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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: T99T

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00260

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245387**
2.STATE VENDOR OR MEDICAID NO.
(L2) **492242500**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST OLAF RESIDENCE**
(L4) **2912 FREMONT AVENUE NORTH**
(L5) **MINNEAPOLIS, MN** (L6) **55411**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/19/2015** (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 **80** (L18)

13.Total Certified Beds **80** (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: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(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): Request for waiver of State Tag 2060 re: bathroom accessibility in Room 107 (MN Rule 4658.4140), has been approved based on the submitted documentation.

17. SURVEYOR SIGNATURE Date :
Kathy Sass, HPR Dietary Specialist 03/20/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/20/2015 (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
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/04/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5387

Electronically Delivered: March 20, 2015

Ms. Mary Hamer, Administrator
St Olaf Residence
2912 Fremont Avenue North
Minneapolis, Minnesota 55411

Dear Ms. Hamer:

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

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

Effective February 23, 2015 the above facility is certified for:

80 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 80 skilled nursing facility beds.

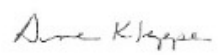
Your request for waiver of State Tag 2060 re: bathroom accessibility in Room 107 (MN Rule 4658.4140), has been approved based on the submitted documentation. If you are not in compliance with the above requirements by October 31, 2015, you will be required to submit a Plan of Correction for the deficiency or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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

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

Please contact me if you have any questions about this electronic notice.

Sincerely,



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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: March 20, 2015

Ms. Mary Hamer, Administrator
St Olaf Residence
2912 Fremont Avenue North
Minneapolis, Minnesota 55411

RE: Project Number S5387024, **Special Focus Facility**

Dear Ms. Hamer:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On February 2, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 15, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On March 19, 2015, the Minnesota Department of Health 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 January 15, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 23, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 15, 2015, effective February 23, 2015 and therefore remedies outlined in our letter to you dated February 2, 2015, will not be imposed.

Correction of the health deficiency cited under State Tag 2060 re: bathroom accessibility in Room 107 (MN Rule 4658.4140) at the time of the January 15, 2015 standard has not yet been verified. Your plan of correction for this deficiency, including your request for a temporary waiver with a date of completion of October 31, 2015, has been approved. Failure to come into substantial compliance with this deficiency by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

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 about this electronic notice.

Sincerely,

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245387	A. Building B. Wing	3/19/2015

Name of Facility	Street Address, City, State, Zip Code
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **02/23/2015**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **02/23/2015**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **02/23/2015**
ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **02/23/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **02/23/2015**	ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **02/23/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **02/23/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **02/23/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **02/23/2015**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **02/23/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **02/23/2015**	ID Prefix **F0366** Reg. # **483.35(d)(4)** LSC	Correction Completed **02/23/2015**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **02/23/2015**	ID Prefix **F0412** Reg. # **483.55(b)** LSC	Correction Completed **02/23/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **02/23/2015**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	03/20/2015	31223	03/19/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245387	A. Building B. Wing	3/19/2015

Name of Facility	Street Address, City, State, Zip Code
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **02/23/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **02/23/2015**	ID Prefix **F0492** Reg. # **483.75(b)** LSC	Correction Completed **02/23/2015**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	03/20/2015	31223	03/19/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 1/15/2015

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: March 20, 2015

Ms. Mary Hamer, Administrator
St Olaf Residence
2912 Fremont Avenue North
Minneapolis, Minnesota 55411

Re: Reinspection Results - Project Number S5387024

Dear Ms. Hamer:

On March 19, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 15, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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 contact me if you have any questions about this electronic notice.

Sincerely,

Anne Kleppe

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

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00260	A. Building B. Wing	3/19/2015

Name of Facility	Street Address, City, State, Zip Code
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 1** LSC	Correction Completed **02/23/2015**	ID Prefix **20570** Reg. # **MN Rule 4658.0405 Subp. 4** LSC	Correction Completed **02/23/2015**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **02/23/2015**
ID Prefix **20965** Reg. # **MN Rule 4658.0600 Subp. 2** LSC	Correction Completed **02/23/2015**	ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp. 1** LSC	Correction Completed **02/23/2015**	ID Prefix **21325** Reg. # **MN Rule 4658.0725 Subp. 1** LSC	Correction Completed **02/23/2015**
ID Prefix **21390** Reg. # **MN Rule 4658.0800 Subp. 4** LSC	Correction Completed **02/23/2015**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Sul** LSC	Correction Completed **02/23/2015**	ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	Correction Completed **02/23/2015**
ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1** LSC	Correction Completed **02/23/2015**	ID Prefix **21565** Reg. # **MN Rule 4658.1325 Subp. 4** LSC	Correction Completed **02/23/2015**	ID Prefix **21685** Reg. # **MN Rule 4658.1415 Subp. 2** LSC	Correction Completed **02/23/2015**
ID Prefix **21810** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **02/23/2015**	ID Prefix **21855** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **02/23/2015**	ID Prefix **22060** Reg. # **MN Rule 4658.4005** LSC	Correction Completed **02/23/2015**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	03/20/2015	31223	03/19/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 1/15/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: T99T

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00260

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245387**
2.STATE VENDOR OR MEDICAID NO.
(L2) **492242500**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST OLAF RESIDENCE**
(L4) **2912 FREMONT AVENUE NORTH**
(L5) **MINNEAPOLIS, MN** (L6) **55411**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/15/2015** (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 **80** (L18)

13.Total Certified Beds **80** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(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 :
Eva Loch, HFE NE II 02/17/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 02/25/2015 (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
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: February 2, 2015

Mr. James Laine, Administrator
St. Olaf Residence
2912 Fremont Avenue North
Minneapolis, Minnesota 55411

RE: Project Number S5387024

Dear Mr. Laine:

St. Olaf Residence is a Special Focus Facility (SFF). On January 15, 2015, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 24, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 15, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human

Services that your provider agreement be terminated by July 15, 2015 (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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Klegge

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING _____ B. WING _____	01/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	**2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411**

(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 St. Olaf Residence is a Special Focus Facility (SFF) and a certification survey was conducted on 12 through January 15, 2015. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal	F 164		2/23/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/12/2015

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 164	Continued From page 1 and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal privacy was provided to 1 of 2 residents (R104) observed during blood glucose testing. Findings include: On 1/12/15, at 6:10 p.m. R104 was observed sitting in the dining room waiting for dinner. There were four other residents sitting at the same table (including R58), and four more residents in the dining room sitting at other tables. On 1/12/15, at 6:12 p.m. the licensed practical nurse (LPN)-F walked into the dining room, poked R104's finger and checked her blood sugar. After the procedure was completed LPN-F requested R104 to hold the cotton ball in place till the bleeding stopped. On 1/12/15, at 7:10 p.m. attempted to interview resident, R104 did not speak English. On 1/13/15, at 9:55 a.m. a family of four members visited resident, when attempted to talk	F 164	Preparation, submission and implementation of this Plan of Correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. " F164: Resident #104 has not had any negative effects from not having dignity respected by doing a blood sugar in a public area. All residents have the potential of not having their dignity protected by doing an invasive procedure in a public area. LN performing blood sugar in a public area has been re- educated on acceptable practices. LN will be educated on not completing invasive procedure in public areas.	

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F 164	Continued From page 2 to them, the male visitor stated he was R104's son, however declined interview. On 1/14/15, and 1/15/15, LPN-F was not available for an interview. R58 (who sat at the table next to R104 during dinner on 1/12/15) was interviewed on 1/14/15, at 10:10 a.m., and stated "I noticed the nurse checking the other lady's blood sugar at the table", "they do that all the time, and staff also used to give insulin to the residents in the dining." R58 further stated "I thought blood sugar checks and giving insulin supposed to be done in resident's rooms for privacy." Review of the undated Resident Admission Record indicated R104 was admitted to the facility on 1/6/15, with diagnoses including anemia, pneumonia and Parkinson's disease; and R104 spoke an "Asian" language. The social service progress note dated 1/8/15, indicated "resident speaks Hmong, family is available to assist" with communication. During interview on 1/14/15, at 10:13 a.m. the director of nursing (DON) stated it was the facility's policy and common nurse practice to provide residents privacy during treatments, by either bringing them into their rooms, or to a location where residents were not visible to others. The DON further stated it was expected from staff to provide privacy during blood sugar checks. The facility's Privacy policy dated reviewed and revised on May 2011, indicated "To provide privacy and protect the dignity of all residents",	F 164	DON/Designee will complete Weekly random audits for 3 months to assure blood sugars are not being completed in a public area. Findings from deficient practice and audit trends will be reviewed at QAA x3 months. Corrective action will be completed by: 02/23/2015	

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F 164	Continued From page 3 privacy curtains and/or window treatments will be closed when the resident is receiving personal care including "during treatments."	F 164		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to determine the practice of self-administration of Lantus (a long-acting insulin) and Novolog (a fast-acting insulin) was safe for 1 of 1 resident (R23) observed to self-administer medications during a medication administration observation. Findings include: On 1/14/15, at 7:52 a.m. licensed practical nurse (LPN)-E was observed to prepare R23's insulins outside the hallway across from R23's room. -At 7:54 a.m. LPN-E entered the room with a Novolog Flex pen dialed up to 18 units and a drawn up syringe of Lantus 85 units. -At 7:55 a.m. LPN-E was observed don a pair of gloves at R23's bedside as R23 was seated on the wheelchair. Then set the Novolog Flex pen on the night stand and then as she approached R23 to give the Lantus insulin R23 grabbed the insulin from LPN-E and was observed to jab the needle to her left lower abdomen without pinching the skin prior and during administration.	F 176	" F176: Resident # 23 was not affected by the practice of SAM a medication without order or assessment. She has been assessed, Does not wish to administer own insulin and is care planned that resident does not wish to give self insulin. Any resident who wishes to self administer their medication may be effected by this deficient practice. LN who assisted the resident with SAM of the insulin has received education related to this deficient practice. LN□s will receive education on Self administering medications and following facility protocols. DON/Designee will complete random weekly audits for 3 months to assure residents who are self administering their medications have been properly	2/23/15

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F 176	Continued From page 4 -At 7:57 a.m. LPN-E picked the Novolog Flex pen from the night stand indicated to R23 it was dialed up already and handed it to R23 and instructed her to pinch the skin and R23 was observed give herself the insulin again to the left lower abdomen again and never pinched her skin. -At 7:59 a.m. when LPN-E came out of room she proceeded to close the three ring binder which contained the Medication Administration Record (MAR) before documenting the administration. Surveyor approached and asked LPN-E when she would be documenting and the facility expectation after administering medications. LPN-E indicated she was supposed to document immediately. LPN-E then opened the MAR initiated the MAR and wrote behind the MAR R23 had self-administered insulin. When asked if R23 had an order to self-administer medication (SAM) LPN-E stated she did not think so and verified after going through the MAR. LPN-E asked "I thought residents had the right to give their own medications." R23's diagnoses included schizoaffective, manic depression and diabetes mellitus obtained from the admission Minimum Data Set (MDS) dated 12/28/14. Review of R23's Physician's Orders dated 1/8/15, revealed R23's orders were as follows: -Lantus injection 100/milliliter (ml) inject 85 units sub-cutaneous (SQ) daily -Novolog injection 18 units SQ three times daily with meals Care plan dated 1/4/15, identified R23 with the potential for complications related to diagnoses of diabetes mellitus and directed the staff to	F 176	assessed, have physician orders and are care planned to self administer medication. Findings from deficient practice and audit trends will be reviewed at QAA x3 months. Corrective action will be completed by: 2/23/2015	

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F 176	Continued From page 5 administer medications per orders and to monitor and rotate injection sites. On 1/13/15, at 8:16 a.m. LPN-D supervisor verified R23 did not have an order to self-administer insulin after going through the orders and the undated Self Administration of Medications Assessment which indicated R23 did not wish to keep any medications at bedside and also did not want to self-administer any medications after set up. When asked if R23 was supposed to SAM he stated "Nope."	F 176		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 3 of 4 residents (R31, R76, R32) call lights were readily accessible reviewed for falls. Findings include: R31's call light was observed on 1/12/15, at 7:00 p.m. hanging on the wall around the call light button. On 1/13/14, at 8:07 a.m. during interview, when	F 246	F246: SW interviewed resident #31,76 & 32 were not adversely affected by this deficient practice. All residents at St. Olaf□s have the potential to be affected by this deficient practice. Staff has received education on call light policy related to assuring that call lights are attached within reach of residents and	2/23/15

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F 246	Continued From page 6 asked if he used the call light R31 stated "Yap" when asked if he was able to reach the call light where it was hanging on the wall at the time he stated "No." On 1/13/15, at 8:21 a.m. nursing assistant (NA)-E verified the call light was hanging on the wall indicated R31 was capable of using the call light. NA-E further stated when R31 was lying in bed the call light would be put at reach close to his strong hand. When asked if the call light was supposed to be at reach when R31 was seated on his wheelchair NA-E indicated "Yes." On 1/13/15, at 9:22 a.m. to 9:47 a.m. R31 was observed in his room seated on his wheelchair call light still hanging on the wall not accessible R31 watching television. On 1/13/15, at 3:29 p.m. NA-F verified the call light was not at reach and indicated "When he is in his room it is supposed to be at reach" as she got the call light off the wall and wrapped it around R31's wheelchair. R31's activity of daily living functional/rehabilitation care plan dated 10/16/14, identified R31 at risk for falls related to right sided weakness. Although the care plan directed staff to give R31 verbal reminders not to ambulate/transfer without assistance, the care plan did not direct R31's call light to be within reach even after indicating R31 was at risk for falls. Review of Resident Incident Reports revealed R31 had falls on 10/5/14, 11/20/14, and 12/26/14, and on two out of the three incident reports it was indicated interventions implemented to prevent	F 246	the residents who are identified as high risk for falls will have call light within reach as intervention if resident is able to use call light as intervention on plan of care. Those residents who are identified as high risk for falls that cannot use call light appropriately will have other interventions placed according to individual need. which may be having resident within sight of staff, frequent monitoring etc. ED/Designee will complete weekly random audits x 3 months throughout the facility to assure call lights are within reach of residents and make sure care plan has appropriate intervention placed for residents who are at high risk for falls. Education will be provided if this practice is found to be deficient at time of audits. Findings from deficient practice and audit trends will be reviewed at QAA x3 months. Corrective action will be completed by: 02/23/2015	

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F 246	Continued From page 7	F 246		

further incidents included "Told resident to put call light for help @ [at] all times. Resident understands to ask for help when transferring."

R76 was observed on 1/12/15, at 3:57 p.m. lying in his bed. The call light was at the head of his bed beyond his pillow. R76 had a brace on his right upper extremity and another on his right lower extremity.

At 4:05 p.m. a NA-H stated R76 was able to use his call light appropriately if the call light was placed within his reach. She then verified R76 would be unable to use the call light when it was in the current spot, placed at the head of his bed beyond his pillow. NA-H further explained that R76 cannot use his right upper extremity to functionalize the call light. She stated he required his left hand to turn the call light on. NA-H then placed the call light across the chest of R76 and within reach of his left hand.

