2013, directed staff "21. Wipe handles of the mechanical lift with a germicidal cloth." after use.	F 441	5. The data collected will be presented in QAPI by the Director of Nursing. The data will be reviewed/discussed and decision/recommendations made regarding any necessary follow up studies.	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465		3/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245235	A. BUILDING ______ B. WING ______	02/04/2016

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F 465	Continued From page 19 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to ensure cupboards and/or drawers in 4 of 6 kitchenettes were kept clean and maintained in good repair. This had the potential to affect 100 of 165 residents residing in the facility. Findings include: During the final kitchen tour on 2/4/16, from 9:35 a.m. to 10:25 a.m. the wood finishes of lower kitchenette cabinets in the 3 North, 3 South, and 2 West units were noted to be worn down to the raw wood in some places. The lower cabinet doors of the 3 North and 2 West units had white spots/spills down the front of the doors. In the 3 North dining room the inside bottom of 3 of 5 drawers were worn down to the raw wood, making the surface uncleanable. In the 1 West dining room the lower corners of 3 of 6 upper kitchenette cabinets were sticky to the touch and debris was noted on the fingers after touching the cabinet corners. The director of nutritional services touched the corners of the cabinets, stated they were sticky and asked the housekeeper in the room to clean the cabinets. The director of nutritional services stated at 10:05 a.m. that maintenance would look at the cupboards and see about having them cleaned and refinished. The director of nutritional services stated it was housekeeping's responsibility to clean the outside of the kitchenette cabinets.	F 465	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that: 1. With respect to the identified kitchen cabinets, all identified cabinets have been cleaned and repaired. 2. Environmental Rounds have been conducted to identify any items in need of repair. 3. All staff will be re educated regarding reporting items in need of repair by March 15, 2016 4. The Director of Maintenance and/or designee will complete audits weekly for 3 months and then on a monthly basis to make needed repairs or schedule larger projects. 5. The data collected will be presented at QAPI by the Director of Maintenance. The data will be reviewed/discussed and decision/recommendations will be made regarding any necessary follow up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 465	Continued From page 20 The facility was unable to provide a preventative maintenance or cleaning schedule for the kitchenette cabinets.	F 465		

F5235026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245235	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**02/04/2016**

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Woodbury Healthcare Center 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 STREET, SUITE 145
ST. PAUL, MN 55101-5145

Or by email to:
Marian.Whitney@state.mn.us and

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/25/2016

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245235	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/04/2016

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K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Woodbury Healthcare Center is a 4-story building with no basement. The building was constructed at 2 different times. The original 3 story building was constructed in 1979 and was determined to be of Type II(222) construction. In 1986, a fourth floor addition was constructed that was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. The building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 175 beds and had a census of 158 at the time of the survey. It is the determination of this Life Safety Code Surveyor that the fire sprinkler coverage in the resident rooms is within 3 feet and adequate to provide complete unobstructed coverage to the exterior of the wardrobe closets in accordance	K 000		

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	245235	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**02/04/2016**

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K 000	Continued From page 2 with NFPA 13 (99) and CMS S&C-05-38, A1. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
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 shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on the observation and staff interview, the facility had several corridor doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3, they did not fit tight in the frame or latch. This deficient practice could affect the safety of approximately 113 of 175 residents and an undetermined number of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 0830 and 1430 on 2/4/2016 observations revealed that the following	K 018	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that: 1. All identified doors are being replaced through Twin City Hardware. 2. Anticipated date of completion is April	4/15/16

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K 018	Continued From page 3 resident room doors did not latch or did not fit tightly in the frame. 130, 128, 123, 126, 119, 118, 224, 203, 207, 213, 328, 327, 324, 308, 322. The deficient practice was observed by the Director of Maintenance and the Facility Administrator.	K 018	15, 2016 3. Tim Kraus, Director of Maintenance and/or designee will audit all door closures on a quarterly basis to assure the doors maintain a proper and tight fit in both the latch and frame.	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 2 of the 8 smoke barrier walls in accordance with the following requirements of 2000 NFPA 101, Section 19.3.7.3, and 8.3.4.1. The deficient practice could affect 26 of the 175 patients and an undetermined amount of staff and visitors. Findings include: On the facility tour between 0830 and 1430 on 2/4/2016 observations revealed that out of the 8 smoke barriers 2 smoke barriers had penetrations in the following locations: a. Second floor in the storage room between rooms 201 and 203. b. Second floor south wing of the skyway leading to the villas. The deficient practice was observed by the Director of Maintenance and the Facility	K 025	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that: 1. Dry wall installation and fire wall caulking has been completed in the second floor storage room and south wing of the skyway. 2. Date of completion: February 22, 2016 3. Tim Kraus, Director of Maintenance and/or designee will complete environmental audits weekly for one month and then monthly to identify and repair any smoke barriers with	2/22/16

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	245235	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**02/04/2016**

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K 025	Continued From page 4 Administrator.	K 025	penetrations.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in 2 of the hazardous rooms in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 70 out of 175 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 0830 and 1430 on 2/4/2016 observations revealed the following deficiencies for hazardous rooms as follows. 1. Penetrations on the corridor side: a. Second floor boiler room located by the skyway b. Storage room in the basement lobby located in front of the west wing entrance 2. Missing door closers: a. Second floor boiler room located by the skyway b. Maintenance Storage room in the basement located by the maintenance tool room.	K 029	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that: 1. Dry wall installation and fire wall caulking has been completed in the second floor boiler room and basement lobby storage room. Door closures have been replaced to the second floor boiler door and maintenance storage room in the basement. 3. Date of completion: February 19, 2016 4. Tim Kraus, Director of Maintenance and/or designee will complete door closure audits with routine fire drills and on a monthly basis. Environmental audits will be conducted weekly for one month and then on a monthly basis.	2/19/16

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K 029	Continued From page 5 The deficient practice was observed by the Director of Maintenance and the Facility Administrator.	K 029		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation and documentation review it was revealed that the facility failed to provide documentation for sensitivity testing of smoke detector in accordance with NFPA 72 and LSC (00) Section 9.6.2.10. Findings Include: 1. On the facility tour between 0830 and 1430 on 2/4/2016 during documentation review and staff interview it was revealed that there was no documentation for smoke detector sensitivity testing and observations revealed 1 smoke detector was missing from the occupational and speech therapy room and a heat detector missing from the boiler room on the second floor located near the skyway. The deficient practice was observed by the Director of Maintenance and the Facility Administrator.	K 054	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that: 1. A smoke detector sensitivity testing is being completed on all the smoke detectors in the building by Nardini Fire Equipment Co. 2. Heat detectors were installed in the second floor boiler room and smoke detectors in the Occupational/Physical therapy rooms. 2 smoke detectors were installed in the identified areas to meet code. 3. Date of completion: February 24, 2016 4. Tim Kraus, Director of Maintenance and/or designee will assure annual inspections are completed to test and inspect the fire alarm systems for proper operation	2/24/16
K 067	NFPA 101 LIFE SAFETY CODE STANDARD	K 067		3/4/16

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K 067 SS=D	Continued From page 6 Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on documentation review it was revealed that the facility failed to provide proof of the fire damper testing in accordance with NFPA 101 (00) 9.3.1. This deficient practice could allow smoke to enter into another compartment causing the smoke barrier to be ineffective in a fire event and could negatively effect 45 of the 175 residents and an undertermined amount of staff and visitors. Findings Include: On the facility tour between 0830 and 1430 on 2/4/2016 during documentation review and staff interview it was revealed that there was no documentation for testing and inspection of fire dampers. The deficient practice was observed by the Director of Maintenance and the Facility Administrator.	K 067	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that: 1. Low voltage Contractors will complete testing and inspection of all dampers. 2. Date of completion: March 4, 2016 3. Tim Kraus, Director of Maintenance and/or designee will assure completion of routine testing and inspection every 4 years	
K 071 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes: (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with	K 071		2/5/16

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K 071	Continued From page 7 section 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4. (4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is not met as evidenced by: Base on observations and staff interview it was revealed that the facility failed to maintain sprinkler protection in the laundry chute per NFPA 101 (00) section 19.5.4.2, 9.7 and NFPA 82. This deficient practice could affect the residents in the 3 wings of the floors the chute passes through as well as all staff and visitors. On the facility tour between 0830 and 1430 on 2/4/2016 observations revealed that a sprinkle head had been removed from the laundry chute on the third floor. The deficient practice was observed by the Director of Maintenance and the Facility Administrator.	K 071	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that: 1. The identified laundry chute already had a sprinkler installed as verified by Viking Sprinkler. 2. Verification date as in place: 2/6/16. 3. Tim Kraus, Director of Maintenance and/or designee will assure completion of annual fire sprinkler inspections and retain records of inspections for 3 years.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by:	K 147		2/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245235	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	7012 LAKE ROAD WOODBURY, MN 55125

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 8 Based on observation and staff interview the facility failed to maintain electrical devices in accordance with NFPA 70 (99), National Electrical Code this deficient practice could negatively affect the safety of staff and visitors. Findings include: On the facility tour between 0830 and 1430 on 2/4/2016 observations revealed that 9 offices and 2 resident rooms utilized unlisted power tap devices as well as connecting more than 1 power tap in series. The deficient practice was observed by the Director of Maintenance and the Facility Administrator.	K 147	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that: 1. All unlisted power tap devices have been removed. Twin City Electricians has updated offices that required additional power sources. 2. Date of completion: February 22, 2016 3. Tim Kraus, Director of Maintenance and/or designee will complete environmental audits weekly for one month and then monthly to identify and remove any unlisted power tap devices.	