On 1/13/15, at 9:41 a.m. R76 was observed in his room sitting in his wheelchair. One call lights was hanging on the far wall and another call light was lying on the floor near the far wall. Both call lights approximately five feet from R76 and to his back. When asked if he could reach either call light R76 shook his head to indicate he could not reach the call lights.

The comprehensive Minimum Data Set (MDS) dated 12/5/14, identified R76's diagnoses as dementia with behavioral disturbances, hemiparesis (weakness of the entire left or right side of the body) and chronic obstructive pulmonary disease (COPD). The MDS further revealed R76 was totally dependent on staff for locomotion, bed mobility, transferring, toileting

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and dressing and he was nonambulatory.

The care plan (CP) dated 12/12/14, identified R76 to be at risk for falls related to immobility and right sided hemiparesis and directs staff to give verbal reminders not to self-transfer and to keep the call light within reach.

The Fall Risk Assessment dated 6/3/14, identified R76 as a high risk for falls noted no falls were noted in past six months. The Fall Risk Assessment dated 12/4/14, not completed.

R32 was observed on 1/13/15, at 8:58 a.m. sitting in her wheelchair in her room. The call light was on the bed near the wall on the far side.
-At 9:12 a.m. R32 was in her chair and the call light was on the bed near the far wall.
-At 9:25 a.m. R32 was in her chair and the call light was on the bed near the far wall.

On 1/15/15, at 2:15 p.m. a licensed practical nurse (LPN)-D stated R32 was capable of using her call light appropriately and staff should always place it within her reach when she was in her room.

The comprehensive MDS dated 12/11/14, identified R32's diagnoses as followed Alzheimer's disease, macular degeneration, dementia with behavior disturbances, hypotension and osteoarthritis. The MDS further revealed R32 was totally dependent on staff for locomotion, bed mobility, transferring, toileting and dressing and was nonambulatory.

The CP dated 12/19/14, identified R32 at risk for falls related to immobility and directs staff to

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keep the call light within reach.

The Fall Risk Assessments dated 6/8/14 and 9/5/14, identified R32 as being at low risk for falls. No falls were noted in past six months.
On 1/15/15, at 8:25 a.m. the DON stated, "I would expect call lights to be in reach of the resident." She indicated further that the nursing staff would generally be responsible for that, but that any and all staff can see if a resident has a call light and offer it to them. She added she, or other staff she designated performed random audits of call light function and placement. She indicated she kept records of these audits.

The DON also indicated if a resident cannot use the usual call light because they cannot push the button, they offered a soft touch call device. She went on to say for residents who just cannot use a light for whatever reason, "We check on them, bring the resident into staff view, offer diversions, stimulation; this would be for the severely aphasic or demented residents."

On 1/15/15, at 8:47 a.m. the director of Environmental Services (M)-A was interviewed and said, "I'd expect to see, if the resident was in bed or in a chair that the call light would be in reach." He added if it was someone in a wheelchair the light should be where they could wheel over and reach it easily. He indicated they did audits, "Every month, in every room, we check that the bedside call light plungers (buttons) work, and that the call light indicator lights above the doors do light up." He added they would check the bathrooms in the same way, "The wall switch string and the light going off."

On 1/15/15, at 9:50 a.m. with the director of

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F 246	Continued From page 10 nursing (DON) stated she would definitely expect call light to be within reach for residents who are capable of using them. She further indicated that R76 and R32 are able to appropriately use their call lights Review of the Resident Call System Policy (Health Dimensions Group 2008) directed all residents to have call system access while in bed or while at their bedside or in the bathroom.	F 246		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278		2/23/15

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	245387	A. BUILDING _____ B. WING _____	01/15/2015

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F 278	Continued From page 11 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was coded accurately for 1 of 3 residents (R81) reviewed for dental concerns. Findings include: On 1/12/15, at 3:09 p.m. during general observations R81 was observed lying in bed and was observed to several missing teeth on the lower jaw to the front and some brown teeth with heavy tartar buildup around the teeth. On 1/14/15, at 9:45 a.m. when asked about her teeth and noted missing teeth R81 stated "I don't want to talk about it I have missing teeth and not seen the dentist but don't have problems with chewing" During conversation observed several teeth missing in the lower jaw and some of the visual teeth were black with build-up tartar around them. On 1/14/15, at 1:52 p.m. via a telephone conversation R81's guardian indicated she had not been called or notified by the facility regarding R81 refusing dental care and she would have expected the facility to assess her dental needs and schedule an appointment with dentist and if any problems were arising she would have expected the facility to call her as she was the emergency contact. R81 was admitted to the facility on 6/6/14, with	F 278	"F278: Incorrect MDS coding on Resident #81. Resident has not had any negative effects from incorrect coding of the dental section of the MDS. All residents at St. Olaf have the potential to be affected by this deficient practice. Corporate MDS Consultant will provide education to MDS coordinator r/t reviewing the oral/dental assessments to code dental section of the MDS correctly. MDS Coordinator will complete 100 % review of residents to assure all residents have a completed oral assessment done and is coded correctly on the MDS. This will be kept on a tracking sheet for the DON to audit weekly. Findings from deficient practice and audit trends will be reviewed at QAA x3 months. Corrective action will be completed by: 02/23/2015	

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diagnoses including paranoid schizophrenia, vitamin D deficiency, anemia, senile psychosis and acute post hemorrhagic obtained from Resident Admission Record printed on 1/14/15.

R81's quarterly MDS dated 12/10/14, identified R81 was independent with personal hygiene, had no behaviors which included rejection of cares and had intact cognition. In review of admission MDS dated 6/12/14, and two quarterly MDS's dated 9/10/14, and 12/10/14, all three dental sections were left blank of any dental concerns which included but not limited to broken or loosely fitting full or partial denture, no natural teeth or tooth fragments, abnormal mouth tissue, obvious cavity or loose natural teeth, inflamed or bleeding gums, mouth or facial pain, discomfort or difficulty with chewing.

In addition, the dental section Care Area Assessment (CAA) did not trigger for CAA completed on 6/12/14.

R81's activities of daily living (ADL) functional/rehabilitation care plan dated 6/19/14, identified R81 was independent but required cues with hygiene/dressing. The care plan directed staff to give R81 cues for hygiene, assist with ADL's as needed and encourage R81 to participate in cares. R81's nutritional status care plan dated 6/12/14, identified R81 had potential for alteration in nutrition, had potential for decreased appetite and weight loss.

Review of documents revealed the following:
-Undated dental Doorstep Healthcare Services Consent For Treatment and Billing Form signed by the guardian indicated R81 had no financial representative and payment was by medical

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assistance.
-Nutritional Re-Assessment dated 9/11/14, and 12/10/14, indicated R81 did not have problems with chewing nor dentition.

On 1/14/15, at 10:13 a.m. registered nurse (RN)-A who was the MDS coordinator and completed all the MDS's at the facility, indicated the facility did not have a dental assessment. RN-A indicated she did not see anything in the chart or medical record that showed when R81 had seen the dentist last even though the facility had a contracted dentist who came to the facility. When asked how the staff completed an oral/dental assessment RN-A stated "I believe they do a visual for obvious problems and check for dentures or own teeth." RN-A verified on the Admission Nursing Evaluation dated 6/6/14, had indicated R81 had "Few, some missing and broken teeth." When asked if she used the information from the assessment to do the admission MDS dated 6/12/14, she indicated "I guess I never looked at the assessment and missed it" as she pointed to the section. RN-A verified and indicated that was why the dental Care Area Assessment (CAA) had not triggered.

On 1/14/15, at 12:05 p.m. when asked about R81's dental care nursing assistant (NA)-D stated R81 was responsible for all that and was not aware R81 had any dental problems including missing and discolored teeth.

On 1/15/15, at 10:04 a.m. when asked her expectation regarding assessment and arranging for dental services director of nursing (DON) stated she would have expected a dental consult to have been scheduled for any resident in need of dental needs. When asked about the

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F 278	Continued From page 14 assessment and care planning DON stated "The assessments and MDS need to be accurate we are human and make mistakes." On 1/15/15, at 11:38 a.m. via telephone the consultant dietician (CD) stated when doing her initial nutritional assessment she got the information about the Admission Nursing Evaluation assessment. -When asked if she was aware R81 had missing and broken teeth, CD stated she was not sure. -When CD was told R81 had missing and broken teeth which had been indicated on the initial Admission Nursing Evaluation dated 6/6/14, CD stated although she used the form to collect her data she may have "over looked" the missing, broken teeth issues which would have probably been addressed under the dentition section of the nutrition assessments and MDS's dated 6/12/14, 9/10/14, and 12/10/14.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280		2/23/15

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F 280	Continued From page 15 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan regarding nutritional monitoring for 1 of 3 residents (R86). Finding Include: On 1/13/15, at 3:35 p.m. R86 stated skipping meals "a lot of times" because her stomach was rejecting the food being served. R86 stated being unhappy with the meals because there were times when the menu did not list food choices that were easy to digest and swallow, and during those times boyfriend brought in food for R86. R86 claimed to have given a list of food preferences as well as food that she could not have to "lady who used to work in dietary" but whenever R86 asked for an alternate such as a sandwich, staff would make it with lettuce which she still could not have. The Care Area Assessments (CAA) dated 9/25/14, indicated R86 was at risk for alteration in nutritional status related to the need of a mechanically altered diet, and weight was over ideal body weight. Care plan considerations noted in the CAA was for monitoring of food intake, tolerance of diet, and weights. R86's care plan initiated on 9/25/14, directed staff to observe for signs of difficulty chewing and	F 280	F280: Residents # 86 care plan has been revised to reflect care refusals. Any resident at St. Olaf who has refusals of care may be affected by this practice. Staff will receive education on resident refusal of care and reproaching. If resident does not accept care LN is to be notified and document refusals in nurse notes and the 24 hour report board then message the DON/ SW. Care plans will be developed from refusal of care. DON will audit 24 hr board prior to daily stand up and report to SW any noted refusals. SW will randomly review nurse notes weekly to review any refusals of care and need to develop a care plan. Corrective action will be completed by: 02/23/2015	

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swallowing, to record intake of food and fluids, to observe for need to add nutritional interventions, and to monitor weights and update physician and dietician as needed.

R86's nutritional assessment dated 9/26/14, relevant conditions to include diabetes mellitus, depression and dysphagia (difficulty swallowing). R86 was described to have no chewing and swallowing problems but had food intolerances to include seafood, lactase, and tomato. The treatment record for 12/14, indicated R86 had additional diagnoses including abdominal pain, abnormal weight loss, B-complex deficiency, back ache, and chronic pain.

A review of nutritional progress notes dated 12/30/14, indicated R86 continued to be on mechanically soft diet due to dysphagia, was at 75 to 100% food and fluid intake, and had no swallowing or chewing issues. R86's weight was noted as stable within three months.

A review of R86's Food and Fluid Intake Record since admission from 9/23/14 to 1/13/15, indicated multiple meal refusals, as follows: 9/14 there were two meals refused and six meals left blank; 10/14 there were 15 meals refused and 50 meals left blank; 11/14 there were 31 meals refused and four meals left blank; 12/14 there were 43 meals refused and two meals left blank; 1/1 through 13/15 there were 21 meals refused and four meals left blank. R86's medical records lacked evidence to show these meal refusals have been thoroughly assessed and addressed.

On 1/14/15, at 7:53 a.m. nursing assistant (NA)-B described R86 as "not a breakfast person" and would pick days when she wanted breakfast.

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F 280	Continued From page 17 -At 8:22 a.m. dietary aide (DA) stated R86 was rarely at the main dining room for meals, and was never down for breakfast. DA denied having heard R86 complain or make any requests about food. -At 8:28 a.m. the dining services director (DSD) denied awareness about R86's problem regarding food choices in the menu. DSD stated residents would be offered to have an alternate such as salad or a sandwich if residents did not want anything from the menu. -At 8:48 a.m. the registered dietician (RD) verified R86's weight refusals since admission were not addressed in her most recent assessment. RD also reviewed R86's weight record and found out that the weight recorded on 1/5/15, was entered in error as 168 instead of 268. RD stated R86 actually had a significant weight gain and not loss. R86's latest weight recorded on 1/12/15, was 267. RD could not explain recent significant weight gain aside from stating that R86's boyfriend was bringing in food from the outside. However, despite RD's knowledge of food being brought from the outside, there was no further assessment to rule out why R86 needed outside food for many times. -At 12:03 p.m. licensed practical nurse (LPN)-A stated she was never aware that R86 had refused meals for so many times. LPN-A acknowledged reasons for refusals should have been known to staff and documented. -At 12:08 p.m. surveyor observed LPN-A inquire about R86's meal refusals and asked R86 to sign a St. Olaf Risk vs. Benefit form regarding refusals of breakfast meals. When LPN-A also asked why there was a stack of four cases ensure (dietary supplement) that was discovered in R86's room, R86 replied, "because I could not eat anything that they have in the menu." LPN-A suggested	F 280		

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F 280	Continued From page 18 the alternate food but R86 went on to say, "like now they have spaghetti, I can't have tomato. The alternate is chicken, I can't swallow chicken. Salad? I cannot swallow lettuce. That is why I keep ensure or Glucerna (a diabetic nutritional supplement) so at least I can have something." -At 12:11 p.m. LPN-A stated LPN-A was going to call the doctor to get an order for R86 to have the ensure as an alternate for meal refusals. -At 12:45 p.m. RD came to conference room to inform surveyor that an alternate sauce for R86's spaghetti was offered, so R86 was then happy eating at the ground floor dining room. - At 2:47 p.m. the director of nursing stated she expected staff to document residents' meal refusals to re-evaluate and revise care plan as needed. The facility's care plan policy dated 4/1/08, outlined the procedure on resident's problem identification to include conducting resident and/or family interviews, nursing assessment and history, and any other available information. The policy directed staff to use results of resident assessments to develop and revise comprehensive care plan and to periodically review and revise the care plan after each assessment.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 281	F281: Resident # 103 has anticoagulation	2/23/15

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F 281	Continued From page 19 review, the facility failed to ensure 1 of 3 residents (R103) temporary care plan included potential for bleeding who used anticoagulation therapy. Findings include: R103 was noted to have multiple bruised areas on her body, and was receiving anticoagulation therapy; however, the facility failed to develop a temporary care plan to include potential for bleeding and non-pressure related skin conditions. On 1/14/15, at 9:57 a.m. R103 was observed lying in the bed. R103 had an approximately 2 inch by 1 inch large dark blue bruise on the right lateral wrist (above thumb), and an approximately quarter sized bruise in the right elbow. When interviewed R103 stated the wrist and elbow bruises were from the hospital needles. R103 also stated she had abdominal bruises also from the twice daily Lovenox (anticoagulant medication) injections. R103 lifted her shirt up and two dime sized bruises were observed on her abdomen. Review of the Resident Admission Record indicated R103 was admitted to the facility on 1/9/15 (only five days ago) with diagnoses including knee joint replacement and major depression. The current Physician's Orders dated 1/12/15, indicated order for Enoxaparin (also called Lovenox) inject 0.3 ml (milliliter)/30 mg (milligram) subcutaneously every 12 hours for 14 days. Review of the Nurses notes in between 1/9/15 to 1/14/15, indicated staff identified bruises upon	F 281	care plan developed with monitoring for potential side effects with use of anticoagulant therapy. no adverse affects from lack of temporary care plan being developed upon admission LN will be educated on need to review medication list on admit and add anticoagulation care plan. All new admits on shall have chart reviewed by MDS Coordinator/ Designee 24 hour post admit to assure a care plan is implemented if they are on anticoagulation therapy. This will be an ongoing audit at facility. Findings from deficient practice and audit trends will be reviewed at QAA x3 months. Corrective action will be completed by: 02/23/2015	

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admission on the top of bilateral hands, right inner wrist and "Two pin point red area noted to R abd [right abdomen]."

Review of R103's January 2015 treatment records and medication administration record did not indicate anticoagulant side effect monitoring including risk for bleeding.

Review of the care plan dated 1/9/15, indicated R103 was not identified with "Potential for bruising R/T [related to] Anticoagulation Therapy."

During interview on 1/14/15, at 1:49 p.m. the director of nursing (DON) stated the facility used the temporary care plans for 21 days after admission until the comprehensive care plan was written by day 21. The DON also explained the purple temporary care plan included multiple areas, and it was individualized by completing it upon admission with eight hours. The DON also stated residents needed to be monitored for high risk for bleeding when there was anticoagulant medication used, and that needed to be identified on the temporary care plan. The DON reviewed R103's medical record and verified R103 used Lovenox injections, however the side effects were not monitored, and staff should have identified risk of bleeding/ bruising as side effect, care plan it and monitor it.

The Anti-Coagulant Use policy and procedure dated revised on March 1, 2014, was provided by the facility for review. The policy indicated:
- "Residents who require anticoagulation therapy will receive appropriate monitoring to ensure safety.'
- "Anti-coagulant is addressed on plan of care as indicated."

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F 281	Continued From page 21 - "Signs of bruising and bleeding are monitored routinely. Examples of common signs of bleeding include: black-tarry or red-looking stool, dark orange or red discolored urine, excessive bleeding from the gums or teeth, uncontrollable nose bleed, cuts or scratches that continue to bleed despite pressure/bandages, sudden change in cognition or mental status, and excessive bruising of the skin and extremities. The Care Plan-Temporary policy last revised in May 2011, indicated: - "A temporary care plan is initiated by the licensed nursing staff when an acute health problem is identified that is self limiting." - "The temporary care plan will be individualized to the resident's needs when initiated."	F 281		
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 care in accordance to the care plan for 1 of 1 resident (R23) who self-administered insulin during a medication administration observation. In addition, the facility failed to ensure dialysis site dressing was removed after dialysis to reduce the risk of access site infection, clotting and to monitor access site for 1 of 1 resident (R63) reviewed for dialysis.	F 282	F282: Resident # 23 has not had any negative effects from self administering a medication (SAM)Resident has been assessed, and resident does not wish to SAM. Care plan is updated to state resident does not want to self administer insulin. All residents have the potential to be	2/23/15

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F 282	Continued From page 22 Findings include: R23 was observed in the dining room on 1/14/15, at 7:52 a.m. and licensed practical nurse (LPN)-E was observed to prepare R23's insulins outside the hallway across from R23's room. -At 7:54 a.m. LPN-E entered the room with a Novolog Flex pen dialed up to 18 units and a drawn up syringe of Lantus 85 units. -At 7:55 a.m. LPN-E was observed don a pair of gloves at R23's bedside as R23 was seated on the wheelchair. Then set the Novolog Flex pen on the night stand and then as she approached R23 to give the Lantus insulin R23 grabbed the insulin from LPN-E and was observed jab the needle to her left lower abdomen without pinching the skin prior and during administration. -At 7:57 a.m. LPN-E picked the Novolog Flex pen from the night stand indicated to R23 it was dialed up already and handed it to R23 and instructed her to pinch the skin and R23 was observed give herself the insulin again to the left lower abdomen again and never pinched her skin either. -At 7:59 a.m. when LPN-E came out of room she proceeded to close the three ring binder which contained the Medication Administration Record (MAR) before documenting the administration. Surveyor approached and asked LPN-E when she would be documenting and the facility expectation after administering medications. LPN-E indicated she was supposed to document immediately. LPN-E then opened the MAR initiated the MAR and wrote behind the MAR R23 had self-administered insulin. When asked if R23 had an order to self-administer medication (SAM) LPN-E stated she did not think so and verified after going through the MAR. LPN-E asked "I	F 282	affected by this deficient practice of not having SAM assessment completed to safely self administer medication. LN who assisted the resident with SAM of the insulin has received education on SAM and facility Policy and procedures of Self Administration of medications. LNs will receive education on Self administering medications and following facility policy and procedure which includes SAM assessment , IDT review and order from MD for self administration of medication and placed on care plan to reflect resident is safe to SAM DON/Designee will complete random weekly audits for 3 months to assure residents who are self administering their medications have been properly assessed, have physician orders and are care planned to self administer medication. Findings from deficient practice and audit trends will be reviewed at QAA x3 months. In addition, Resident #63 has had no adverse effects from facility deficient practice of not following facility policy and procedure on care of dialysis site of when to remove dressing to observe for signs and symptoms of infection and bleeding to reduce the risk of infection and monitoring for bleeding from access site. All residents who receive dialysis would be affected by this deficient practice.	

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	245387	A. BUILDING _____ B. WING _____	01/15/2015

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F 282	Continued From page 23 thought residents had the right to give their own medications." R23's diagnoses included schizoaffective, manic depression and diabetes Mellitus obtained from the admission Minimum Data Set (MDS) dated 12/28/14. Review of R23's Physician's Orders dated 1/8/15, revealed R23's orders were as follows: -Lantus injection 100/milliliter (ml) inject 85 units sub-cutaneous (SQ) daily -Novolog injection 18 units SQ three times daily with meals Care plan dated 1/4/15, identified R23 with the potential for complications related to diagnoses of diabetes mellitus and directed the staff to administer medications per orders and to monitor and rotate injection sites. On 1/13/15, at 8:16 a.m. LPN-D supervisor verified R23 did not have an order to self-administer insulin after going through the orders and the undated Self Administration of Medications Assessment which indicated R23 did not wish to keep any medications at bedside and also did not want to self-administer any medications after set up. When asked if R23 was supposed to SAM he stated "Nope." On 1/13/15, at 10:03 a.m. the director of nursing (DON) stated because of that incident she had the nurses get an order for R23 to SAM as resident had lived in the assisted living next door and thought probably R23 did give herself the insulin there. DON acknowledged the nurse should have told R23 she would give the insulin and stated she did not have an order to SAM and	F 282	All LN will be educated on facility policy and procedure of care of dialysis access site and follow plan of care such as: checking thrills/bruit of grafts and fistulas, when to remove dressing placed on by dialysis center, signs and symptoms of infection and documentation on TAR. In addition, emergency protocol is placed on care plan for uncontrolled bleeding from dialysis site. Nurses to document in nurses note dialysis report from dialysis center if given verbal report. Written communication from dialysis center will be placed in medical record. Don/Designee will complete random weekly audits for 3 months to assure facility policy and procedure is followed on care of residents dialysis access site and documentation on TAR is completed and plan of care is followed. Findings from deficient practice and audit trends will be reviewed at QAA x3 months. Corrective action will be completed by: 02/23/2015	

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F 282	Continued From page 24 the care plan should have been followed. Self-Administration of Medications policy revised May 2011, indicated if a resident had expressed a desire to self-administer medications an assessment would be done, the facility would require drugs to be administered by the nurse until the interdisciplinary team (IDT) had the opportunity to obtain information necessary to complete an assessment and update the care plan. In addition, the policy indicated nursing would obtain an order from the physician for self-administration of medications. On 1/13/15, at 10:03 a.m. when asked about the Insulin SAM the director of nursing (DON) stated she was not told about the second insulin that the nurse had handed to R23 and because of the incident she had the nurses get an order for R23 to SAM as resident leaved in the assisted living next door and thought probably R23 did give herself the insulin there. DON acknowledged the nurse should have told R23 she would give the insulin and stated she did not have an order to SAM and the care plan should have been followed. Self-Administration of Medications policy revised May 2011, indicated if a resident had expressed a desire to self-administer medications an assessment would be done, the facility would require drugs to be administered by the nurse until the interdisciplinary team (IDT) had the opportunity to obtain information necessary to complete an assessment and update the care plan. In addition the policy indicated nursing would obtain an order from the physician for self-administration of medications.	F 282		

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F 282	Continued From page 25	F 282		

R63 was observed seated in his room watching television on 1/14/15, at 10:06 a.m. The resident was wearing a short sleeved shirt which exposed left arm dialysis access site observed with cotton and secured with paper tape. R63 stated had been to dialysis the day before and had no report of pain.

R63's signed Physician Orders dated 1/13/15, indicated monitor dialysis access site for intact dressing, closed clamp caps, signs and symptoms of infections, bleeding, petechiae, prolonged bleeding with blood draw, bleeding gums, and drop in blood pressure. The staff was to notify the medical doctor (MD) if resident had any bleeding every shift, check access site for bruit thrill every shift, notify MD if there is no bruit or thrill every shift and replace pressure dressing to shunt site as needed (PRN). Staff was directed to use dialysis emergency protocol for access problems or bad weather that may have caused resident to have missed or delay dialysis. Staff was to remove the pressure dressing every Wednesday, Friday and Sunday morning and apply pressure dressing if bleeding persisted. Staff was to check the shunt, palpate and auscultate thrill daily. The nurse was to check bruit/thrill daily every morning on the left antecubital area.

Review of R63's treatment sheet dated 11/9/13, indicated pressure dressing to be removed every Wednesday, Friday and Sunday morning and to apply pressure dressing if bleeding persists. It also indicated nurse was to check bruit/thrill daily every morning on left antecubital area and shunt palpate and auscultate thrill daily.

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F 282	Continued From page 26	F 282		

R63's quarterly MDS dated 1/2/15, noted diagnoses including diabetes mellitus (DM), hypertension, dementia, and indicated R63 received dialysis. The resident's Brief Interview for Mental Status (BIMS-tool used to measure cognition) indicated R63 had moderate impaired cognition, and R63 received limited assistance self-performance with one person physical assistance support with cares.

The plan of care: renal function/dialysis dated 1/5/15, identified R63 with diagnosis of end stage renal disease (ESRD). The goal was the dialysis access site will be free of infection and remain patent during review period. Interventions were to monitor dialysis access site for intact dressing, closed clamp caps, signs/symptoms of infection, check access site for bruit or thrill every shift and staff may remove dressing to shunt site four hours after return from dialysis.

When interviewed on 1/14/15, at 12:40 p.m. a licensed practical nurse (LPN)-A stated what she should do with resident's dialysis dressing. LPN-A stated she had to remove dressing on R63's fistula today and that would be done on her morning shift. If it had still been bleeding she would replace dressing, and would check thrill also. If there had been an emergency and it did not stop bleeding, she would get an order to send R63 to the emergency room (ER).

The dialysis center's registered nurse (RN)-B was interviewed on 1/15/15, at 8:44 a.m. and when asked, reported how the runs are going with R63, RN-B explained they are "going good so far." When asked what the expectation would be regarding removing the dressing after runs,

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F 282	Continued From page 27 stated "dialysis center would prefer dressing to be removed three to four hours after, probably by bedtime." RN-B indicated R63 had come back for the next run with the dressing from the previous time he was at the facility and "we have communicated with the facility several times about this issue." When asked what the implications would be if the dressing was not removed stated "the site would be warm and it would increase the chances of infection and clotting." On 1/15/15, at 11:07 a.m. when asked director of nursing (DON) indicated she thought dialysis dressing removal was PRN. Resident Care Policies and Procedures-Skilled Nursing Facility, Health Dimensions Group dated 2013, indicated: "f. Dialysis center's expectation of care to be completed by skilled nursing facility (SNF) (if any) such as: checking thrills/bruit of grafts and fistulas, documented on TAR, when to remove dressing from the access site placed on from the dialysis center, emergency protocol for uncontrolled bleeding from any dialysis site g. A communication tool is utilized to receive a report on the resident to the facility after each dialysis session. A verbal report is accepted and the licensed nurse will document this in the resident's medical record."	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309		2/23/15

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F 309	Continued From page 28 and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services to ensure a dialysis site dressing was removed after dialysis to reduce the risk of access site infection, clotting and to monitor access site for 1 of 1 resident (R63) reviewed for dialysis. Findings include: R63 was observed seated in his room watching television on 1/14/15, at 10:06 a.m. The resident was wearing a short sleeved shirt which exposed left arm dialysis access site observed with cotton and secured with paper tape. R63 stated had been to dialysis the day before and had no report of pain. R63's signed Physician Orders dated 1/13/15, indicated monitor dialysis access site for intact dressing, closed clamp caps, signs and symptoms of infections, bleeding, petechiae, prolonged bleeding with blood draw, bleeding gums, and drop in blood pressure. The staff was to notify the medical doctor (MD) if resident had any bleeding every shift, check access site for bruit thrill every shift, notify MD if there is no bruit or thrill every shift and replace pressure dressing to shunt site as needed (PRN). Staff was directed to use dialysis emergency protocol for access problems or bad weather that may have caused resident to have missed or delay dialysis. Staff was to remove the pressure dressing every Wednesday, Friday and Sunday morning and	F 309	F309: Resident # 63 was not adversely affected from not having his dressing changed after dialysis session. Orders have been obtained for specific dressing changes on the resident. All residents who receive dialysis would be affected by this deficient practice. All LN will be educated on facility policy and procedure of care of dialysis access site and follow plan of care such as: checking thrills/bruit of grafts and fistulas, when to remove dressing placed on by dialysis center, signs and symptoms of infection and documentation on TAR. In addition, emergency protocol is placed on care plan for uncontrolled bleeding from dialysis site. Nurses to document in nurses note dialysis report from dialysis center if given verbal report. Written communication from dialysis center will be placed in medical record. Don/Designee will complete random weekly audits for 3 months to assure facility policy and procedure is followed on care of residents dialysis access site and documentation on TAR is completed and plan of care is followed. Findings from deficient practice and audit trends will be reviewed at QAA x3 months. Corrective action will be completed by:	