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
February 16, 2016

Mr. Allan Barr, Administrator
Woodbury Health Care Center
7012 Lake Road
Woodbury, Minnesota 55125

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5235027

Dear Mr. Barr:

The above facility was surveyed on February 1, 2016 through February 4, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,

"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

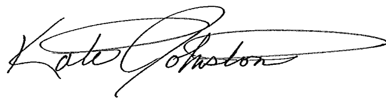
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susanne Reuss, Unit Supervisor at (651) 201-3793.

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

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

Please feel free to call me with any questions.

Sincerely,



Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00803	A. BUILDING: ______ B. WING ______	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	7012 LAKE ROAD WOODBURY, MN 55125

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 1	2 000		

Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

On February 1, 2, 3, 4, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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2 000 Continued From page 2

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

2 560 MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents

Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to identify the presence of hand contractures in the care plan for 1 of 2 residents reviewed for range of motion, (R181).

Findings include:

R181's most recent comprehensive minimum data set [MDS], a significant change assessment completed on 9/16/15, revealed R181 had functional impairment in range of motion (ROM) in both upper extremities. The 12/9/15, quarterly MDS revealed no functional impairment in range of motion in the upper extremities. The 12/9/15, MDS revealed R181 had short and long term memory problems and significant impairment in decision making ability.

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2 560	Continued From page 3	2 560		

Continued From page 3

On 2/2/16, at 11:19 a.m. the registered nurse unit manager, (RN)-B, reported R181 had a contracture in her hand and was not receiving range of motion services and did not have a splint device in place.

On 2/3/16, at 1:43 p.m. surveyor made observations of R181 with RN-B. RN-B gently attempted to uncurl R181's left hand, which was contracted with fingers in toward the palm. R181 said "ouch" and RN-B stopped attempting to uncurl R181's hand.

On 2/3/16, at 1:43 p.m. RN-B and RN-C, who was responsible for completion of the MDS and care plan reviewed R181's care plan and reported R181's contractures were not addressed. RN-B reported it was determined R181 would not benefit from range of motion services or a splint device due to it not causing her pain or impairing her significantly at this point since staff provided almost all cares for R181. RN-B reported R181 developed the contracture in August after a fall at the facility. RN-B and RN-C were unable to find any documentation in the medical record related to the facility's interdisciplinary team decision making process to not pursue range of motion or splint services for R181 and what were appropriate goals and interventions related to R181's left hand contracture. RN-C reported she was unsure if the most recent quarterly MDS, dated 12/9/15, should have indicated no functional impairment in ROM.

A review of R181's care plan, last revised 12/15/15, revealed no indication R181's left hand contracture was addressed in the plan of care

The Care Plan Completion Policy, last revised 8/2013 directed staff to include "Functional

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2 560	Continued From page 4 Limitations in ROM" in the care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate interventions for all identified care needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for the provision of activities of daily living for 1 of 3 residents (R125) dependent on staff for completion of ADL's. Findings include: The care plan revised on 4/11/14, revealed R125 had cognitive loss, with deficits in memory, judgement, decision making and thought processes. The care plan directed staff R125 could be resistive with cares and required one	2 565		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 565	Continued From page 5 staff to assist with completing grooming needs. The care plan did not indicate R125 did not mind chin whiskers. On 2/1/16, at 5:45 p.m. approximately 1/8-1/4th inch long hairs were noted on the resident's chin and corners of the mouth. The chin hairs were still present on 2/2/16, at 8:26 a.m.; on 2/3/16, at 8:26 a.m.; and on 2/4/16, at 8:34 a.m. On 2/4/16, at 8:59 a.m. nursing assistant (NA)-Z stated R125 had a bath on Saturday evenings, but NA-Z had not given R125 a bath that evening. NA-Z state R125 had been on NA-Z's assignment list for 2/3 and 2/4/16, and had not attempted to remove R125's chin hairs on these dates. NA-Z stated R125 would "fight" when shaved but would try to remove the chin hairs today if the resident would allow it. NA-Z verified the presence of the chin hairs at this time. The facility's policy titled Functional Maintenance Program, dated 4/15, indicated functional maintenance programs were to be initiated to assist to maintain a resident's highest practicable level of function and well-being. The policy included the provision of grooming for residents. SUGGESTED METHOD OF CORRECTION: The director of nurses or designee should review resident care plans to ensure the care plans were an accurate reflection of the services required by the resident. Nursing staff could then be educated on ensuring care was provided to residents in accordance with each resident's care plan. Audits of care plans and observation of cares could be conducted to ensure care was provided according	2 565		

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2 565	Continued From page 6	2 565		

to the care plan.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

2 570 MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision (2 570)

Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure the care plan was revised for 1 of 3 residents (R125) with a limited range of motion.

Findings include:

On 2/2/16, at 9:26 a.m. R125 was observed sitting in a Broda chair with both hands lightly clenched together in a fist. No splints or other devices were noted in the resident's hands or nearby. On 2/3/16, at 8:26 a.m. R125 was observed holding a glass in the right hand and independently drank from the glass. R125 was also observed to use the left hand, pointer finger

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2 570	Continued From page 7	2 570		

to scratch left ear. However, R125 did not entirely open the hand. There was no splint or cloth in R125's left hand.

On 2/2/16, at 9:14 a.m. registered nurse (RN)-B stated the facility has tried hand splints for R125 in the past and R125 would remove them right away.

On 2/3/16, at 3:32 p.m. RN-B stated staff would put cloths in R125's hands. RN-B was informed at this time there were no cloths in R125's hands, and was asked about range of motion (ROM) to R125's left hand. RN-B stated R125 had been on hospice at one time and the hospice staff did not want ROM or anything which would cause R125 pain; and ROM to R125's had was "very painful."

On 2/4/16, at 8:57 a.m. nursing assistant (NA)-Z stated R125 would allow staff to wash R125's hands, and did not complain of pain when the hands were washed. NA-Z stated that gentle ROM to the left hand during cares if R125 would allow it. NA-Z stated R125 would not allow a cloth to remain in the hand, as staff had tried that and R125 would remove the cloth.

The most recent care plan dated/revised on 4/11/14, indicated R125 would hold both hands tight, didn't extend all digits consistently or purposefully; had received occupational therapy (OT) services; refused to wear splints, as they caused increased agitation; and nursing staff were to complete recommendations from OT, which according to the care plan had been provided on 1/17/14.

When the care plan was reviewed with RN-B on 2/3/16, at 3:32 p.m. and RN-B was asked why the care plan did not address putting a cloth in

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2 570	Continued From page 8	2 570		
	R125's left hand or that the resident would take the cloths out. RN-B stated the hospice care plan had indicated ROM was not to be completed. The hospice care plan dated 12/8/14, was reviewed and indicated passive ROM was to be done to all extremities, except the right arm, which had a fractured ulna. The facility's policy titled Care Plan Completion and revised 8/13, indicated a resident's care plan was to be updated/revised as changes occur. SUGGESTED METHOD OF CORRECTION: The director of nurse or designee should review and revise the care plan for residents with limitation in range of motion to ensure the appropriate services were provided to maintain and/or improved range of motion. TIME PERIOD FOR CORRECTION: Fourteen (14) days.			
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs	2 920		
	Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate			

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2 920	Continued From page 9	2 920		

Continued From page 9

grooming to 1 of 3 residents (R125) dependent on staff for completion of activities of daily living (ADL.)

Findings include:

On 2/1/16, at 5:45 p.m. approximately 1/8-1/4th inch long hairs were noted on the resident's chin and corners of the mouth. The facial hairs were still present on 2/2/16, at 8:26 a.m.; on 2/3/16, at 8:26 a.m.; and on 2/4/16, at 8:34 a.m.

On 2/4/16, at 8:59 a.m. nursing assistant (NA)-Z stated R125 had a bath on Saturday evenings, but NA-Z had not given R125 a bath that evening. NA-Z stated R125 had been on NA-Z's assignment list for 2/3 and 2/4/16, and had not attempted to remove R125's chin hairs on these dates. NA-Z stated R125 would "fight" when shaved but would try to remove the chin hairs today if the resident would allow it. NA-Z verified the presence of the chin hairs at this time.

On 2/3/16, at 3:40 p.m. a family member stated not being able to provide information as to whether or not the facial hair would bother R125. On 2/3/16, at 3:47 p.m. a message was left for R125's conservator to determine if the facial hair would bother R125, however, the conservator was unable to be interviewed.

The facility's policy titled Functional Maintenance Program, dated 4/15, indicated functional maintenance programs were to be initiated to assist to maintain a resident's highest practicable level of function and well-being.

SUGGESTED METHOD OF CORRECTION: The director of nurses or designee should review

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resident care plans to ensure the care plans were an accurate reflection of the services required by the resident. Nursing staff could then be educated on ensuring care was provided to residents in accordance with each resident's care plan. Audits of care plans and observation of cares could be conducted to ensure care was provided according to the care plan.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

21325 MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser — 21325

Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure routine dental services were provided to 1 of 3 residents (R125) on an annual basis to ensure there were no dental issues.

Findings include:

On 2/2/16, at 9:33 a.m. R125 was observed to have several lower front teeth missing. On 2/3/16,

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at 8:39 a.m. R125 was observed to feed self bite size pieces of an omelet and toast. There were no problems noted with chewing or swallowing.

The care plan revised on 1/17/14, indicated R125 was to be referred to the dentist as needed; the resident would grind their teeth; and staff were to assess/observe for mouth and tooth issues. Another portion of the care plan revised on 9/21/15, noted R125 had some natural teeth missing, staff performed oral care, as R125 did not participate, but was cooperative; and refer to dentist as needed. However, the care plan did not indicate R125 was not to see the dentist for annual oral exams.

A dental agreement with the facility's contract dental service revealed the conservator had signed the form on 10/11/12, which authorized the consulting dental service to provide comprehensive and periodic oral evaluation. There was no indication on the form that the conservator did not want the resident to see the dentist.

A review of the consult section of the medication record did not indicate R125 had seen a dentist since the dental agreement had been signed on 10/11/12.

On 2/3/16, at 3:22 p.m. registered nurse (RN)-C stated they would check the thinned medical record for any documentation regarding dental visits. By 2/4/16, at 1:00 p.m. RN-C had not been able to find any documentation of a dental visit.

On 2/4/16, at 11:30 a.m. health unit coordinator (HUC)-A stated there had been a dental screening of R125 at the time the dental agreement had been signed, and the facility was

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trying to find the screening. HUC-A stated the contracting dental service did not keep dental screenings, but provided the documentation to the facility. HUC-A stated R125 had not had any dental issues that they were aware of.

On 2/4/16, at 8:59 a.m. nursing assistant (NA)-Z stated R125 was resistive with oral cares, but was not having any problems with chewing or swallowing.

The facility's Dental Services policy, revised 8/13, indicated annual dental services and dental services as indicated were to be provided to residents.

SUGGESTED METHOD OF CORRECTION: The director of nurses or designee could contact the resident's legal representative to determine if the annual dental services were to be provided or if dental services were only to be provided after contacting the legal representative. The nursing staff should be made aware of all resident's dental needs and how to ensure dental services were provided on an annual basis.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

21375 MN Rule 4658.0800 Subp. 1 Infection Control; Program 21375

Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.

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This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure hand hygiene was provided for 2 of 4 residents (R161, R96) observed during cares and failed to ensure the mechanical stand lift was sanitized between uses.

Findings include:

On 2/3/16, at 10:21 a.m., nursing assistant, (NA)-E, was observed to don gloves and assist R161 with standing using the mechanical stand lift. R161 grabbed the handles as she stood. NA-E assisted R161 to sit on the toilet after removing the disposable brief. R161 urinated in the toilet. NA-E used disposable wipes to clean R161, assisted R161 with applying a brief and to stand by holding the handles of the mechanical stand lift. NA-E then assisted R161 to sit down in her wheelchair. NA-E removed gloves, and without washing or sanitizing hands, opened the door to R161's room, took the mechanical stand lift to the storage room and opened the door with unwashed hands, and pushed the mechanical stand lift into the storage room. NA-E then proceeded to open the door to R96's room, using unwashed hands, and began to make R96's bed by straightening out the linens and blankets. NA-E did not sanitize the mechanical stand lift after assisting R161 with using the toilet. Sanitizing wipes were attached to the mechanical stand lift. When asked at this time when NA-E had last washed or sanitized his hands, NA-E reported he performed hand hygiene prior to assisting R161 with using the toilet. NA-E then continued to straighten out R96's bed linens with unwashed hands. NA-E reported he did not sanitize the mechanical stand lift after use and prior to putting in storage.

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On 2/3/16, at 10:36 a.m. the registered nurse floor manager, (RN)-B, reported staff should perform hand hygiene after assisting a resident with using the toilet and should clean and sanitize the mechanical stand prior to returning it to storage as someone might need to use it right away.

The Hand Washing Policy, last revised 8/2013, directed staff "Handwashing involves five simple and effective steps (Wet, Lather, Scrub, Rinse, Dry) to reduce the spread of diarrheal and respiratory illness. Regular handwashing, particularly before and after certain activities, is one of the best ways to remove germs, avoid getting sick, and prevent the spread of germs to others." The policy also directed staff that hand sanitizer may be used if hands were not visibly soiled.

The Mechanical Lift Policy, last revised 12/2013, directed staff "21. Wipe handles of the mechanical lift with a germicidal cloth." after use.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee would review and revise the policy and procedures related to infection control concerns while passing medications, performing wound care, perinal cares and provide education to staff members. A monitoring system could be developed to ensure staff are providing cares as directed and report the results to the quality assurance committee.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to document the interpretation and induration results of tuberculin skin test (TST) for 5 of 5 residents (R5, R87, R148, R249 & R294) reviewed. Findings include: R5 was admitted to the facility on 5/22/15. R5's medical record indicated R5 received the first dose step of Tubersol Solution 5 unit/0.1 milliliter (ML) intradermally on 5/22/15. There were no	21426		

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documents to indicate the interpretation or induration of the TST given on 5/22/15. Furthermore, a second dose step of Tubersol Solution 5 unit/0.1 milliliter (ML) intradermally was given on 6/3/15, and there was no documents to indicate the interpretation or induration of the TST given on 6/3/15.

R87 was admitted to the facility on 9/30/15. R87's medical record indicated R87 received the first dose step of Tubersol Solution 5 unit/0.1 milliliter (ML) intradermally on 9/30/15. There were no documents to indicate the interpretation or induration of the TST given on 9/30/15. Furthermore, a second dose step of Tubersol Solution 5 unit/0.1 milliliter (ML) intradermally was given on 10/10/15, and there was no documents to indicate the interpretation or induration of the TST given on 10/10/15.

R148 was admitted to the facility on 10/18/15. R148's medical record indicated R148 received the first dose step of Tubersol Solution 5 unit/0.1 milliliter (ML) intradermally on 10/18/15. There were no documents to indicate the interpretation or induration of the TST given on 10/18/15

R249 was admitted to the facility on 10/12/15. R249's medical record indicated R249 received the first dose step of Tubersol Solution 5 unit/0.1 milliliter (ML) intradermally on 10/12/15. There were no documents to indicate the interpretation or induration of the TST given on 10/12/15.

R294 was admitted to the facility on 11/2/15. R294's medical record indicated R294 received the first dose step of Tubersol Solution 5 unit/0.1 milliliter (ML) intradermally on 11/2/15. There were no documents to indicate the interpretation or induration of the TST given on 11/2/15.

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21426	Continued From page 17 When interviewed on 2/4/15, at 11:00 a.m. registered nurse (RN)-E verified (R5, R87, R148, R249 & R294 did not have documented interpretation or induration of the TST. A review of the facility policy dated 2013, titled Screening, read, "TST documentation for residents should include the date (i.e., month, day, year). the number of millimeters of induration (if no induration, document "0" mm), and interpretation (i.e., positive or negative)." SUGGESTED METHOD OF CORRECTION: The DON or designee could conduct resident screening audits, interventions and monitoring to ensure residents are free from communicable disease. The DON or designee could ensure the staff were educated on the importance of induration and interpretation of tuberculin skin testing. The DON or designee could randomly audit resident's documents to ensure adequate documentation for induration and interpretation. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21426		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were stored and labeled properly for 3 of 45 residents (R332, R123 and R234) reviewed for	21620		

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medication storage.

Findings include:

During observations of multiple medication storage areas throughout the facility, medications for R332, R123 and R234, which included eye drops, ear drop and insulins, lacked dates to indicate when they were opened.

During the medication storage tour on 2/3/16, at 9:10 a.m. with registered nurse (RN)-A, in the transition care unit team 3 medication cart, multiple opened, used and undated medication bottles were stored in medication carts.
Observations included the following:
R332's Azelastine (redness of eye) eye drop bottle was opened, used and was undated.
R332's Ciprodex (for infection) ear drop bottle was opened, used and was undated.
R123's Lantus (for diabetes) insulin vial was opened, used and was undated.

On 2/3/16, at 9:17 a.m. RN-A verified the medications needed to be labeled and stored properly. RN-A added that opened medications should be dated when opened and stated she will removed from medication cart, disposed properly and reorder them.

During the medication administration on 2/3/16, at 9:41 a.m., with LPN-A, the third floor south medication storage cart was reviewed. The following observation was made:
R234's Latanoprost (anti-glaucoma) eye drop bottle was opened, used and was undated.