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F 309	Continued From page 29 apply pressure dressing if bleeding persisted. Staff was to check the shunt, palpate and auscultate thrill daily. The nurse was to check bruit/thrill daily every morning on the left antecubital area. Review of R63's treatment sheet dated 11/9/13, indicated pressure dressing to be removed every Wednesday, Friday and Sunday morning and to apply pressure dressing if bleeding persists. It also indicated nurse was to check bruit/thrill daily every morning on left antecubital area and shunt palpate and auscultate thrill daily. R63's quarterly MDS dated 1/2/15, noted diagnoses including diabetes mellitus (DM), hypertension, dementia, and indicated R63 received dialysis. The resident's Brief Interview for Mental Status (BIMS-tool used to measure cognition) indicated R63 had moderate impaired cognition, and R63 received limited assistance self-performance with one person physical assistance support with cares. The plan of care: renal function/dialysis dated 1/5/15, identified R63 with diagnosis of end stage renal disease (ESRD). The goal was the dialysis access site will be free of infection and remain patent during review period. Interventions were to monitor dialysis access site for intact dressing, closed clamp caps, signs/symptoms of infection, check access site for bruit or thrill every shift and staff may remove dressing to shunt site four hours after return from dialysis. When interviewed on 1/14/15, at 12:40 p.m. a licensed practical nurse (LPN)-A stated what she should do with resident's dialysis dressing. LPN-A stated she had to remove dressing on R63's	F 309	02/23/2015 F309: Resident #63 has had no adverse effects from facility deficient practice of not following facility policy and procedure on care of dialysis site of when to remove dressing to observe for signs and symptoms of infection and bleeding to reduce the risk of infection and monitoring for bleeding from access site. . Orders have been obtained for specific dressing changes on the resident. All residents who receive dialysis would be affected by this deficient practice. LN will be educated on facility policy and procedure of care of dialysis access site and follow plan of care. All LN will be educated on facility policy and procedure of care of dialysis access site and follow plan of care such as: checking thrills/bruit of grafts and fistulas, when to remove dressing placed on by dialysis center, signs and symptoms of infection and documentation on TAR. In addition, emergency protocol is placed on care plan for uncontrolled bleeding from dialysis site. Nurses to document in nurses note dialysis report from dialysis center if given verbal report. Written communication from dialysis center will be placed in medical record. Don/Designee will complete random weekly audits for 3 months to assure facility policy and procedure is followed on care of residents dialysis access site and	

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F 309	Continued From page 30 fistula today and that would be done on her morning shift. If it had still been bleeding she would replace dressing, and would check thrill also. If there had been an emergency and it did not stop bleeding, she would get an order to send R63 to the emergency room (ER). The dialysis center's registered nurse (RN)-B was interviewed on 1/15/15, at 8:44 a.m. and when asked, reported how the runs are going with R63, RN-B explained they are "going good so far." When asked what the expectation would be regarding removing the dressing after runs, stated "dialysis center would prefer dressing to be removed three to four hours after, probably by bedtime." RN-B indicated R63 had come back for the next run with the dressing from the previous time he was at the facility and "we have communicated with the facility several times about this issue." When asked what the implications would be if the dressing was not removed stated "the site would be warm and it would increase the chances of infection and clotting." On 1/15/15, at 11:07 a.m. when asked director of nursing (DON) indicated she thought dialysis dressing removal was PRN. Resident Care Policies and Procedures-Skilled Nursing Facility, Health Dimensions Group dated 2013, indicated: "f. Dialysis center's expectation of care to be completed by skilled nursing facility (SNF) (if any) such as: checking thrills/bruit of grafts and fistulas, documented on TAR, when to remove dressing from the access site placed on from the dialysis center, emergency protocol for uncontrolled bleeding from any dialysis site g. A communication tool is utilized to receive a report	F 309	documentation on TAR is completed and plan of care is followed. Findings from deficient practice and audit trends will be reviewed at QAA x3 months. Corrective action will be completed by: 02/23/2015	

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F 309	Continued From page 31 on the resident to the facility after each dialysis session. A verbal report is accepted and the licensed nurse will document this in the resident's medical record."	F 309		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 3 of 5 residents (R23, R58, R14) who took antidepressants and	F 329	"F329: Resident #23, 58, 14 Due to an end of the month paper error residents did not get targeted behaviors placed in their	2/23/15

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F 329	Continued From page 32 antipsychotics medications had adequate monitoring. In addition, failed to ensure monitor for side effects for the use of Lovenox (an anticoagulant medication) for 1 of 3 residents (R103) reviewed for anticoagulant medication use. Findings include: Psychotropic use: R23 was observed on 1/13/15, at 7:14 a.m. as R23 was observed lying in bed lights were on in the room and R23 was observed wearing a mask around her mouth and nose, eyes were closed and was asleep. On 1/14/15, at 7:52 a.m. to 7:57 a.m. licensed practical nurse (LPN)-E was observed prep R23's two insulins and R23 self-administered the insulins. When asked how she had slept R23 indicated she had slept well "thanks for asking." R23 appeared calm and with a flat affect. R23's diagnoses included schizoaffective, manic depression and diabetes Mellitus obtained from the admission Minimum Data Set (MDS) dated 12/28/14. In addition the MDS indicated R23's cognition was intact, had indicated having trouble falling or staying asleep or sleeping too much and was feeling or had little energy. The MDS also indicated R23 had no behaviors but received daily both an antipsychotic and an antidepressant. Psychotropic drug use Care Area Assessment (CAA) dated 1/2/15, indicated R23 received psychotropic medications related to bipolar disorder, schizoaffective disorder. Monitor and administer medications per order. Psychotropic Drug use care plan dated 1/4/15, identified R23 was at risk for adverse consequences related to	F 329	MARs/Tars for nurses to document. These have since been replaced so staff can document targeted behaviors. In addition, Res # 23, 58, 14 did not have monthly orthostatic blood pressures and side effects of psychotropic medications monthly orthostatic and side effects have been now placed on Tar Resident #103 did not have side effects listed on Mar and Tar and careplan for anticoagulant therapy use. Side effects have now been placed on Mar, Tar and careplan. Residents #23,58,14 and 103 have not had any adverse effects from these deficient practices. All residents at facility on psychotropic medication and residents with anticoagulant therapy have the potential to be affected by this deficient practice. LN will receive education on assuring residents on antipsychotics to assure medication have targeted behavior sheets in place to monitor their targeted behaviors and orthostatic blood pressures checked monthly. In addition to side effects of psychotropic medications are placed on Mar, Tar and care plan. LN will receive education on placing side effects of antiocoagulant therapy on Mar,Tar and care plan. SW/Designee will do a 100% audit of residents on antipsychotics to assure they have targeted behaviors in place and then will complete weekly audits x three months to assure the system is sustained.	

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F 329	Continued From page 33 receiving antipsychotic medications for treatment of schizophrenia and bipolar disorder and also received an antidepressant. The care plan directed staff to administer medications per orders, monitor resident behavior and response to medications and assess/record effectiveness of drug treatment. Review of R23's Physician's Orders dated 1/8/15, revealed R23's orders were as follows: -Olanzapine (atypical antipsychotic used currently in the treatment of schizophrenia and bipolar illness) 20 milligrams (mg) 1 tablet orally every bedtime. -Escitalopram (medication used for treating depression and generalized anxiety disorder) 20 mg 1 tablet orally daily. Review of the Medication Administration Records (MAR's) and Treatment Administration Records (TAR's) from 12/22/14, through January 15th 2015, revealed R23 lack behavior tracking/monitoring, no orthostatic blood pressures had been completed since admission and no side effects monitoring had been initiated despite R23 was receiving both an antidepressant and antipsychotic. On 1/14/15, at 8:35 a.m. registered nurse (RN)-A verified R23 did not have both behavior monitoring, mood monitoring, orthostatic blood pressure and side effects for the antidepressant and antipsychotic. RN-A went through the TAR and verified all the required monitoring were missing and stated she would ask the nurse who checked the MAR and TAR sheets during end of month change over to see what happened. RN-A went through the TAR and showed surveyor how the behavior, mood and side effects sheets would	F 329	DON/designee will do 100% audit to assure that residents that are on anticoagulant therapy and psychotropic medications will have side effects listed on the Mar, Tar and is care planned. Orthostatic blood pressure will be monitored monthly on the TAR. Temporary care plans on admission will have if needed both psychotropic medication side effects and anticoagulant side effects placed on care plan. In addition to target behaviors on TAR. Then will complete weekly audits x□s three months to assure the system is sustained Findings from deficient practice and audit trends will be reviewed at QAA x3 months. Corrective action will be completed by: 02/23/2015	

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F 329	Continued From page 34 look like as they were printed from the pharmacy. RN-A further stated the admission nurse would check to make sure this was all in place when a resident was admitted. -At 9:31 a.m. RN-A approached surveyor indicated the behavior monitoring sheets for December 2014, were in the chart to the back which R23 was transferred with from the assisted living next door. She verified again the behavior, side effects, orthostatic and mood monitoring were missing in the TAR and MAR for January 2015. On 1/13/14, at 10:03 a.m. the director of nursing (DON) stated "These sheets do not have the month they cannot possibly be for December as resident was admitted to the facility on 12/22/14." DON verified after going through the entire chart orthostatic blood pressures, side effects and behavior monitoring were all lacking and indicated "they should have been in place. I have put a list of medications with side effects which were supposed to be attached to the care plan and I guess it's not there." R58 was observed and interviewed on 1/14/15, at 10:45 a.m. R58 sat at the edge of the bed, had a flat affect and was calm. R58 stated she had the total parenteral nutrition going all night long, she didn't feel like eating breakfast since she was a late riser. R58 had no concerns or a question, her mood was "Ok", and stated "I can tell staff if I need something." The undated Resident Admission Record indicated R58 was admitted to the facility on 3/7/14, with most recent admission to the facility on 12/11/14.	F 329		

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R58's quarterly MDS completed on 12/4/14, indicated R58 had intact cognition, and had no behaviors, hallucinations or delusions. The MDS also indicated R58 had depression and anxiety.

The current physician's order dated 12/12/14, indicated resident took the following medications including:
- Citalopram (antidepressant medication) 20 mg 1 tablet daily
- Zyprexa (anti-psychotic medication) 5 mg 1 tablet at bedtime
- Mitrazapine (antidepressant medication) 7.5 mg at bedtime

Review of R58's medication administration and treatment record from July 2014 to present indicated R58 took the Zyprexa continuously; however there was no anti-psychotic medication side effect monitoring (including monthly orthostatic blood pressure) completed.

The DON was interviewed on 1/15/15, at 8:44 a.m. and stated she expected staff to monitor the anti-psychotic medication side effects, which included orthostatic blood pressure monitoring. The DON reviewed R58's medical record and confirmed the lack of side effect monitoring.

R14 was observed on 1/15/15, at 11:03 a.m. seated in a wheelchair in her room watching the television (TV). R14 had a flat affect and was calm. She was asked if she knew what medications (meds) she was on, and she said, "Some of them." She further indicated her mood was "good." During an additional interview, R14 indicated she had no symptoms of feeling tired, down, or depressed. She indicated she was at

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the facility for rehabilitation following a leg fracture, and was hoping to go home soon.

R14's chart was reviewed for:
- A review of Nurse's Notes at the time of admission going forward to 1/15/15, indicated BPs were taken however, they were not orthostatic blood pressures (OBPs, a condition in which a person's blood pressure drops significantly when changing positions from lying down or sitting to standing up. When stood up after sitting or lying down, blood pools in the legs. The direct cause of orthostatic hypotension is failure of the body to react quickly to the position change by shunting blood from the legs back to the heart. With not enough blood to be pumped out of the heart, blood pressure drops. A person with orthostatic hypotension usually becomes dizzy or falls down when standing up too fast). The facility did not monitor the side effects of the psychotropic medication in relationship to the identified falls risk.
- The MAR noted R14 was ordered Abilify on 12/22/14, Nortriptyline on 12/22/14, Zoloft on 12/22/14, and Klonopin on 12/30/14.
- One Nurse's Note dated 12/22/14, at 4:30 p.m. indicated "...no behavior problems noted @ this time." The medical record lacked evidence of ongoing monitoring of behavior or mood symptoms nor was any OBPs noted in the Nurse's Notes.
- R14's MDS dated 12/28/14, indicated R14 had diagnoses which included depression and anxiety. The MDS also depicted R14 as being cognitively intact, as displaying mood symptoms such feeling down, depressed or hopeless, poor appetite or overeating, and feeling bad about yourself, displaying no behaviors as of admission, and as having fallen at least once in the last

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month which resulted in a fracture within the last six months. The facility identified R14 as taking antipsychotics, antidepressants, antianxiety, and diuretic medication in the last seven days.
- The CAA for falls dated 12/28/14, indicated the facility's analysis identified the resident as being at risk for falls due to mobility and history of fall with fracture. The interventions were for staff to assist with transfers, physical therapy/occupational therapy per orders and wheelchair for locomotion. The facility was to proceed to care plan. The analysis lacked evidence of how the facility was going to intervene for falls regarding the resident's psychotropic medication and diuretic use. The CAA for psychotropic medication dated 12/28/14, noted the analysis section indicated, "resident receives Psychotropic r/t [related to] Dx [diagnosis] Anxiety and Depression. See Admission H&P [history and physical] for psychiatric documentation. Proceed with cp [care plan]." The CAA lacked evidence of how the facility intended to implement interventions and monitor the use of the psychotropic medication for adverse side effects and efficacy in relationship to the identified falls risk. The CAAs for mood and behavior did not trigger from the facility findings.
- No behaviors were monitored for the month of December 2014 when R14 was admitted. The medical record lacked evidence of justification and appropriate behavior monitoring as the facility identified R14 as being monitored for "altered mental status" on the January 2015 TAR sheets. The inappropriate behavior monitoring was started during the survey process. The medical record lacked evidence of the facility staff monitoring specific behavioral symptoms due to mania or psychosis such as auditory, visual, or

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F 329	Continued From page 38 other hallucinations, delusions, paranoia and/or grandiosity. - A "Psychotropic Drug Use" CP dated 1/3/15, indicated R14 was using medications for depression and anxiety and had a history of alcoholism. Goal: "R14 will result in maintenance of functional status..." The CP directed the administration of meds per orders, Dyskinesia Identification System: Condensed User Scale (DISCUS) on admission and quarterly, monitor for effectiveness and side effects of medications and pharmacy consult review. - A "Behavioral Symptoms" CP dated 1/15/15, identified R14 had a history of treatment noncompliance, diagnoses that affect her behavior included depression, anxiety, and persistent mental disorder. In addition the CP indicated R14 had a history of alcohol abuse and attended weekly Alcoholics Anonymous meetings..."Goal: will accept cares." The CP directed staff to reapproach later as needed, use a calm, gentle approach with R14, explain steps of cares as they were being performed. - A review of the January 2015 TAR sheets revealed orthostatic blood pressures had not been done for the months of December 2014 and January 2015 to determine if R14 displayed any low blood pressure related to medication. In addition, the medical record lacked evidence of justification and appropriate mood monitoring as the facility identified R14 as being monitored for "mood changes" on the January 2015 TAR sheets even though the facility identified mood symptoms on the 12/28/14, MDS. The "mood changes" monitoring was started during the survey process. On 1/15/15, at 10:32 a.m. an interview was conducted with LPN-D. LPN-D indicated he was	F 329		