On 2/3/16, at 9:41 a.m. LPN-A verified the medications should be labeled and stored properly. LPN-A added that opened medications

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should be dated when opened and will removed and reorder new ones.

On 2/3/16, at 10:30 a.m. the director of nursing (DON) explained that staff were supposed to date medication bottles and vials when opened. In addition, the DON indicated that staff should follow policies and pharmacy recommendations.

Undated Medication storage and expiration guidelines, directed, "insulin 10 ML (milliliter) vials opened - room temperature, 28 days after 1st use, date when open yes. Xalatan eye drops opened - room temperature, 45 days after 1st use, date when open yes."

Policy and procedure titled EXPIRATION AND BEYOND-USE DATING, dated 1/27/15, reads, "D. Certain medications have beyond-use dates specified by the manufacturer that are dependent on storage conditions and/or date of this use. (see chart for example). Nursing staff will write date of first use on the container label for these specified medications."

SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of labeling medications properly and discarding expired medications. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty one (21) days.

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21685	Continued From page 20	21685		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, and interview, the facility failed to ensure cupboards and/or drawers in 4 of 6 kitchenettes were maintained in good repair. This had the potential to affect 100 of 165 residents residing in the facility. Findings include: During the final kitchen tour on 2/4/16, from 9:35 a.m. to 10:25 a.m. the wood finishes of lower kitchenette cabinets in the 3 North, 3 South, and 2 West units were noted to be worn down to the raw wood in some places. In the 3 North dining room the inside bottom of 3 of 5 drawers were worn down to the raw wood, making the surface uncleanable. The director of nutritional services stated at 10:05 a.m. that maintenance would look at the cupboards and see about having them cleaned and refinished. The facility was unable to provide a preventative maintenance schedule for the kitchenette	21685		

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cabinets.

SUGGESTED METHOD OF CORRECTION: The administrator or designee, could ensure the kitchenette cabinets were cleaned and refinished; and the inside of the kitchenette drawers were refinished to ensure a cleanable surface. The administrator could coordinate with nursing, dietary, maintenance and/or housekeeping staff to conduct periodic audits of the kitchenettes to ensure the cabinets were kept clean and in good repair.

TIME PERIOD FOR CORRECTION: Thirty (30) days.

21695 — MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance — 21695

Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings.

This MN Requirement is not met as evidenced by:
Based on observation, and interview, the facility failed to ensure cupboards and/or drawers in 4 of 6 kitchenettes were kept clean. This had the potential to affect 100 of 165 residents residing in the facility.

Findings include:

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During the final kitchen tour on 2/4/16, from 9:35 a.m. to 10:25 a.m. the lower cabinet doors of the 3 North and 2 West units had white spots/spills down the front of the doors.

In the 1 West dining room the lower corners of 3 of 6 upper kitchenette cabinets were sticky to the touch and a debris was noted on the fingers after touching the cabinet corners. The director of nutritional services touched the corners of the cabinets, stated they were sticky and asked the housekeeper in the room to clean the cabinets.

The director of nutritional services stated at 10:05 a.m. that it was housekeeping's responsibility to clean the outside of the kitchenette cabinets.

The facility was unable to provide a preventative maintenance or cleaning schedule for the kitchenette cabinets.

SUGGESTED METHOD OF CORRECTION: The administrator or designee, could ensure the kitchenette cabinets were cleaned. The administrator could coordinate with nursing, dietary, maintenance and/or housekeeping staff to conduct periodic audits of the kitchenettes to ensure the cabinets were kept clean.

TIME PERIOD FOR CORRECTION: Thirty (30) days.

21710 — MN Rule 4658.1415 Subp. 7 Plant Housekeeping, Operation, & Maintenance — 21710

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Subp. 7. Hot water temperature. Hot water supplied to sinks and bathing fixtures must be maintained within a temperature range of 105 degrees Fahrenheit to115 degrees Fahrenheit at the fixtures.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to maintain water temperatures within acceptable limits for 3 of 4 resident rooms reviewed, rooms 118, 236 and 319.

Findings include:

An environmental tour was completed on 2/3/16, between 3:30 p.m. and 4:30 p.m. with the maintenance supervisor (MS). The following water temperatures were noted in resident bathroom sinks, using the facility water thermometer: room 118: 116.7 F [degrees Fahrenheit]; room 236: 117.1 F and room 319: 116.6 F. MS confirmed findings. MS reported the facility completed audits for hot water in resident rooms and provided a log for surveyor. However, MS reported the facility allowed an upper limit of 120 F. MS reported he would adjust the hot water system so water would reach an upper limit of 115 F in resident rooms and bathrooms.

The Water Temperature Policy, last revised 3/12/15, directed staff: "The water temperatures for all public areas, resident rooms (including tubs and showers) will stay in a range of 105 degrees to 115 degrees Fahrenheit."

SUGGESTED METHOD OF CORRECTION:
The maintenance supervisor, administrator or

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	7012 LAKE ROAD WOODBURY, MN 55125

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21710	Continued From page 24 designee could review and revise policies and procedures related to ensuring hot water supplied to sinks and bathing fixtures is maintained within a temperature range of 105 degrees Fahrenheit to115 degrees Fahrenheit at the fixtures.The maintenance supervisor, administrator or designee could develop a system to educate staff and develop a monitoring system to ensure hot water supplied to sinks and bathing fixtures is maintained within a temperature range of 105 degrees Fahrenheit to115 degrees Fahrenheit at the fixtures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21710		
21825	MN St. Statute 144.651 Subd. 9 Patients & Residents of HC Fac.Bill of Rights Subd. 9. Information about treatment. Residents shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the residents can reasonably be expected to understand. Residents may be accompanied by a family member or other chosen representative, or both. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a resident's medical record, the information shall be given to the resident's guardian or other person designated by the resident as a representative. Individuals have the right to refuse this information. Every resident suffering from any form of	21825		

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21825	Continued From page 25	21825		

breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of treatments and the risks associated with each of those methods.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to obtain informed consent from R161's family decision makers, (F)-A, prior to the initiation of occupational therapy for 1 of 1 resident reviewed for informed consent, (R161).

Findings include:

Review of R161's most recent annual minimum data set (MDS), dated 10/21/15, revealed R161 was significantly cognitively impaired.

During interview on 2/1/16, at 7:04 p.m., F-A reported he was a designated decision maker for health and financial matters for R161. F-A reported he received an explanation of benefit form which indicated he owed over $90 for occupational therapy (OT) for the month of November. F-A then reported he found out he would get similar statements for December and January. F-A reported he was not aware R161 was receiving occupational therapy until he was told by the facility to come down and sign a form that it was ending and received a form in the mail stating R161 would owe over $90 for OT in

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21825	Continued From page 26 November . F-A reported he had heard R161 was getting new silverware from OT, but had no idea the extent of services R161 was receiving or that it would be several sessions of OT during November, December and January. F-A reported he would want to be fully informed in advance of any rehabilitation services prior to initiation and had told the facility this after a similar incident occurred about a year prior. F-A reported if R161 needed rehabilitation therapy, he wanted her to have it, but he wanted enough information to make that determination. On 2/3/16, at 12:48 p.m. the director of rehabilitation therapy (DRT) explained she was just informed after R161's care conference a day or so ago that F-A had expressed concerns about not being fully informed about R161's receiving OT. DRT reported R161 received OT services to improve self feeding ability in November, December and January. DRT confirmed the rehabilitation therapy staff had not obtained informed consent for OT prior to initiation of services. DRT reported she would expect staff to obtain informed consent from the resident or the resident decision makers prior to the start of rehabilitation therapy services. DRT reported she had recently discussed this with her staff after learning of F-A's concern. However, this was not documented. DRT reported she discovered rehabilitation therapy staff were not routinely getting informed consent prior to starting services. There was no formal process in place to ensure informed consent was obtained prior to the start of rehabilitation services. DRT reported, to her knowledge, F-A still needed to use R161's funds to pay the co-pay of over $90 for R161's OT services, even though informed consent was not obtained. A policy on obtaining informed consent prior to initiating rehabilitation therapy	21825		

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21825	Continued From page 27 services was requested but not provided. Review of R161's admission record, printed 2/4/16, revealed F-A was the primary decision maker for R161's financial and care decisions. Another family member was noted as an emergency contact, but not a decision maker. Review of R161's OT Plan of Care, Therapist Progress and Updated Plan of Care and Therapist Progress and Discharge Summary, dated 11/10/15 to 1/18/16 revealed R161 received OT services to improve self feeding ability between those dates. Review of a Concern and/or Questions Form, undated revealed a hand written note: "Therapy: See attached therapy charge understand there will be more for Dec and Jan-Please let me know when therapy is provided in the future. This is a surprise! [F-A-phone number]. Attached was an Explanation of Benefits, dated 1/9/16 with 10 claims for OT services between 11/10/15 and 11/23/15. R161 was responsible for paying $94.75 for these services. A handwritten note read "Surprise! 2 months later." On 2/11/16, the facility sent an email and attachment with an OT care plan, dated 11/10/15, effective 11/10/15 until 12/7/15. The OT care plan noted "Treatment Plan, including benefits, risks and alternatives discussed with patient and/or family, who agree to treatment." However, the note did not indicate the individual that gave informed consent and the date and time it was received. The note did not indicate OT obtained informed consent from R161's designated decision maker for healthcare and financial matters, (F)-A. The note did not indicate how F-A was informed of the treatment plan, risks,	21825		

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benefits and alternatives and what plan, risks, benefits and alternatives were discussed to ensure it was in a manner F-A could understand. There was no documentation indicating F-A was given updates on updated plans of care, dated 12/8/15, 12/28/15 and 1/18/16 since initiation on 11/10/15 and ending 1/18/16.

SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing or designee could review and/or revise current policy and procedure regarding informed consent with education to staff provided on current or revised policy and procedures regarding informed consent. The administrator, director of nurses or designee would initiate a program to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On February 1, 2, 3, 4, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify the presence of hand contractures in the care plan for 1 of 2 residents reviewed for range of motion, (R181). Findings include: R181's most recent comprehensive minimum data set [MDS], a significant change assessment completed on 9/16/15, revealed R181 had functional impairment in range of motion (ROM) in both upper extremities. The 12/9/15, quarterly MDS revealed no functional impairment in range of motion in the upper extremities. The 12/9/15, MDS revealed R181 had short and long term memory problems and significant impairment in decision making ability.	2 560	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that: 1. With respect to resident R181 the care plan was revised regarding the resident's contractures and interventions as indicated. 2. All residents with contractures will have there care plans reviewed to assure the contractures have been addressed along	3/15/16

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2 560	Continued From page 3 On 2/2/16, at 11:19 a.m. the registered nurse unit manager, (RN)-B, reported R181 had a contracture in her hand and was not receiving range of motion services and did not have a splint device in place. On 2/3/16, at 1:43 p.m. surveyor made observations of R181 with RN-B. RN-B gently attempted to uncurl R181's left hand, which was contracted with fingers in toward the palm. R181 said "ouch" and RN-B stopped attempting to uncurl R181's hand. On 2/3/16, at 1:43 p.m. RN-B and RN-C, who was responsible for completion of the MDS and care plan reviewed R181's care plan and reported R181's contractures were not addressed. RN-B reported it was determined R181 would not benefit from range of motion services or a splint device due to it not causing her pain or impairing her significantly at this point since staff provided almost all cares for R181. RN-B reported R181 developed the contracture in August after a fall at the facility. RN-B and RN-C were unable to find any documentation in the medical record related to the facility's interdisciplinary team decision making process to not pursue range of motion or splint services for R181 and what were appropriate goals and interventions related to R181's left hand contracture. RN-C reported she was unsure if the most recent quarterly MDS, dated 12/9/15, should have indicated no functional impairment in ROM. A review of R181's care plan, last revised 12/15/15, revealed no indication R181's left hand contracture was addressed in the plan of care The Care Plan Completion Policy, last revised 8/2013 directed staff to include "Functional	2 560	with the appropriate intervention. 3. All licensed nursing staff will be re-educated by March 15, 2016 regarding revisions to care plans when a change of condition occurs. 4. The Director of Nursing and/or designee will audit 5 resident care plans each week for one month and then 3 resident care plans a week for two months to assure care plans are accurate and reflect resident conditions. 5. The data collected will be presented at QAPI by the Director of Nursing. The data will be reviewed/discussed and decision/recommendations made regarding any necessary follow up studies.	

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2 560	Continued From page 4 Limitations in ROM" in the care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate interventions for all identified care needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for the provision of activities of daily living for 1 of 3 residents (R105) dependent on staff for completion of ADL's. Findings include: The care plan revised on 4/11/14, revealed R105 had cognitive loss, with deficits in memory, judgement, decision making and thought processes. The care plan directed staff R105 could be resistive with cares and required one	2 565	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that: 1. With respect to R105, the Nurse	3/15/16

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2 565	Continued From page 5 staff to assist with completing grooming needs. The care plan did not indicate R105 did not mind chin whiskers. On 2/1/16, at 5:45 p.m. approximately 1/8-1/4th inch long hairs were noted on the resident's chin and corners of the mouth. The chin hairs were still present on 2/2/16, at 8:26 a.m.; on 2/3/16, at 8:26 a.m.; and on 2/4/16, at 8:34 a.m. On 2/4/16, at 8:59 a.m. nursing assistant (NA)-Z stated R105 had a bath on Saturday evenings, but NA-Z had not given R105 a bath that evening. NA-Z state R105 had been on NA-Z's assignment list for 2/3 and 2/4/16, and had not attempted to remove R105's chin hairs on these dates. NA-Z stated R105 would "fight" when shaved but would try to remove the chin hairs today if the resident would allow it. NA-Z verified the presence of the chin hairs at this time. The facility's policy titled Functional Maintenance Program, dated 4/15, indicated functional maintenance programs were to be initiated to assist to maintain a resident's highest practicable level of function and well-being. The policy included the provision of grooming for residents. SUGGESTED METHOD OF CORRECTION: The director of nurses or designee should review resident care plans to ensure the care plans were an accurate reflection of the services required by the resident. Nursing staff could then be educated on ensuring care was provided to residents in accordance with each resident's care plan. Audits of care plans and observation of cares could be conducted to ensure care was provided according	2 565	Manager is working with the staff to develop a routine for grooming the resident, re-approaching or obtaining the assistance of the nurse when resident refuses. The resident care plan and nursing assistant assignment sheet have been updated accordingly. 2. All residents have been reviewed for refusal of grooming and a plan of care established for approaches to promote a routine for shaving that best meets the residents needs. The NAR assignment sheet and resident care plan have been revised as indicated. 3. All nursing staff will receive education by March 15, 2016 regarding managing challenges during grooming and interventions/approaches to ensure each individuals needs are met. 4. The Director of Nursing and/or designee will audit 5 resident care plans each week for one month and 3 resident care plans each week for 2 months to assure care plans have been revised to reflect any resident changes. 5. The data collected will be presented at QAPI by the Director of Nursing. The data will be reviewed/discussed and decision/recommendations made regarding any necessary follow up studies.	

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2 565	Continued From page 6 to the care plan. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the care plan was revised for 1 of 3 residents (R105) with a limited range of motion. Findings include: On 2/2/16, at 9:26 a.m. R105 was observed sitting in a Broda chair with both hands lightly clenched together in a fist. No splints or other devices were noted in the resident's hands or nearby. On 2/3/16, at 8:26 a.m. R105 was observed holding a glass in the right hand and independently drank from the glass. R105 was also observed to use the left hand, pointer finger	2 570	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that: 1. With respect to R105, the care plan was revised regarding the residents limited ROM and interventions as	3/15/16

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2 570	Continued From page 7 to scratch left ear. However, R105 did not entirely open the hand. There was no splint or cloth in R105's left hand. On 2/2/16, at 9:14 a.m. registered nurse (RN)-B stated the facility has tried hand splints for R105 in the past and R105 would remove them right away. On 2/3/16, at 3:32 p.m. RN-B stated staff would put cloths in R105's hands. RN-B was informed at this time there were no cloths in R105's hands, and was asked about range of motion (ROM) to R105's left hand. RN-B stated R105 had been on hospice at one time and the hospice staff did not want ROM or anything which would cause R105 pain; and ROM to R105's had was "very painful." On 2/4/16, at 8:57 a.m. nursing assistant (NA)-Z stated R105 would allow staff to wash R105's hands, and did not complain of pain when the hands were washed. NA-Z stated that gentle ROM to the left hand during cares if R105 would allow it. NA-Z stated R105 would not allow a cloth to remain in the hand, as staff had tried that and R105 would remove the cloth. The most recent care plan dated/revised on 4/11/14, indicated R105 would hold both hands tight, didn't extend all digits consistently or purposefully; had received occupational therapy (OT) services; refused to wear splints, as they caused increased agitation; and nursing staff were to complete recommendations from OT, which according to the care plan had been provided on 1/17/14. When the care plan was reviewed with RN-B on 2/3/16, at 3:32 p.m. and RN-B was asked why the care plan did not address putting a cloth in	2 570	indicated. 2. All residents with contractures will have there care plans reviewed to assure the contractures have been addressed along with the appropriate intervention. 3. All licensed staff will be re-educated by March 15, 2016 regarding revisions to care plans with any change in status and orders. 4. The Director of Nursing and/or designee will audit 5 resident care plans each week for one month and 3 resident care plans each week for 2 months to assure care plans have been revised to reflect any resident changes. 5. The data collected will be presented at QAPI by the Director of Nursing. The data will be reviewed/discussed and decision/recommendations made regarding any necessary follow up studies.	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 570	Continued From page 8 R105's left hand or that the resident would take the cloths out. RN-B stated the hospice care plan had indicated ROM was not to be completed. The hospice care plan dated 12/8/14, was reviewed and indicated passive ROM was to be done to all extremities, except the right arm, which had a fractured ulna. The facility's policy titled Care Plan Completion and revised 8/13, indicated a resident's care plan was to be updated/revised as changes occur. SUGGESTED METHOD OF CORRECTION: The director of nurse or designee should review and revise the care plan for residents with limitation in range of motion to ensure the appropriate services were provided to maintain and/or improved range of motion. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 570		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate	2 920	The preparation of the following plan of correction of this deficiency does not	3/15/16