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F 329	Continued From page 39 unable to find records of monitoring of medication side effects (SE) or monitoring of OBPs prior to the survey process. LPN-D expected the SE and OBP monitoring to be found in the treatment book, however, he verified no specific SE or OBP monitoring was being completed as of 1/15/15. LPN-D showed the surveyor the "Behavior Monitoring Record," for R14's medication Nortriptyline, an antidepressant med. The record indicated monitoring by check-off box for nonspecific "mood changes," and the Behavior Monitoring Record for R14's Abilify, an antipsychotic med indicated monitoring by check-off box for nonspecific "altered mental status." No specific behaviors at all were identified for monitoring. Both sheets were started on 1/13/15, however that contradicted LPN-D's above interview which noted no evidence of SE monitoring could be located in the medical record. LPN-D indicated they would do vital signs (VS) which would include blood pressures every shift and all should be charted in the Nurse's Notes. He added there was no graphic chart for VS, which included OPBs. - During an interview on 1/15/15, at 10:55 a.m. LPN-C indicated he would expect OBPs to be documented on the pharmacology sheet in the chart. LPN-C looked in R14's chart and verified, "No, they're not in there." LPN-C added SEs should be found on side effects documentation sheets in the TAR, but on 1/15/15, at 10:56 a.m. LPN-C verified he could find no SE sheet in the TAR for R14. - At 10:44 a.m. the MDS nurse, RN-A was asked to show where the monitoring of orthostatic blood pressures and side effects for psychotropic meds could be found. She indicated she could not locate the information and they should have been in R14's chart. It was her expectation they were to	F 329		

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be done on admission and quarterly.
R103
Anticoagulant use:
On 1/14/15, at 9:57 a.m. R103 was observed lying in the bed. R103 had an approximately 2 inch by 1 inch large dark blue bruise on the right lateral wrist (above thumb), and an approximately quarter sized bruise in the right elbow. When interviewed R103 stated the wrist and elbow bruises were from the hospital needles. R103 also stated she had the abdominal bruises from the twice daily Lovenox (anticoagulant medication) injections. R103 lifted her shirt up and two dime sized bruises were observed on her abdomen.

Review of the Resident Admission Record dated 1/9/15, indicated R103 was admitted to the facility on 1/9/15, (only five days ago) with diagnoses including knee joint replacement and major depression.

The current Physician's Orders dated 1/12/15, indicated order for Enoxaparin (also called Lovenox) inject 0.3 ml (milliliter)/30 mg (milligram) subcutaneously every 12 hours for 14 days.

Review of the Nurses notes dated 1/9/15, indicated staff identified bruises upon admission on the top of bilateral hands, right inner wrist and "Two pin point red area noted to R abd [right abdomen]."

Review of R103's treatment and medication administration record for January 2015 revealed lack of anticoagulant side effect monitoring including risk for bleeding.

Review of the care plan dated 1/9/15, indicated

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F 329	Continued From page 41 R103 was not identified with potential for bruising related to anticoagulation therapy. During interview on 1/14/15, at 1:49 p.m. the DON stated the facility used the temporary care plans from the day of admission until the comprehensive care plan was written by day 21. The DON also explained the purple temporary care plan included multiple areas, and it was individualized by completing it upon admission. The DON also stated residents needed to be monitored for high risk for bleeding when there was anticoagulant medication used, and this had to be identified on the temporary care plan. The DON reviewed R103's medical record and verified R103 used Lovenox injections, however the side effects were not monitored, and the DON stated staff should have identified risk of bleeding/ bruising as side effect, care plan it and monitor it. The Anti-Coagulant Use policy and procedure dated revised on March 1, 2014, was provided by the facility for review. The policy indicated: - "Residents who require anticoagulation therapy will receive appropriate monitoring to ensure safety.' - "Anti-coagulant is addressed on plan of care as indicated." - "Signs of bruising and bleeding are monitored routinely. Examples of common signs of bleeding include: black-tarry or red-looking stool, dark orange or red discolored urine, excessive bleeding from the gums or teeth, uncontrollable nose bleed, cuts or scratches that continue to bleed despite pressure/bandages, sudden change in cognition or mental status, and excessive bruising of the skin and extremities."	F 329		

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F 334	Continued From page 42	F 334		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal	F 334		2/23/15

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F 334	Continued From page 43 immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 residents (R98, R29, R4) received pneumococcal vaccinations as recommended by Centers for Disease Control (CDC). Findings include: R98 was admitted to the facility on 9/29/14	F 334	F334: Residents # 98, 29, 4 were offered pneumoccal vaccines. All residents admitted to St. Olaf have the potential to be affected by this practice. LN will receive education to offer	

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F 334	Continued From page 44 according to the Minimum Data Set (MDS). Review of R98's medical record lacked evidence of a Pneumococcal vaccination if had been received, was contraindicated or refused. R29's MDS entry tracking record dated 8/14/14, indicated R29 was admitted to the facility on 8/14/14. Review of R29's medical record lacked evidence of a Pneumococcal vaccination if had been received, was contraindicated or refused. R4's MDS entry tracking record dated 9/11/14, indicated R4 was admitted to the facility on 9/11/14. Review of R4's medical record lacked evidence of a Pneumococcal vaccination if had been received, was contraindicated or refused. On 1/14/15, at 8:46 a.m. the director of nursing (DON) was interviewed and asked where the documentation for influenza and pneumococcal vaccinations could be located in the medical record. The DON stated she had immunization records available in her office; they are not in the charts. DON was unable to provide pneumococcal documentation. The facility Pneumovax Policy & Procedure dated January 2006, directed "all new admissions are offered the pneumococcal vaccine if: vaccination status is unknown, physician's order is present, and consent is signed by the appropriate party. Residents with a history of receiving the vaccine will be revaccinated ONCE if > 5 [equal to or greater to] years have passed since 1st dose	F 334	pneumoccal vaccination upon admission and document refusals. If resident states they have received the vaccination LN will consult medical records (MR) to assure that a copy from clinic is received. MR is to complete 100% chart review to assure all pneumococcal documentation of refusal, acceptance or medical record of past immunization is in place. This will be followed weekly for review for three months of new admits to assure practice is sustained. Findings from deficient practice and audit trends will be reviewed at QAA x3 months. Corrective action will be completed by: 2/23/2015	

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F 334	Continued From page 45 AND: resident was < [below] 65 when 1st vaccinated, OR, resident is at high risk for serious pneumococcal infection, OR, resident has rapidly declining pneumococcal antibody levels (asplenic or immunocompromised)."	F 334		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356		2/23/15

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F 356	Continued From page 46 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure actual registered nursing hours were consistently written in the staff posting of Daily Nursing Hours. This had the potential to affect all 68 residents, family members and visitors. Findings include: On 1/12/15, at 11:50 a.m. the nurse staff posting was observed to lack information about registered nurse (RN) hours for 1/12/15. When the staff posting for the past week (1/4/15 through 1/11/15) was reviewed, there were more days that did not have the actual RN hours listed in the posting. The review was then expanded to include all staff posting for one month from 12/12/14 to 1/13/15, there was a total of 13 days that did not have the actual RN hours. During interview on 1/15/15, at 8:43 a.m. the staffing coordinator stated when there was no RN in the building, the director of nursing (DON) or RN-A alternated schedules to be on site, including weekends and holidays. -At 8:50 a.m. nursing assistant (NA)-B stated that when there were no RNs on duty, the practice was for the licensed practical nurses (LPNs) who were working to call the on-call RN if needed. -At 8:52 a.m. LPN-B stated DON or RN-A will usually cover on weekends alternately, will have to call them to come on-site if there was a need. -At 8:56 a.m. LPN-C stated DON or RN-A would come on site if the night RN was not present during the weekend.	F 356	F356: No resident care was affected by this deficient practice. Facility will implement a new staffing sheet that adequately reflects changes in staff hours. Staffer/PM charge nurse will be educated on making staffing changes on the daily staffing sheet to assure accuracy. ED/ Designee will complete random weekly audits x 3 months to assure staffing schedule is up current and accurate for staffing hours. Correction action will be completed by: 02/23/2015	

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	245387	A. BUILDING _____ B. WING _____	01/15/2015

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F 356	Continued From page 47 -At 9:01 a.m. DON stated if there was no RN in the building either RN-A or herself would be onsite to do eight hour tour of duty or call the night RN to be on duty. DON verified actual RN hours were not written for the 13 days out of 30 days reviewed for staff posting. Facility's policy regarding staffing and posting was asked but policy provided did not address requirements for nurse staff posting.	F 356		
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure proper food substitute was offered to 1 of 3 residents (R86) reviewed for nutritional status. Findings include: On 1/13/15, at 3:35 p.m. R86 stated skipping meals "a lot of times" because her stomach was rejecting the food being served. R86 stated being unhappy with the meals because there were times when the menu did not list food choices that were easy to digest and swallow, and during those times boyfriend brought in food for R86. R86 claimed to have given a list of food preferences as well as food that she could not have to "lady who used to work in dietary" but still the food choices provided were things she could	F 366	F366 : Resident # 86 has not had any negative affects of facility not ensuring proper food substitute. All residents in the facility has potential to be affected by this practice. Food Service Director will complete initial resident interview within seventy two hours. If excessive dislikes, FSD will work with resident on specific menu for resident. If a new or current resident refuses one meal per day for three days nursing will notify FSD who will contact RD for a consult and meet with resident to update likes and dislikes. FSD will conduct on going resident satisfaction audits twice weekly with current residents and update tray card information as needed x□s three months	2/23/15

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F 366	Continued From page 48 not have. R86 added whenever an alternate was asked such as sandwich, the staff would make it with lettuce which she could not have. The Care Area Assessments (CAA) dated 9/25/14, indicated R86 was at risk for alteration in nutritional status related to the need of a mechanically altered diet, and weight was over ideal body weight. Care plan considerations noted in the CAA was for monitoring of food intake, tolerance of diet, and weights. R86's care plan initiated on 9/25/14, directed staff to observe for signs of difficulty chewing and swallowing, to record intake of food and fluids, to observe for need to add nutritional interventions, and to monitor weights and update physician and dietician as needed. R86's nutritional assessment dated 9/26/14, relevant conditions to include diabetes mellitus, depression and dysphagia (difficulty swallowing). R86 was described to have no chewing and swallowing problems but had food intolerances to include seafood, lactase, and tomato. A review of nutritional progress notes dated 12/30/14, indicated R86 continued to be on mechanically soft diet due to dysphagia, was at 75 to 100% food and fluid intake, and had no swallowing or chewing issues. R86's weight was noted to be stable within three months. A review of R86's Food and Fluid Intake Record since admission from 9/23/14 to 1/13/15, indicated multiple meal refusals, as follows: 9/14 there were two meals refused and six meals left blank; 10/14 there were 15 meals refused and 25 meals left blank; 11/14 there were 31 meals refused and four meals left blank; 12/14 there	F 366	to assure resident satisfaction.	

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F 366	Continued From page 49	F 366		

were 43 meals refused and two meals left blank; 1/1 through 13/15, there 21 meals refused and four meals left blank. R86's medical records lacked evidence to show these meal refusals have been thoroughly assessed and addressed.

On 1/14/15, at 7:53 a.m. nursing assistant (NA)-B described R86 as "not a breakfast person" and would pick days when she wanted breakfast.
-At 8:22 a.m. dietary aide (DA)-A stated R86 was rarely at the main dining room for meals, and was never down for breakfast. DA-A denied having heard R86 complain or make any requests about food.
-At 8:28 a.m. the dining services director (DSD) denied awareness about R86's problem regarding food choices in the menu. DSD stated residents would be offered to have an alternate such as salad or a sandwich if residents did not want anything from the menu.
-At 8:48 a.m. the registered dietician (RD) verified R86's weight refusals since admission were not dealt with in her most recent assessment. RD also reviewed R86's weight record and found out that the weight recorded on 1/5/15 was entered in error as 168 instead of 268. RD stated R86 actually had a significant weight gain and not loss. R86's latest weight recorded on 1/12/14 was 267. RD could not explain recent significant weight gain aside from stating that R86's boyfriend was bringing in food from the outside. However, despite RD's knowledge of food being brought from the outside, there was no further assessment to rule out why R86 needed outside food for many times.
-At 12:03 p.m. licensed practical nurse (LPN)-A stated she was never aware that R86 had refused meals for so many times. LPN-A acknowledged reasons for refusals should have been known to

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F 366	Continued From page 50 staff and documented. -At 12:08 p.m. LPN-A was observe to ask R86 about the meal refusals and asked R86 to sign a St. Olaf Risk versus Benefit form regarding refusals of breakfast meals. In addition, LPN-A also asked why there was a stack of four cases ensure (dietary supplement) that was kept in R86's room. R86 replied, "Because I could not eat anything that they have in the menu." LPN-A suggested the alternate food but R86 went on to say, " Like now they have spaghetti, I can't have tomato. The alternate is chicken, I can't swallow chicken. Salad? I cannot swallow lettuce. That is why I keep ensure or Glucerna (diabetic nutritional supplement) so at least I can have something." -At 12:11 p.m. LPN-A stated LPN-A was to call the doctor to get an order for R86 to have the Ensure (nutritional supplement) as an alternate for meal refusals. -At 12:45 p.m. RD came to conference room to inform surveyor that an alternate sauce for R86's spaghetti was offered, so R86 was then happy eating at the ground floor dining room. On 1/14/15, at 2:47 p.m. the director of nursing stated she expected staff to do ongoing assessments to include residents' meal refusals, in order to address and prevent further problems.	F 366		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		2/23/15

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F 371	Continued From page 51 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident food was stored under sanitary conditions in one of two reach-in coolers used for storage in the kitchen where food was prepared for consumption by residents in the facility and 2 of 3 refrigerators on the units. In addition, 3 of 3 refrigerators and 3 of 3 microwaves in the kitchenette area on the units were not maintained in a sanitary manner which had the potential to effect 66 of 68 residents who use the main kitchen or the kitchenettes located on each floor of the facility. Findings Include: On 1/12/15, at 12:30 p.m., a tour of the kitchen with the director of dietary services (O)-E was conducted and the following was observed: -a walk-in cooler contained a resident's tray with a container of half-eaten fried rice with a white plastic fork inside and had the letters SHFR hand-written indicating the contents of shrimp fried rice, a meat sandwich in a clear plastic bag and a small covered container of spiced apple slices. There was no name or date observed on these food items. -the facility toaster had old crumbs and debris behind the grates -the facility stove/oven unit was dirty with baked on debris to one half, the grids and -the back splash were corroded with dries -on food -the floor fan had dust between the grids on the	F 371	" F371: There was no negative outcome to residents when facility failed to ensure resident food was stored under sanitary conditions. All residents have the potential to be affected by this deficient practice. Food Service Director will implement revised cleaning schedules for kitchen equipment. All food service staff will be educated by 2/23/15. All food service staff will be educated on the correct procedure to label and date food items by 2/23/15 All food service staff will be educated on proper food storage by 2/23/15 St. Olaf has entered into a comprehensive maintenance agreement for housekeeping and floor maintenance services effective February 16, 2015 with BSG Maintenance of Green Bay, Inc. Dining and kitchenettes will be cleaned daily including equipment. These areas will be monitored by the BSG supervisor. Nursing staff to clean refrigerator□s weekly and checked daily for outdated, unlabeled or uncovered foods, and any immediate spills that need cleaning. After meals, resident food trays including uneaten meals will be sent back to the kitchen for proper cleaning, sanitizing and storage. DON or Designee to do random audits	