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2 920	Continued From page 9 grooming to 1 of 3 residents (R105) dependent on staff for completion of activities of daily living (ADL.) Findings include: On 2/1/16, at 5:45 p.m. approximately 1/8-1/4th inch long hairs were noted on the resident's chin and corners of the mouth. The facial hairs were still present on 2/2/16, at 8:26 a.m.; on 2/3/16, at 8:26 a.m.; and on 2/4/16, at 8:34 a.m. On 2/4/16, at 8:59 a.m. nursing assistant (NA)-Z stated R105 had a bath on Saturday evenings, but NA-Z had not given R105 a bath that evening. NA-Z stated R105 had been on NA-Z's assignment list for 2/3 and 2/4/16, and had not attempted to remove R105's chin hairs on these dates. NA-Z stated R105 would "fight" when shaved but would try to remove the chin hairs today if the resident would allow it. NA-Z verified the presence of the chin hairs at this time. On 2/3/16, at 3:40 p.m. a family member stated not being able to provide information as to whether or not the facial hair would bother R105. On 2/3/16, at 3:47 p.m. a message was left for R105's conservator to determine if the facial hair would bother R105, however, the conservator was unable to be interviewed. The facility's policy titled Functional Maintenance Program, dated 4/15, indicated functional maintenance programs were to be initiated to assist to maintain a resident's highest practicable level of function and well-being. SUGGESTED METHOD OF CORRECTION: The director of nurses or designee should review	2 920	constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that: 1. With respect to R105, the Nurse Manager is working with the staff to develop a routine for shaving the resident, re-approaching or obtaining the assistance of the nurse when resident refuses. The resident care plan and nursing assistant assignment sheet have been updated accordingly. 2. All residents have been reviewed for refusal of shaving and a plan of care established for approaches to promote a routine for shaving that best meets the residents needs. The NAR assignment sheet and resident care plan have been revised as indicated. 3. All nursing staff will receive education by March 15, 2016 regarding managing challenges during grooming and interventions/approaches to ensure each individuals needs are met. 4. The Director of Nursing and/or designee will complete 5 resident audits each week for one month and 3 resident audits each week for two months to assure care of the individual resident is being completed according to the individual plan of care. 5. The data collected will be presented at QAPI by the Director of Nursing. The data will be reviewed/discussed and	

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2 920	Continued From page 10 resident care plans to ensure the care plans were an accurate reflection of the services required by the resident. Nursing staff could then be educated on ensuring care was provided to residents in accordance with each resident's care plan. Audits of care plans and observation of cares could be conducted to ensure care was provided according to the care plan. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 920	decision/recommendations made regarding any necessary follow up studies.	
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure routine dental services were provided to 1 of 3 residents (R105) on an annual basis to ensure there were no dental issues. Findings include: On 2/2/16, at 9:33 a.m. R105 was observed to have several lower front teeth missing. On 2/3/16,	21325	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the	3/15/16

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21325	Continued From page 11	21325		

at 8:39 a.m. R105 was observed to feed self bite size pieces of an omelet and toast. There were no problems noted with chewing or swallowing.

The care plan revised on 1/17/14, indicated R105 was to be referred to the dentist as needed; the resident would grind their teeth; and staff were to assess/observe for mouth and tooth issues. Another portion of the care plan revised on 9/21/15, noted R105 had some natural teeth missing, staff performed oral care, as R105 did not participate, but was cooperative; and refer to dentist as needed. However, the care plan did not indicate R105 was not to see the dentist for annual oral exams.

A dental agreement with the facility's contract dental service revealed the conservator had signed the form on 10/11/12, which authorized the consulting dental service to provide comprehensive and periodic oral evaluation. There was no indication on the form that the conservator did not want the resident to see the dentist.

A review of the consult section of the medication record did not indicate R105 had seen a dentist since the dental agreement had been signed on 10/11/12.

On 2/3/16, at 3:22 p.m. registered nurse (RN)-C stated they would check the thinned medical record for any documentation regarding dental visits. By 2/4/16, at 1:00 p.m. RN-C had not been able to find any documentation of a dental visit.

On 2/4/16, at 11:30 a.m. health unit coordinator (HUC)-A stated there had been a dental screening of R105 at the time the dental agreement had been signed, and the facility was

forgoing statement, the facility states that:

1. With respect to R105, an oral screen was completed and dental recommendations presented to the family for making determination for treatment.
2. All resident records have been audited by Health Information to ensure they have been offered dental care/services within the past 12 months.
3. All Health Information staff will be re-educated by March 15, 2016 regarding the guidelines and process for dental visits and other ancillary services.
4. The Director of Nursing and/or designee will complete 2 resident chart audits each week for one month and then one resident chart audit each week for two months to assure dental services are offered and obtained as requested.
5. The data collected will be presented at QAPI by the Director of Nursing. The data will be reviewed/recommendations made regarding any necessary follow up studies.

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21325	Continued From page 12 trying to find the screening. HUC-A stated the contracting dental service did not keep dental screenings, but provided the documentation to the facility. HUC-A stated R105 had not had any dental issues that they were aware of. On 2/4/16, at 8:59 a.m. nursing assistant (NA)-Z stated R105 was resistive with oral cares, but was not having any problems with chewing or swallowing. The facility's Dental Services policy, revised 8/13, indicated annual dental services and dental services as indicated were to be provided to residents. SUGGESTED METHOD OF CORRECTION: The director of nurses or designee could contact the resident's legal representative to determine if the annual dental services were to be provided or if dental services were only to be provided after contacting the legal representative. The nursing staff should be made aware of all resident's dental needs and how to ensure dental services were provided on an annual basis. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21325		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		3/15/16

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21375	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure hand hygiene was provided for 2 of 4 residents (R161, R96) observed during cares and failed to ensure the mechanical stand lift was sanitized between uses. Findings include: On 2/3/16, at 10:21 a.m., nursing assistant, (NA)-E, was observed to don gloves and assist R161 with standing using the mechanical stand lift. R161 grabbed the handles as she stood. NA-E assisted R161 to sit on the toilet after removing the disposable brief. R161 urinated in the toilet. NA-E used disposable wipes to clean R161, assisted R161 with applying a brief and to stand by holding the handles of the mechanical stand lift. NA-E then assisted R161 to sit down in her wheelchair. NA-E removed gloves, and without washing or sanitizing hands, opened the door to R161's room, took the mechanical stand lift to the storage room and opened the door with unwashed hands, and pushed the mechanical stand lift into the storage room. NA-E then proceeded to open the door to R96's room, using unwashed hands, and began to make R96's bed by straightening out the linens and blankets. NA-E did not sanitize the mechanical stand lift after assisting R161 with using the toilet. Sanitizing wipes were attached to the mechanical stand lift. When asked at this time when NA-E had last washed or sanitized his hands, NA-E reported he performed hand hygiene prior to assisting R161 with using the toilet. NA-E then continued to straighten out R96's bed linens with unwashed hands. NA-E reported he did not sanitize the mechanical stand lift after use and prior to putting in storage.	21375	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that: 1. Staff immediately sanitized the mechanical standing device and residents hands. 2. With respect to identified employee, education was provided to ensure proper hand washing and cleaning of equipment was provided between resident cares on February 3, 2016. 3. All staff will be re educated regarding hand washing and disinfecting resident equipment between resident use by March 15, 2016 4. The Director of Nursing and/or designee will audit 5 resident cares each week for one month and 3 resident cares each week for 2 months to assure proper hand washing and disinfection of equipment is occurring. 5. The data collected will be presented in QAPI by the Director of Nursing. The data will be reviewed/discussed and decision/recommendations made regarding any necessary follow up studies.	