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F 371	Continued From page 52 head of the fan near the blades At 12:40 p.m. the (O)-E stated the container of half-eaten food looked like Chinese food from a nearby Chinese restaurant. He further stated it was not facility practice to put outside food or resident food in the kitchen area or coolers. O-E stated he was recently hired and was getting systems in various areas in place including cleaning of kitchen appliances. He further explained the grids on the toaster needed to be removed to be cleaned and verified this had not been done. On 1/13/14, at 9:13 a.m. the following was observed in the kitchenette area on the second floor: -a resident's tray for R73 was inside the microwave -a resident's tray for R7 was in top of the microwave -a resident's tray for R70 was on top of the full-size refrigerator each tray contained a bowl of hot cereal and a breakfast sandwich which consisted of sausage, egg and cheese. A nursing assistant (NA)-F stated that one of these residents was out of the building at an appointment and the other two come to breakfast at a later time. She further explained that there was not enough room in the refrigerator to hold all the trays of residents who were not at breakfast in a timely manner. At 3:22 p.m. the microwave in the kitchenette on the second floor had spillage of clear liquid on the bottom, inside of the microwave. A brownish tinged stain was noted to the inside, left back. A moderate amount sugar sprinkles was observed	F 371	once per week and then monthly x□s three months to ensure compliance. Findings from deficient practice and audit trends will be reviewed at QAA x3 months. Corrective action to be completed by: 2/23/15	

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F 371	Continued From page 53 on the top of this same microwave. At 3:25 p.m. in the refrigerator of the second floor kitchenette NA-E verified the following: -a meat sandwich with various condiment packages was stored between two styrofoam plates, a vanilla pudding with a dollop of whipped cream was placed on the styrofoam plate and was not covered. It was not identified by a name or with a date. -a covered plate containing a baked potato, green beans and meat sauce. placed on top was a bowl of vanilla pudding with a dollop of whipped cream, uncovered. It was not identified with a name or with a date. NA-E stated did not know who it was for or who placed it there. She stated, We are not suppose to put it in here like this. We should cover and date it." On 1/14/15, 9:46 a.m. the kitchenette continued to have food splatters and debris and large amount of liquid was spilled inside the microwave. In addition, the freezer compartment of the full-size refrigerator had food particle at the base and food splatters to the back and side walls. At 2:57 p.m. the director of environmental services/maintenance (M)-A stated the kitchenette areas are checked daily by the housekeepers assigned to that unit. He further explained they are directed to throw away any unmarked food items belonging to staff or residents. He explained a thorough weekly cleaning was done and staff marked off when this task was complete and daily as checked. He would expect housekeeping to wipe down the area for spills and splatters and for staff to wipe down after each use, especially is a spill or	F 371		

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F 371	Continued From page 54	F 371		

splatter occurred. M-A stated the microwaves were "getting old and may need to be replaced".

During a conversation on 1/15/15, at 9:44 a.m. the director of nursing (DON) stated it was unacceptable practice to store resident food of in the refrigerators of the main kitchen area. She further stated all food should be dated, labeled with name and covered when stored. Refrigerators on the units were used for resident food storage and all food that was saved for residents who are out of the building or delayed coming to breakfast should be kept in these refrigerators. The DON also explained the kitchenette including the refrigerators and microwaves and kitchen appliances and surfaces should be cleaned daily and after each use.

3rd Floor Kitchenette Microwave
On 1/12/15, at 2:38 p.m. observed the microwave located on the 3rd Floor kitchenette seated on top of a low stand at the end of the kitchenette by the window next to the toaster. On top of the microwave was observed a heavy build-up of sticky dried up liquid and upon opening the microwave it was observed to have yellow food splashes, spattered all over the inside of the microwave and heavy build-up of food debris.
-At 5:37 p.m. the microwave remained the same not been cleaned still.

On 1/15/15, at 9:22 a.m. nursing assistant (NA)-A verified the microwave was not clean. NA-indicated the microwave was used by residents and was cleaned by house-keeping. NA-A further indicated "Right away I will let them know."

First floor kitchenette:
On 1/12/15, at 6:21 p.m. the first kitchenette

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F 371	Continued From page 55 observed with nursing assistant (NA)-G and the following were observed: - There was no thermometer in the refrigerator. The refrigerator had two containers of open juice undated. There were two open milk cartons and one of them had not been dated. - The inside of the microwave was stained brown and had small amount of dried food debris which could have contaminated the food being microwaved. NA-G made no comment about the findings of the lack of a thermometer in the refrigerator and the dried on food debris in the microwave. On 1/14/15, at 10:02 a.m. the 1st floor microwave remained in the same condition as the observation 1/12/15. The refrigerator freezer had been cleaned and all items in the refrigerator were now dated and labeled. The St. Olaf Policies and Procedures for Refrigerator Cleaning, review date 10/02, directs staff as follows: To maintain clean and sanitary refrigerators on resident floors: -remove any food item that is note labeled with a resident name and date, or are not from dietary for resident consumption, and discard. -remove and discard outdated items -wipe out any spills from interior surfaces and wipe down exterior with disinfectant cleaner. -the refrigerators are to be cleaned in all floors daily The St. Olaf Policies and Procedures for Resident Dining Room and Floors, review date 10/01/02, directed staff as follows: To daily maintain a clean, orderly and attractive dining room / kitchenette	F 371		

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F 371	Continued From page 56 -damp wipe with disinfectant cleaner and with a separate cloth: tables, countertops, microwaves (inside and out), refrigerators (inside and out) and ice machines.	F 371		
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 facilitate dental services for 1 of 3 residents (R81) reviewed for dental concerns. Findings include: On 1/12/15, at 3:09 p.m. during general observations R81 was observed lying in bed and was several missing teeth on the lower jaw to the front and some brown teeth with heavy tartar around the teeth. On 1/14/15, at 9:45 a.m. when asked who assisted her with grooming R81 stated she was responsible and would ask when she needed assistance. When asked about her teeth and	F 412	F412: Resident #81 has been offered dental services and did receive dental care with appointment on 1/29/2015 and has another appointment scheduled for 3/10/15. All residents at St. Olaf may be affected by the deficient practice of not offering dental care. MDS coordinator will be educated on need to consult SW if initial assessment reveals resident needs dental services. Residents will be reviewed at quarterly care conferences to assure dental needs are met and on a prn basis if any dental needs arise. DON/ Designee will complete weekly	2/23/15

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F 412	Continued From page 57 noted missing teeth R81 stated "I don't want to talk about it I have missing teeth and not seen the dentist but don't have problems with chewing." During conversation observed several teeth missing in the lower jaw and some of the visual teeth were black with build-up tartar around them. On 1/14/15, at 1:52 p.m. via a telephone conversation R81's guardian indicated she had not been called or notified by the facility regarding R81 refusing dental care and she would have expected the facility to assess her dental needs and schedule an appointment with dentist and if any problems were arising she would have expected the facility to call her as she was the emergency contact. R81 was admitted to the facility on 6/6/14 with diagnoses including paranoid schizophrenia, vitamin D deficiency, anemia, senile psychosis and acute post hemorrhagic obtained from Resident Admission Record 1/14/15. R81's quarterly Minimum Data Set (MDS) dated 12/10/14, identified R81 was independent with personal hygiene, had no behaviors which included rejection of cares and had intact cognition. In review of admission MDS dated 6/12/14, and two quarterly MDS's dated 9/10/14, and 12/10/14, all three dental sections were left blank of any dental concerns which included but not limited to broken or loosely fitting full or partial denture, no natural teeth or tooth fragments, abnormal mouth tissue, obvious cavity or loose natural teeth, inflamed or bleeding gums, mouth or facial pain, discomfort or difficulty with chewing. In addition, the dental section Care Area	F 412	audits x three months to assure residents dental care needs are met. Findings from deficient practice and audit trends will be reviewed at QAA x3 months. Corrective action will be completed by: 2/23/14	

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F 412	Continued From page 58	F 412		

Assessment (CAA) did not trigger for CAA completed on 6/12/14.

R81's ADL functional/rehabilitation care plan dated 6/19/14, identified R81 was independent but required cues with hygiene/dressing. The care plan directed staff to give R81 cues for hygiene, assist with ADL's as needed and encourage R81 to participate in cares.

R81's nutritional status care plan dated 6/12/14, identified R81 had potential for alteration in nutrition, had potential for decreased appetite and weight loss.

Review of documents revealed the following:
-Undated dental Doorstep Healthcare Services Consent For Treatment and Billing Form signed by the guardian indicated R81 had no financial representative and payment was by medical assistance.
-Nutritional Re-Assessment dated 9/11/14, and 12/10/14, indicated R81 did not have problems with chewing nor dentition.

On 1/14/15, at 10:13 a.m. registered nurse (RN)-A who was the MDS coordinator and completed all the MDS's at the facility, indicated the facility did not have a dental assessment when asked if the facility had a tool. RN-A indicated she did not see anything in the chart or medical record that showed when R81 had seen the dentist last even though the facility had a contracted dentist who came to the facility.
-When asked how the staff completed an oral/dental assessment RN-A stated "I believe they do a visual for obvious problems and check for dentures or own teeth." RN-A verified on the Admission Nursing Evaluation dated 6/6/14, had

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ST OLAF RESIDENCE	**2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411**

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F 412	Continued From page 59 indicated R81 had "Few, some missing and broken teeth." -When asked if she used the information from the assessment to complete the admission MDS dated 6/12/14, she indicated "I guess I never looked at the assessment and missed it" as she pointed to the section. RN-A verified and indicated that was why the dental Care Area Assessment (CAA) had not triggered. On 1/14/15, at 12:05 p.m. when asked about R81's dental care nursing assistant (NA)-D assigned to R81 stated R81 was responsible for all that and was not aware R81 had any dental problems including missing and discolored teeth. On 1/14/15, at approximately 10:27 a.m. RN-A approached surveyor provided a copy of the schedule book which indicated R81 had a scheduled appointment scheduled for Thursday January 29th. On 1/14/15, at 3:28 p.m. health information coordinator (HUC) approached surveyors indicated she had just scheduled the dental appointment the very day 1/14/15, after the concern had been brought to the facility staff attention and provided the number to the clinic. On 1/15/15, at 10:04 a.m. when asked her expectation regarding assessment and arranging for dental services director of nursing (DON) stated she would have expected a dental consult to have been scheduled for any resident in need of dental needs. When asked about the assessment and care planning DON stated "The assessments and MDS need to be accurate we are human and make mistakes."	F 412		

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F 412	Continued From page 60 On 1/15/15, at 11:38 a.m. via telephone the consultant dietician (CD) was interviewed and stated when doing her initial nutritional assessment she got the information about the Admission Nursing Evaluation assessment. -When asked if she was aware R81 had missing and broken teeth, CD stated she was not sure. -When CD was told R81 had missing and broken teeth which had been indicated on the initial Admission Nursing Evaluation dated 6/6/14, CD stated although she used the form to collect her data she may have "over looked" the missing, broken teeth issues which would have probably been addressed under the dentition section of the nutrition assessments and MDS's dated 6/12/14, 9/10/14, and 12/10/14. Dental Services (General) policy dated April 1, 2008 indicated the facility would provide or obtain from an outside resource, routine and emergency dental services to meet the need of each resident. In addition the policy indicated the facility would assist the resident in making appointments by arranging transportation to and from the dentist's office and promptly refer residents with lost or damaged dentures to a dentist.	F 412		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		2/23/15

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F 428	Continued From page 61 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility consultant pharmacist failed to identify medications irregularity regarding adequate monitoring for 3 of 5 residents (R23, R58, R14) who used antidepressants and antipsychotics. Findings include: On 1/13/15, at 7:14 a.m. R23 room door was observed shut upon opening the door R23 was observed lying in bed lights were on in the room and R23 was observed wearing a mask around her mouth and nose, eyes were closed and was asleep. On 1/14/15, at 7:52 a.m. to 7:57 a.m. licensed practical nurse (LPN)-E was observed prep R23's two insulins and R23 self-administered the insulins. When asked how she had slept R23 indicated she had slept well "thanks for asking." R23 appeared calm and with a flat affect. R23's diagnoses included schizoaffective, manic depression and diabetes Mellitus obtained from the admission Minimum Data Set (MDS) dated 12/28/14. In addition the MDS indicated R23's cognition was intact, had indicated having trouble falling or staying asleep or sleeping too much and was feeling or had little energy. The MDS also indicated R23 had no behaviors but received daily both an antipsychotic and an antidepressant. Psychotropic drug use Care Area Assessment	F 428	F428: Resident # 23,58,14 has had a pharmacy review completed and DON has addressed recommendations. All residents at St. Olaf have the potential to be affected by this deficient practice. Consultant Pharmacist has been educated on need to meet with DON/Designee prior to exit Q visit to give a report and recommendations of medication irregularities. DON will set up a binder and track recommendations made and audit weekly that nursing have completed recommendations and that physicians have addressed recommendations. This will be audited weekly x three months to assure system is sustained. DON or Designee will request medication review with pharmacy consultant of residents who have frequent falls which may be r/t psychotropic/or other medications that may contribute to falls with tracking residents fall log. This will be audited weekly x□s one month then monthy x□s three months to assure system is sustained. LN will receive education on assuring residents on antipsychotics to assure medication have targeted behavior sheets in place to monitor their targeted behaviors and orthostatic blood pressures	

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F 428	Continued From page 62 (CAA) dated 1/2/15, indicated R23 received psychotropic medications related to bipolar disorder, schizoaffective disorder. Monitor and administer medications per order. Psychotropic Drug use care plan dated 1/4/15, identified R23 was at risk for adverse consequences related to receiving antipsychotic medications for treatment of schizophrenia and bipolar disorder and also received an antidepressant. The care plan directed staff to administer medications per orders, monitor resident behavior and response to medications and assess/record effectiveness of drug treatment. Review of R23's Physician's Orders dated 1/8/15, revealed R23's orders were as follows: -Olanzapine (atypical antipsychotic used currently in the treatment of schizophrenia and bipolar illness) 20 milligrams (mg) 1 tablet orally every bedtime. -Escitalopram (medication used for treating depression and generalized anxiety disorder) 20 mg 1 tablet orally daily. Review of the Medication Administration Records (MAR's) and Treatment Administration Records (TAR's) from 12/22/14, through January 15th 2015, revealed R23 lack behavior tracking/monitoring, no orthostatic blood pressures had been completed since admission and no side effects monitoring had been initiated despite R23 was receiving both an antidepressant and antipsychotic. Merwin Long Term Care Pharmacy Record of Medication Regimen Review completed monthly by the consultant pharmacist revealed the review was last done 1/13/15, and behavior tracking, orthostatic blood pressures and side effects	F 428	checked monthly. In addition to side effects of psychotropic medications are placed on Mar, Tar and care plan. LN will receive education on placing side effects of antiocoagulant therapy on Mar,Tar and care plan. SW/Designee will do a 100% audit of residents on antipsychotics to assure they have targeted behaviors in place and then will complete weekly audits x three months to assure the system is sustained. DON/designee will do 100% audit to assure that residents that are on anticoagulant therapy and psychotropic medications will have side effects listed on the Mar, Tar and is care planned. Orthostatic blood pressure will be monitored monthly on the TAR. Then will complete weekly audits x□s three months to assure the system is sustained Findings from deficient practice and audit trends will be reviewed at QAA x3 months. Corrective action will be completed by: 02/23/15	

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monitoring were not identified as missing in the medical record.

On 1/14/15, at 8:35 a.m. registered nurse (RN)-A verified R23 did not have both behavior monitoring, mood monitoring, orthostatic blood pressure and side effects for the antidepressant and antipsychotic. RN-A went through the TAR and verified all the required monitoring were missing and stated she would ask the nurse who checked the MAR and TAR sheets during end of month change over to see what happened. RN-A went through the TAR and showed surveyor how the behavior, mood and side effects sheets would look like as they were printed from the pharmacy. RN-A further stated the admission nurse would check to make sure this was all in place when a resident was admitted.
-At 9:31 a.m. RN-A approached surveyor indicated the behavior monitoring sheets for December 2014, were in the chart to the back which R23 was transferred with from the assisted living next door. She verified again the behavior, side effects, orthostatic and mood monitoring were missing in the TAR and MAR for January 2015.

On 1/13/14, at 10:03 a.m. the director of nursing (DON) stated "These sheets do not have the month they cannot possibly be for December as resident was admitted to the facility on 12/22/14." DON verified after going through the entire chart orthostatic blood pressures, side effects and behavior monitoring were all lacking and indicated "they should have been in place. I have put a list of medications with side effects which were supposed to be attached to the care plan and I guess it's not there."
R58 was observed and interviewed on 1/14/15, at

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10:45 a.m. R58 sat at the edge of the bed, had a flat affect and was calm. R58 stated she had the total parenteral nutrition going all night long, she didn't feel like eating breakfast since she was a late riser. R58 had no concerns or a question, her mood was "Ok", and stated "I can tell staff if I need something."

The undated Resident Admission Record indicated R58 was admitted to the facility on 3/7/14, with most recent admission to the facility on 12/11/14.

R58's quarterly MDS completed on 12/4/14, indicated R58 had intact cognition, and had no behaviors, hallucinations or delusions. The MDS also indicated R58 had depression and anxiety.

The current physician's order dated 12/12/14, indicated resident took the following medications including:
- Citalopram (antidepressant medication) 20 mg 1 tablet daily
- Zyprexa (anti-psychotic medication) 5 mg 1 tablet at bedtime
- Mitrazapine (antidepressant medication) 7.5 mg at bedtime

Review of R58's medication administration and treatment record from July 2014 to present indicated R58 took the Zyprexa continuously; however, there was no anti-psychotic medication side effect monitoring (including monthly orthostatic blood pressure) completed.

The Record of Medication Regimen Review indicated the consultant pharmacist reviewed R58's medication regimen on 7/10/14, 8/14/14, 9/16/14, 10/14/14, 11/18/14, 12/16/14, and

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1/13/15. There were notes written for nursing on 8/14/14, 9/16/14 and 10/14/14, however, only the one dated 8/14/14, was provided by the facility for review, which addressed possible gradual dose reduction. There were no irregularities identified regarding lack of psychotropic medication side effect monitoring.

The DON was interviewed on 1/15/15, at 8:44 a.m. and stated she expected staff to monitor the anti-psychotic medication side effects, which included orthostatic blood pressure monitoring. The DON reviewed R58's medical record and confirmed the lack of side effect monitoring.

The consultant pharmacist was contacted via phone call on 1/15/15, at 8:37 a.m. but was not available for an interview.

R14 was observed on 1/15/15, at 11:03 a.m. seated in a wheelchair in her room watching the television (TV). R14 had a flat affect and was calm. She was asked if she knew what medications (meds) she was on, and she said, "Some of them." She further indicated her mood was "good." During an additional interview, R14 indicated she had no symptoms of feeling tired, down, or depressed. She indicated she was at the facility for rehabilitation following a leg fracture, and was hoping to go home soon.

R14's chart was reviewed for:
- A review of Nurse's Notes at the time of admission going forward to 1/15/15, indicated BPs were taken however, they were not orthostatic blood pressures (OBPs, a condition in which a person's blood pressure drops significantly when changing positions from lying down or sitting to standing up. When stood up

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after sitting or lying down, blood pools in the legs. The direct cause of orthostatic hypotension is failure of the body to react quickly to the position change by shunting blood from the legs back to the heart. With not enough blood to be pumped out of the heart, blood pressure drops. A person with orthostatic hypotension usually becomes dizzy or falls down when standing up too fast). The facility did not monitor the side effects of the psychotropic medication in relationship to the identified falls risk.
- The MAR noted R14 was ordered Abilify on 12/22/14, Nortriptyline on 12/22/14, Zoloft on 12/22/14, and Klonopin on 12/30/14.
- One Nurse's Note dated 12/22/14, at 4:30 p.m. indicated "...no behavior problems noted @ this time." The medical record lacked evidence of ongoing monitoring of behavior or mood symptoms nor was any OBPs noted in the Nurse's Notes.
- R14's MDS dated 12/28/14, indicated R14 had diagnoses which included depression and anxiety. The MDS also depicted R14 as being cognitively intact, as displaying mood symptoms such feeling down, depressed or hopeless, poor appetite or overeating, and feeling bad about yourself, displaying no behaviors as of admission, and as having fallen at least once in the last month which resulted in a fracture within the last six months. The facility identified R14 as taking antipsychotics, antidepressants, antianxiety, and diuretic medication in the last seven days.
- The CAA for falls dated 12/28/14, indicated the facility's analysis identified the resident as being at risk for falls due to mobility and history of fall with fracture. The interventions were for staff to assist with transfers, physical therapy/occupational therapy per orders and wheelchair for locomotion. The facility was to

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F 428	Continued From page 67 proceed to care plan. The analysis lacked evidence of how the facility was going to intervene for falls regarding the resident's psychotropic medication and diuretic use. The CAA for psychotropic medication dated 12/28/14, noted the analysis section indicated, "resident receives Psychotropic r/t [related to] Dx [diagnosis] Anxiety and Depression. See Admission H&P [history and physical] for psychiatric documentation. Proceed with cp [care plan]." The CAA lacked evidence of how the facility intended to implement interventions and monitor the use of the psychotropic medication for adverse side effects and efficacy in relationship to the identified falls risk. The CAAs for mood and behavior did not trigger from the facility findings. - No behaviors were monitored for the month of December 2014 when R14 was admitted. The medical record lacked evidence of justification and appropriate behavior monitoring as the facility identified R14 as being monitored for "altered mental status" on the January 2015 TAR sheets. The inappropriate behavior monitoring was started during the survey process. The medical record lacked evidence of the facility staff monitoring specific behavioral symptoms due to mania or psychosis such as auditory, visual, or other hallucinations, delusions, paranoia and/or grandiosity. - A "Psychotropic Drug Use" care plan dated 1/3/15 indicated R14 was using medications for depression and anxiety and had a history of alcoholism. Goal: "R14 will result in maintenance of functional status..." The care plan directed the administration of meds per orders, Dyskinesia Identification System: Condensed User Scale (DISCUS) on admission and quarterly, monitor for effectiveness and side effects of medications and	F 428		

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F 428	Continued From page 68 pharmacy consult review. - A "Behavioral Symptoms" care plan dated 1/15/15, identified R14 had a history of treatment noncompliance, diagnoses that affect her behavior included depression, anxiety, and persistent mental disorder. In addition the care plan indicated R14 had a history of alcohol abuse and attended weekly Alcoholics Anonymous meetings..."Goal: will accept cares." The care plan directed staff to reapproach later as needed, use a calm, gentle approach with R14, explain steps of cares as they were being performed. - A review of the January 2015 TAR sheets revealed orthostatic blood pressures OBPs had not been done for the months of December 2014 and January 2015 to determine if R14 displayed any low blood pressure related to medication. The medical record lacked evidence of justification and appropriate mood monitoring as the facility identified R14 as being monitored for "mood changes" on the January 2015 TAR sheets even though the facility identified mood symptoms on the 12/28/14 MDS. The inappropriate mood monitoring was started during the survey process. On 1/15/15, at 10:32 a.m. an interview was conducted with LPN-D. LPN-D indicated he was unable to find records of monitoring of medication side effects (SE) or monitoring of OBPs prior to the survey process. LPN-D expected the SE and OBP monitoring to be found in the treatment book, however, he verified no specific SE or OBP monitoring was being completed as of 1/15/15. LPN-D showed the surveyor the "Behavior Monitoring Record," for R14's medication Nortriptyline, an antidepressant med. The record indicated monitoring by check-off box for nonspecific "mood changes," and the Behavior	F 428		

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F 428	Continued From page 69 Monitoring Record for R14's Abilify, an antipsychotic med indicated monitoring by check-off box for nonspecific "altered mental status." No specific behaviors at all were identified for monitoring. Both sheets were started on 1/13/15, however that contradicted LPN-D's above interview which noted no evidence of SE monitoring could be located in the medical record. LPN-D indicated they would do vital signs (VS) which would include blood pressures every shift and all should be charted in the Nurse's Notes. He added there was no graphic chart for VS, which included OPBs. - During an interview on 1/15/15, at 10:55 a.m. LPN-C indicated he would expect OBPs to be documented on the pharmacology sheet in the chart. LPN-C looked in R14's chart and verified, "No, they're not in there." LPN-C added SEs should be found on side effects documentation sheets in the TAR, but on 1/15/15, at 10:56 a.m. LPN-C verified he could find no SE sheet in the TAR for R14. - At 10:44 a.m., the MDS nurse, RN-A was asked to show where the monitoring of orthostatic blood pressures and side effects for psychotropic meds could be found. She indicated she could not locate the information and they should have been in R14's chart. It was her expectation they were to be done on admission and quarterly. - On 1/15/15, at 12:15 p.m., the consulting pharmacist was interviewed. When he was asked what he would expect to see for monitoring of OBPs and SE he stated, "I don't look for anything to be ordered every week, unless they're having falling or other issues. I don't expect even one a month unless there's a doctor's order." On 1/15/15, 12:15 p.m. when asked her expectation about the facility doing orthostatic	F 428		

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F 428	Continued From page 70 blood pressures for residents who were on psychotics the consultant pharmacist stated "I don't look for anything to be ordered every week, unless they're having falls or other issues and I don't expect even every one month unless there a doctor's order." -When asked about behavior tracking and side effects monitoring the consultant pharmacist stated she expected the facility to have this in place specific to what the resident was currently taking and there were sheets generated. -When asked what her expectation was regarding the facility monitoring for bruising when resident was on Lovenox the consultant pharmacist stated "I would look in skin checks, nursing notes, to see if concerns for bruising during my reviews." - When asked if the facility needed to have bruising and risk of bleeding care planned as resident was at risk for bruising and bleeding, the consultant pharmacist stated she would have expected that to be in place.	F 428		
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	F 441		2/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING _____ B. WING _____	01/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

(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 71 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not ensure infection control practices were maintained during dressing change for 1 of 1 resident (R62) reviewed for pressure ulcer. Findings include: On 1/13/15, at 2:43 p.m. licensed practical nurse (LPN)-A stated she was going to do a scheduled wound dressing change for R62. LPN-A informed R62 about the procedure. While LPN-A prepared the dressing supplies, another nurse, LPN-G stood by as R62 slowly transferred himself to	F 441	F441: Resident # 1 has not had any negative outcomes R/T this deficient practice. All residents at St. Olaf receiving wound care can be affected be this deficient practice. The LN performing wound care was given education on proper wound care infection control practices. LN□s will receive in-service and wound care competency checks. DON/Designee will observe wound care weekly for three months as an audit to ensure infection control practices are	

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F 441	Continued From page 72 bed. R62 was lying in bed with the head of part elevated at about 60-degree angle. There was a strong odor as LPN-A removed R62's boots. LPN-A placed a pillow lined with a white towel under R62's feet. LPN-A washed her hands, wore a pair of gloves and cut R62's old Unna boots (a compression bandage that contains zinc oxide impregnated into the rolled gauze used to treat edema and leg ulcers) with a pair of scissors. LPN-A removed the old 2x2 gauze dressing on R62's left foot. There was a strong odor and a moderate amount of yellowish drainage observed on the old dressing. LPN-A stated the wound was at Stage II (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). The wound base was beefy red. LPN-A slowly put R62's left leg down. The wound was on the left sole which was directly pressed against the bed's foot board. LPN-A washed hands, wore a new pair of gloves, took a soapy wash cloth and scrubbed R62's left leg from below the knee down to the foot but did not touch left plantar area's wound. LPN-A flipped the soapy wash cloth then went to scrub the right leg from below the knee to the foot. LPN-A flipped the soapy wash cloth again then finally wiped the left foot plantar wound. Throughout the soap washing procedure, LPN-A used one soapy wash cloth. There was minimal bleeding observed as LPN-A washed the wound. LPN-A put the soapy wash cloth aside and was observed to have small amount of bloody stain. LPN-A then took another white wash cloth which was wet with tap water, wiped R62's left leg, flipped the wash cloth, wiped the right leg then went back to wash the left plantar wound. R62 re-acted with discomfort as the R62's face had a grimaced look during the	F 441	maintained. Findings from deficient practice and audit trends will be reviewed at QAA x3 months. Corrective action will be completed by: 02/23/15	

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ST OLAF RESIDENCE	**2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411**

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F 441	Continued From page 73	F 441		

procedure. LPN-A assured R62 by explaining what she was doing. LPN-A left the wet wash cloth pressed against R62's wound, between the left sole and the bed's foot board. There was one wash cloth used to rinse.