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21375	Continued From page 14 On 2/3/16, at 10:36 a.m. the registered nurse floor manager, (RN)-B, reported staff should perform hand hygiene after assisting a resident with using the toilet and should clean and sanitize the mechanical stand prior to returning it to storage as someone might need to use it right away. The Hand Washing Policy, last revised 8/2013, directed staff "Handwashing involves five simple and effective steps (Wet, Lather, Scrub, Rinse, Dry) to reduce the spread of diarrheal and respiratory illness. Regular handwashing, particularly before and after certain activities, is one of the best ways to remove germs, avoid getting sick, and prevent the spread of germs to others." The policy also directed staff that hand sanitizer may be used if hands were not visibly soiled. The Mechanical Lift Policy, last revised 12/2013, directed staff "21. Wipe handles of the mechanical lift with a germicidal cloth." after use. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee would review and revise the policy and procedures related to infection control concerns while passing medications, performing wound care, perinal cares and provide education to staff members. A monitoring system could be developed to ensure staff are providing cares as directed and report the results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		

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21426	Continued From page 15	21426		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to document the interpretation and induration results of tuberculin skin test (TST) for 5 of 5 residents (R5, R87, R148, R249 & R294) reviewed. Findings include: R5 was admitted to the facility on 5/22/15. R5's medical record indicated R5 received the first dose step of Tubersol Solution 5 unit/0.1 milliliter (ML) intradermally on 5/22/15. There were no	21426	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that:	3/15/16

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21426	Continued From page 16 documents to indicate the interpretation or induration of the TST given on 5/22/15. Furthermore, a second dose step of Tubersol Solution 5 unit/0.1 milliliter (ML) intradermally was given on 6/3/15, and there was no documents to indicate the interpretation or induration of the TST given on 6/3/15. R87 was admitted to the facility on 9/30/15. R87's medical record indicated R87 received the first dose step of Tubersol Solution 5 unit/0.1 milliliter (ML) intradermally on 9/30/15. There were no documents to indicate the interpretation or induration of the TST given on 9/30/15. Furthermore, a second dose step of Tubersol Solution 5 unit/0.1 milliliter (ML) intradermally was given on 10/10/15, and there was no documents to indicate the interpretation or induration of the TST given on 10/10/15. R148 was admitted to the facility on 10/18/15. R148's medical record indicated R148 received the first dose step of Tubersol Solution 5 unit/0.1 milliliter (ML) intradermally on 10/18/15. There were no documents to indicate the interpretation or induration of the TST given on 10/18/15 R249 was admitted to the facility on 10/12/15. R249's medical record indicated R249 received the first dose step of Tubersol Solution 5 unit/0.1 milliliter (ML) intradermally on 10/12/15. There were no documents to indicate the interpretation or induration of the TST given on 10/12/15. R294 was admitted to the facility on 11/2/15. R294's medical record indicated R294 received the first dose step of Tubersol Solution 5 unit/0.1 milliliter (ML) intradermally on 11/2/15. There were no documents to indicate the interpretation or induration of the TST given on 11/2/15.	21426	1. With respect to the identified residents, screens and 2 step mantoux process was initiated for residents R5, R87, R148, R249, and R 294. 2. All new admissions for the current month have been reviewed to assure proper screening, TST administration and interpretation of results had occurred. 3. All licensed staff has received education regarding procedure for TB screening including symptoms, risk factors, testing, interpretation of results. Education will be completed by March 15, 2016. 4. The Director of Nursing and/or designee will audit 2 newly admitted residents each week for one month and then 1 newly admitted resident for 2 months to assure proper implementation of the TB screening program has occurred. 5. The data collected will be presented in the QAPI meeting by the Director of Nursing. The data will be reviewed/discussed and decision/recommendations made regarding any follow up studies.	

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21426	Continued From page 17 When interviewed on 2/4/15, at 11:00 a.m. registered nurse (RN)-E verified (R5, R87, R148, R249 & R294 did not have documented interpretation or induration of the TST. A review of the facility policy dated 2013, titled Screening, read, "TST documentation for residents should include the date (i.e., month, day, year). the number of millimeters of induration (if no induration, document "0" mm), and interpretation (i.e., positive or negative)." SUGGESTED METHOD OF CORRECTION: The DON or designee could conduct resident screening audits, interventions and monitoring to ensure residents are free from communicable disease. The DON or designee could ensure the staff were educated on the importance of induration and interpretation of tuberculin skin testing. The DON or designee could randomly audit resident's documents to ensure adequate documentation for induration and interpretation. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21426		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were stored and labeled properly for 3 of 45 residents (R332, R123 and R234) reviewed for	21620	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the	3/15/16

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21620	Continued From page 18 medication storage. Findings include: During observations of multiple medication storage areas throughout the facility, medications for R332, R123 and R234, which included eye drops, ear drop and insulins, lacked dates to indicate when they were opened. During the medication storage tour on 2/3/16, at 9:10 a.m. with registered nurse (RN)-A, in the transition care unit team 3 medication cart, multiple opened, used and undated medication bottles were stored in medication carts. Observations included the following: R332's Azelastine (redness of eye) eye drop bottle was opened, used and was undated. R332's Ciprodex (for infection) ear drop bottle was opened, used and was undated. R123's Lantus (for diabetes) insulin vial was opened, used and was undated. On 2/3/16, at 9:17 a.m. RN-A verified the medications needed to be labeled and stored properly. RN-A added that opened medications should be dated when opened and stated she will removed from medication cart, disposed properly and reorder them. During the medication administration on 2/3/16, at 9:41 a.m., with LPN-A, the third floor south medication storage cart was reviewed. The following observation was made: R234's Latanoprost (anti-glaucoma) eye drop bottle was opened, used and was undated. On 2/3/16, at 9:41 a.m. LPN-A verified the medications should be labeled and stored properly. LPN-A added that opened medications	21620	facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that: 1. With respect to residents R123,R234, R332; medications were removed from the storage areas and disposed of properly. 2. All medication storage areas have been inspected for proper compliance with handling, storage and dating of opened medications. All medications not in compliance have been disposed of according to facility protocol. 3. Processes have been developed for periodic inspection of the medication storage areas for cleanliness, proper storage and disposal. All licensed staff/trained medication aides will be re educated regarding medication expiration and storage guidelines by March 15, 2016 4. The Director of Nursing and/or designee will audit 3 medication storage areas each week for one month and 2 medication storage areas each week for 2 months to assure proper storage, dating and disposal of expired medications. 5. The data collected will be presented in QAPI by the Director of Nursing. The data will be reviewed/discussed and decision/recommendations made regarding any follow up studies.	

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21620	Continued From page 19 should be dated when opened and will removed and reorder new ones. On 2/3/16, at 10:30 a.m. the director of nursing (DON) explained that staff were supposed to date medication bottles and vials when opened. In addition, the DON indicated that staff should follow policies and pharmacy recommendations. Undated Medication storage and expiration guidelines, directed, "insulin 10 ML (milliliter) vials opened - room temperature, 28 days after 1st use, date when open yes. Xalatan eye drops opened - room temperature, 45 days after 1st use, date when open yes." Policy and procedure titled EXPIRATION AND BEYOND-USE DATING, dated 1/27/15, reads, "D. Certain medications have beyond-use dates specified by the manufacturer that are dependent on storage conditions and/or date of this use. (see chart for example). Nursing staff will write date of first use on the container label for these specified medications." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of labeling medications properly and discarding expired medications. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		

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21685	Continued From page 20	21685		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, and interview, the facility failed to ensure cupboards and/or drawers in 4 of 6 kitchenettes were maintained in good repair. This had the potential to affect 100 of 165 residents residing in the facility. Findings include: During the final kitchen tour on 2/4/16, from 9:35 a.m. to 10:25 a.m. the wood finishes of lower kitchenette cabinets in the 3 North, 3 South, and 2 West units were noted to be worn down to the raw wood in some places. In the 3 North dining room the inside bottom of 3 of 5 drawers were worn down to the raw wood, making the surface uncleanable. The director of nutritional services stated at 10:05 a.m. that maintenance would look at the cupboards and see about having them cleaned and refinished. The facility was unable to provide a preventative maintenance schedule for the kitchenette	21685	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that: 1. With respect to the identified kitchen cabinets, all identified cabinets have been cleaned and repaired. 2. Environmental Rounds have been conducted to identify any items in need of repair. 3. All staff will be re educated regarding reporting items in need of repair by March 15, 2016 4. The Director of Maintenance and/or designee will complete audits weekly for 3 months and then on a monthly basis to make needed repairs or schedule larger	3/15/16

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21685	Continued From page 21 cabinets. SUGGESTED METHOD OF CORRECTION: The administrator or designee, could ensure the kitchenette cabinets were cleaned and refinished; and the inside of the kitchenette drawers were refinished to ensure a cleanable surface. The administrator could coordinate with nursing, dietary, maintenance and/or housekeeping staff to conduct periodic audits of the kitchenettes to ensure the cabinets were kept clean and in good repair. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21685	projects. 5. The data collected will be presented at QAPI by the Director of Maintenance. The data will be reviewed/discussed and decision/recommendations will be made regarding any necessary follow up studies.	
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, and interview, the facility failed to ensure cupboards and/or drawers in 4 of 6 kitchenettes were kept clean. This had the potential to affect 100 of 165 residents residing in the facility. Findings include:	21695	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of	3/15/16

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21695	Continued From page 22 During the final kitchen tour on 2/4/16, from 9:35 a.m. to 10:25 a.m. the lower cabinet doors of the 3 North and 2 West units had white spots/spills down the front of the doors. In the 1 West dining room the lower corners of 3 of 6 upper kitchenette cabinets were sticky to the touch and a debris was noted on the fingers after touching the cabinet corners. The director of nutritional services touched the corners of the cabinets, stated they were sticky and asked the housekeeper in the room to clean the cabinets. The director of nutritional services stated at 10:05 a.m. that it was housekeeping's responsibility to clean the outside of the kitchenette cabinets. The facility was unable to provide a preventative maintenance or cleaning schedule for the kitchenette cabinets. SUGGESTED METHOD OF CORRECTION: The administrator or designee, could ensure the kitchenette cabinets were cleaned. The administrator could coordinate with nursing, dietary, maintenance and/or housekeeping staff to conduct periodic audits of the kitchenettes to ensure the cabinets were kept clean. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21695	correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that: 1. With respect to the identified kitchen cabinets, all identified cabinets have been cleaned and repaired. 2. Environmental Rounds have been conducted to identify any items in need of repair. 3. All staff will be re educated regarding reporting items in need of repair by March 15, 2016 4. The Director of Maintenance and/or designee will complete audits weekly for 3 months and then on a monthly basis to make needed repairs or schedule larger projects. 5. The data collected will be presented at QAPI by the Director of Maintenance. The data will be reviewed/discussed and decision/recommendations will be made regarding any necessary follow up studies.	
21710	MN Rule 4658.1415 Subp. 7 Plant Housekeeping, Operation, & Maintenance	21710		3/15/16

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21710	Continued From page 23 Subp. 7. Hot water temperature. Hot water supplied to sinks and bathing fixtures must be maintained within a temperature range of 105 degrees Fahrenheit to115 degrees Fahrenheit at the fixtures. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain water temperatures within acceptable limits for 3 of 4 resident rooms reviewed, rooms 118, 236 and 319. Findings include: An environmental tour was completed on 2/3/16, between 3:30 p.m. and 4:30 p.m. with the maintenance supervisor (MS). The following water temperatures were noted in resident bathroom sinks, using the facility water thermometer: room 118: 116.7 F [degrees Fahrenheit]; room 236: 117.1 F and room 319: 116.6 F. MS confirmed findings. MS reported the facility completed audits for hot water in resident rooms and provided a log for surveyor. However, MS reported the facility allowed an upper limit of 120 F. MS reported he would adjust the hot water system so water would reach an upper limit of 115 F in resident rooms and bathrooms. The Water Temperature Policy, last revised 3/12/15, directed staff: "The water temperatures for all public areas, resident rooms (including tubs and showers) will stay in a range of 105 degrees to 115 degrees Fahrenheit." SUGGESTED METHOD OF CORRECTION: The maintenance supervisor, administrator or	21710	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that: 1. With respect to water temperatures; the Director of Maintenance adjusted the hot water system on February 3, 2016 so the water temperatures would reach an upper limit of 115 degrees Fahrenheit. 2. The water temperature controller was replaced on the hot water tank on 2/11/16. 3. All maintenance staff will receive education regarding the procedure for monitoring and documenting water temperatures daily. Water temperatures not in range are to be reported to the Director of Maintenance immediately. Education will be completed by March 15, 2016 4. The Director of Maintenance will and/or designee will audit water temperature logs weekly to assure temperatures being recorded daily are maintained within range.	

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21710	Continued From page 24 designee could review and revise policies and procedures related to ensuring hot water supplied to sinks and bathing fixtures is maintained within a temperature range of 105 degrees Fahrenheit to115 degrees Fahrenheit at the fixtures.The maintenance supervisor, administrator or designee could develop a system to educate staff and develop a monitoring system to ensure hot water supplied to sinks and bathing fixtures is maintained within a temperature range of 105 degrees Fahrenheit to115 degrees Fahrenheit at the fixtures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21710	5. The data collected will be presented in the QAPI meeting by the Director of Maintenance. The data will be reviewed/discussed and decision/recommendations made for follow up studies.	
21825	MN St. Statute 144.651 Subd. 9 Patients & Residents of HC Fac.Bill of Rights Subd. 9. Information about treatment. Residents shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the residents can reasonably be expected to understand. Residents may be accompanied by a family member or other chosen representative, or both. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a resident's medical record, the information shall be given to the resident's guardian or other person designated by the resident as a representative. Individuals have the right to refuse this information. Every resident suffering from any form of	21825		3/15/16

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21825	Continued From page 25 breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of treatments and the risks associated with each of those methods. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to obtain informed consent from R161's family decision makers, (F)-A, prior to the initiation of occupational therapy for 1 of 1 resident reviewed for informed consent, (R161). Findings include: Review of R161's most recent annual minimum data set (MDS), dated 10/21/15, revealed R161 was significantly cognitively impaired. During interview on 2/1/16, at 7:04 p.m., F-A reported he was a designated decision maker for health and financial matters for R161. F-A reported he received an explanation of benefit form which indicated he owed over $90 for occupational therapy (OT) for the month of November. F-A then reported he found out he would get similar statements for December and January. F-A reported he was not aware R161 was receiving occupational therapy until he was told by the facility to come down and sign a form that it was ending and received a form in the mail stating R161 would owe over $90 for OT in	21825	The preparation of the following plan of correction of this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State of Law. Without waiving the forgoing statement, the facility states that: 1. With respect to resident #161, the resident decision maker has been informed of the Occupational Therapy services provided. Facility has offered to refund costs incurred to the family. 2. All residents currently receiving rehab therapies have been reviewed to assure informed consents have been completed with appropriate decision maker. 3. All licensed staff receiving physician orders for rehab therapies will notify resident decision maker of new orders and rationale. All licensed nursing staff will be re-educated by March 15, 2016 regarding	

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21825	Continued From page 26 November . F-A reported he had heard R161 was getting new silverware from OT, but had no idea the extent of services R161 was receiving or that it would be several sessions of OT during November, December and January. F-A reported he would want to be fully informed in advance of any rehabilitation services prior to initiation and had told the facility this after a similar incident occurred about a year prior. F-A reported if R161 needed rehabilitation therapy, he wanted her to have it, but he wanted enough information to make that determination. On 2/3/16, at 12:48 p.m. the director of rehabilitation therapy (DRT) explained she was just informed after R161's care conference a day or so ago that F-A had expressed concerns about not being fully informed about R161's receiving OT. DRT reported R161 received OT services to improve self feeding ability in November, December and January. DRT confirmed the rehabilitation therapy staff had not obtained informed consent for OT prior to initiation of services. DRT reported she would expect staff to obtain informed consent from the resident or the resident decision makers prior to the start of rehabilitation therapy services. DRT reported she had recently discussed this with her staff after learning of F-A's concern. However, this was not documented. DRT reported she discovered rehabilitation therapy staff were not routinely getting informed consent prior to starting services. There was no formal process in place to ensure informed consent was obtained prior to the start of rehabilitation services. DRT reported, to her knowledge, F-A still needed to use R161's funds to pay the co-pay of over $90 for R161's OT services, even though informed consent was not obtained. A policy on obtaining informed consent prior to initiating rehabilitation therapy	21825	the process for notification when receiving new orders. 4. The Director of Nursing and/or designee will audit 3 therapy referrals each week for one month and two therapy referrals each week for two months to assure informed consent has been received on new therapy orders as long as new orders for therapy services have been obtained. 5. The data collected will be presented at QAPI by the Director of Nursing. The data will be reviewed/discussed and decision/recommendations made regarding any necessary follow up studies.	

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21825	Continued From page 27	21825		

services was requested but not provided.

Review of R161's admission record, printed 2/4/16, revealed F-A was the primary decision maker for R161's financial and care decisions. Another family member was noted as an emergency contact, but not a decision maker.

Review of R161's OT Plan of Care, Therapist Progress and Updated Plan of Care and Therapist Progress and Discharge Summary, dated 11/10/15 to 1/18/16 revealed R161 received OT services to improve self feeding ability between those dates.

Review of a Concern and/or Questions Form, undated revealed a hand written note: "Therapy: See attached therapy charge understand there will be more for Dec and Jan-Please let me know when therapy is provided in the future. This is a surprise! [F-A-phone number]. Attached was an Explanation of Benefits, dated 1/9/16 with 10 claims for OT services between 11/10/15 and 11/23/15. R161 was responsible for paying $94.75 for these services. A handwritten note read "Surprise! 2 months later."

On 2/11/16, the facility sent an email and attachment with an OT care plan, dated 11/10/15, effective 11/10/15 until 12/7/15. The OT care plan noted "Treatment Plan, including benefits, risks and alternatives discussed with patient and/or family, who agree to treatment." However, the note did not indicate the individual that gave informed consent and the date and time it was received. The note did not indicate OT obtained informed consent from R161's designated decision maker for healthcare and financial matters, (F)-A. The note did not indicate how F-A was informed of the treatment plan, risks,

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21825	Continued From page 28 benefits and alternatives and what plan, risks, benefits and alternatives were discussed to ensure it was in a manner F-A could understand. There was no documentation indicating F-A was given updates on updated plans of care, dated 12/8/15, 12/28/15 and 1/18/16 since initiation on 11/10/15 and ending 1/18/16. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing or designee could review and/or revise current policy and procedure regarding informed consent with education to staff provided on current or revised policy and procedures regarding informed consent. The administrator, director of nurses or designee would initiate a program to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21825		