LPN-A took a dry towel and used it to dry R62's legs then wiped starting from left leg to right leg and back to left plantar wound using the same towel. LPN-A put down R62's left leg where the wound was again pressing against the bed's foot board. When surveyor commented about wound touching the bed's foot board, LPN-A instructed R62 to move himself up from the bed but R62 stated he could not do it, instead suggested that left foot be elevated more using one more pillow. LPN-E took one pillow from R62's left side and placed it under the R62's legs. The wound was no longer touching the bed's foot board. LPN-A measured the wound as 4.3centimeters (cm) X 0.5cm X 0.05cm, with minimal bleeding. LPN-A put a new 2X2 gauze dressing over the wound and wrapped the leg with Unna boots.

On 1/3/15, at 3:30 p.m. when asked to review the process of R62's wound dressing that was just concluded, both LPN-A and LPN-G stated washing started from the "clean" area going towards the "dirty" area referring to the wound. Both licensed practical nurses confirmed R62's lower legs were washed first before washing the wound. LPN-A also confirmed using one wash cloth for the soap, one wash cloth for the rinse and one towel to dry.

The Resident Admission Record indicated R62 was admitted to facility on 8/2/13 with diagnoses including diabetes type II, dementia, and lower extremity venous ulcer.

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F 441	Continued From page 74 R86's current treatment record dated 1/15, directed staff to cleanse bilateral legs with soap and water; pat dry; apply 2X2 gauze to open area on left foot; apply bilateral Unna boot cover with Coban (a self-adhesive wrap used to treat wounds); change every 5 days and PRN; off-load shoe on left foot. On 1/14/15, at 7:29 a.m. the wound doctor clarified R62's wound was a diabetic ulcer and stated nurses were expected to wash "starting from the wound outwards and not the other way." LPN-A was present when the wound doctor made the clarifications. LPN-A admitted she washed the wound from the outside and towards the wound and stated she would wash wounds starting from the wound outwards from then on. During interview with the director of nursing (DON) on 1/14/15, at 2:47 p.m. she stated expectations that nurses wash wounds following infection control measures, that was to wash from the wound to the outside and also not to let an open wound be in contact with any surface. The facility's undated Policy for Wound Care and Documentation included procedure for clean dressing technique which directed staff to use "no-touch" technique; do not directly touch any item that would be in contact with the wound; and wash from the center of the wound to the periphery.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional,	F 465		2/23/15

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F 465	Continued From page 75 sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a sanitary and comfortable environment was provided, and resident equipment was in good repair. This had the potential to affect 6 of 35 residents in the sample which included (R72, R36, R58, R98, R33, R29). Findings include: An environmental tour was conducted on 1/14/15, with personnel from the Environmental Services (ES) department: maintenance person (M)-A (the environmental services and housekeeping director), and M-B (the maintenance assistant), who were present starting at 11:35 a.m. Joining the tour after 12:14 p.m. were the director of nursing (DON) and the administrator. The following were observed: 1. Room 218-1: R72 was in her room, 218-1 and pointed out a small area of loose debris and dust between two dressers. M-A noted it and indicated he had "not known about it," and would have Housekeeping clean it. 2. Room 224-1: There were black scuffs observed on a wall on the left side of the room. M-A revealed, "We would normally catch this when we [ES] do rounds of all rooms every month, and would patch and repaint." 3. Room 303-1: The bathroom's toilet bowl had brown streaks on its outside, and also inside the bowl. Further, in the deepest part of the interior	F 465	"F465: Resident #72, 36, 58, 98, 33, 29 have had no negative outcome r/t facility deficient environmental controls All residents have potential to be affected by this deficient practice. St. Olaf has entered into a comprehensive maintenance agreement for housekeeping and floor maintenance services effective February 16, 2015 with BSG Maintenance of Green Bay, Inc. This contract encompasses the entire facility. Specific cleaning policies have been developed for resident rooms, general offices, dining rooms, activity rooms, kitchenettes, and common areas. All facility floors are included under the cleaning agreement. Dining and kitchenettes will be cleaned daily including equipment. These areas will be monitored by the BSG supervisor to ensure compliance. Improvement will be noted by 2/23/15	

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F 465	Continued From page 76	F 465		

bowl, in the narrow flush passage was visible a black area of discoloration, and the toilet had missing caulk in a section around the base at floor level. M-A confirmed these problems were not acceptable and stated on 1/15/15, at 12:51 p.m. "We were not notified of this, and we will put it on our repair list - a housekeeper should have caught this." M-A also repeated what he had said several times during the tour, "We fix things as soon as we hear about them."

4. Room 304-2: Observation noted a yellowish, smeared/gritty-looking area on the floor tiling between the wall and the rear of the toilet, below the toilet's exit pipe to the wall. On 1/15/15, at 12:53 p.m. M-A indicated that was "not reported." M-A identified the discolored area under the pipe as lime deposits, and said, "We will have to change the cleaner to make sure we get that off."

5. Room 319-1: Observation noted unpainted white plaster patches on the wall. In addition, observation of the bathroom doorway revealed scuffing off of paint at the bottom. M-A stated at 12:57 p.m. "We found this on monthly rounds. That's something we do, patch first, let the patch dry well, and come back to paint, and this one is just between steps of that process." M-B, however, admitted he had patched the wall areas about two weeks before, and had not yet gotten to painting it over. He added he would normally follow up as soon as possible, but cosmetic issues could be delayed by prioritizing repairs of call lights and other safety issues.

6. Room 330-1: Observation of a stuffed chair was noted to have a seat cushion stained: the chair was covered in light brown fabric and the stain was a larger, darker irregular outline on the cushion. M-A indicated ES was "not notified," adding they would shampoo the area. The DON stated, "Any staff should have reported this,

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F 465	Continued From page 77 nursing, housekeeping..." A three-ring binder titled "Environmental Services Requisition Communication Log" was observed on 1/15/15, at 1:21 p.m. after the room tour. It contained pages titled, "Environmental Services Requisitions (ESR)," which were filled out specific to each of the three units. The ES director, M-A indicated the most current pages were still on the units. Copies of these from August, 2013 to the present were provided and reviewed. M-A's indicated ES had not been notified of the problems observed during the tour as facility staff who may have observed environmental problems did not follow the protocol/policy for reporting identified environmental concerns. The log sheets included column headings for "Reported by," whose boxes below were almost always completed; and for Priorty [sic] level," which were rarely completed; and headings for "Response or (Follow-up) [sic]," which had written entries which were seen to indicate either the response, or in some cases a note on what the problem actually was, without a notation of the response. Most responses were simply written as "Done," with no specifics on what/how the repair was done. There were also seen headings for "Date Complete," which had dates indicated for August and September of 2014, but rarely in more recent months; and there were headings for "Completed by," and a similar pattern was observed in these columns. The entries may have indicated a problem-logging system that was only sporadically and incompletely being followed. Two documents titled, "St. Olaf Residence Policies and Procedures...Environmental Services," each with a last review date of 10/2/02	F 465		

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F 465	Continued From page 78 , was observed. One was subtitled "Spot Cleaning of Walls," and included the following: "Procedure...4. Report any wallpaper tears, cracks or chips in paint or plaster by writing it in the maintenance books at each nursing station." The other document included the subheading, "Resident Room Cleaning (General)," and included, "Procedure...9. Write any damaged items, such as...nurse call cords, etc., repairs needed or unsafe conditions, in the maintenance books at each nursing station." An interview was conducted on 1/14/15, at 1:59 p.m. with the ES director to ask about department staffing, because of the indication of delayed or prolonged responses to problems known to the ES department, despite repeated assertions that they would respond to problems as soon as they were known, and because of repeated responses during the tour which indicated the ES department had not been informed of problems observed by ES while on the tour with the surveyor. When M-A was asked about staffing in the department: he stated, "There are only two of us to do all this place. We are down two employees. They are waiting for the census to come up to replace the positions."	F 465		
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.	F 492		2/23/15

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 492	Continued From page 79 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed ensure 1 of 1 resident (R8) rooms (room 107) which had a toilet in the room met the applicable codes/ regulations. Findings include: On 1/12/15, at 12:15 a.m. during entrance conference the interim administrator stated he was not aware the facility had a bedroom which had a toilet in the room, and for which the facility needed to apply for a waiver. The administrator further stated he was the interim administrator and started working only six weeks ago. The director of the nursing (DON) stated she was aware there was a room in the facility that had a toilet in the room, but was not aware the facility had a waiver for it, and that they needed to renew that waiver. Review of R8's current physician's orders dated 1/1/15 indicated diagnoses including traumatic amputation of leg and morbid obesity. The quarterly minimum data set (MDS) dated 11/5/14 indicated R8 needed limited assistance of one staff with toileting. On 1/14/15, at 9:40 a.m. R8's room was toured with the interim administrator. The bathroom was observed immediately to the right of the entry way with a toilet covered with a big brown carton box, and a folded wheel chair in front of it. The room was observed, there was a bed in the left side of the room against the wall. On the right side there was the toilet and the sink (closer to the window). The door sign indicated R8 lived in the room.	F 492	"F492: Waiver Approved by the engineering services section. Benjamin J. Zwart, P.E. Public Health Engineer. Letter dated January 20, 2015. Waiver in effect until October 31, 2015. Room 108 toilet does not meet the regulator code (waiver applied) Room # is 107	

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F 492	Continued From page 80 On 1/14/15, at 2:45 PM R8 was observed and interviewed in the room. R8 stated he just finished using the toilet, and it was a great idea to have the toilet in the room for easier access during transfers. R8 did not want to answer any additional questions. On 1/15/15, at 10.00 a.m. the administrator provided the room 107 waiver dated October 14, 2013, for review, and stated he will apply for a waiver renewal. Review of the waiver revealed the following information "This waiver will remain in effect until October 31, 2014 or until the resident currently assigned to room 107 was assigned to a different bedroom or departs the facility, whichever occurs first. Please be advised that all waivers are subject to review as deemed necessary by the Department. Please remember that all alternative measures of conditions attached to a variance or waiver shall have the force and effect of a licensure."	F 492		

Protecting, Maintaining and Improving the Health of Minnesotans

January 20, 2015

Mr. David M. Uselman
Administrator
St. Olaf Residence
2912 Fremont Avenue North
Minneapolis, Minnesota 55411

HFID # 00260

Dear Mr. Uselman

I am writing in response to your letter, dated October 31, 2014, requesting a waiver for MN. Rule 4658.4140 regarding the requirement that each resident toilet room be directly accessible from the bedroom. According to your letter room 107 was remodeled resulting in the elimination this room's complying toilet room. A toilet and lavatory were installed within the sleeping area of room 107. Upon completion of this remodeling project, room 107 was no longer a complying resident bedroom and therefore, could not be either licensed or certified as such.

Your letter indicates that room 107 was put into use for a bariatric resident in June of 2013. In the letter you provide justification for using room 107 as a private resident bedroom to accommodate the needs of this particular bariatric resident currently assigned to this room.

Your request to temporarily use room 107 as a private resident bedroom was reviewed and approved by the Engineering Services Section. The following conditions are applicable to this temporary waiver.

1. Use of this room as a resident bedroom is approved only to accommodate the needs of the one resident currently assigned to this room. Once this resident departs the facility of is assigned to a different room, room 107 must be either remodeled to a complying resident bedroom or be de-licensed and decertified. This may result in a change to the facility's total number of licensed nursing home beds.
2. This waiver will remain in effect until October 31, 2015 or until the resident currently assigned to room 107 is assigned to a different resident bedroom or departs the facility, whichever occurs first.

Please remember that all alternative measures or conditions attached to a variance or waiver shall have the force and effect of the licensure rule(s) and shall be subject to the issuance of correction orders and penalty assessments in accordance with the provisions of Minnesota Statute 144.653 and 144A.10. The period of time for correction and the amount of fines specified for the particular rules for which the variance or waiver was requested, shall apply.

Should the facility need to renew this temporary waiver in 2015 please submit a request for extension with justification.

Please be advised that although this temporary waiver was approved in this one instance, the Department most likely will not approve a similar waiver request for a different resident in the future. Should the facility desire to admit bariatric residents, it is strongly recommended that room 107 and/or other rooms be remodeled to include a complying private bariatric toilet room within each bedroom.

If you have any questions concerning this matter, please contact me at 651-201-3715.

Sincerely,

Benjamin J. Zwart, P.E.
Public Health Engineer
Engineering Services Section

cc: Waiver File
G. Derfus – Metro C
File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/21/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	**2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, St Olaf Residence was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 482.41 (b), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, "The Life Safety Code" (LSC), Chapter 19 Existing Health Care. St Olaf Residence is a 4-story building with a basement. The original building was constructed in 1964, is separated from a church with a 2 hour fire rated barrier and was determined to be of Type I (332) construction. The facility is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection throughout the corridor system, in common areas and areas open to the corridor system and is monitored for automatic fire department notification. The facility has a capacity of 80 beds and had a census of 65 at the time of the survey. The requirement at 42 CFR, Subpart 482.41 (b), is MET.	K 000		

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

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.

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: February 2, 2015

Mr. James Laine, Administrator
St. Olaf Residence
2912 Fremont Avenue North
Minneapolis, Minnesota 55411

Re: Enclosed State Nursing Home Licensing Orders - Project Number S538702

Dear Mr. Laine:

St. Olaf Residence is a Special Focus Facility (SFF) and was surveyed on January 12, 2015 through January 15, 2015 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:

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

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

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 about this electronic notice.

Sincerely,

Anne Kleppe

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00260	A. BUILDING: _____ B. WING _____	01/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On January 12 through January 15, 2015, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Monitoring, Licensing and Certification Program; 3333 West Division St, Suite 212, St. Cloud, MN 56301. The facility has 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 electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 565	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	2 565		2/23/15

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2 565	Continued From page 2 by: Based on observation, interview and document review, the facility failed to follow care in accordance to the care plan for 1 of 1 resident (R23) who self-administered insulin during a medication administration observation. In addition, the facility failed to ensure dialysis site dressing was removed after dialysis to reduce the risk of access site infection, clotting and to monitor access site for 1 of 1 resident (R63) according to the plan of care. Findings include: R23 was observed in the dining room on 1/14/15, at 7:52 a.m. and licensed practical nurse (LPN)-E was observed to prepare R23's insulins outside the hallway across from R23's room. -At 7:54 a.m. LPN-E entered the room with a Novolog Flex pen dialed up to 18 units and a drawn up syringe of Lantus 85 units. -At 7:55 a.m. LPN-E was observed don a pair of gloves at R23's bedside as R23 was seated on the wheelchair. Then set the Novolog Flex pen on the night stand and then as she approached R23 to give the Lantus insulin R23 grabbed the insulin from LPN-E and was observed jab the needle to her left lower abdomen without pinching the skin prior and during administration. -At 7:57 a.m. LPN-E picked the Novolog Flex pen from the night stand indicated to R23 it was dialed up already and handed it to R23 and instructed her to pinch the skin and R23 was observed give herself the insulin again to the left lower abdomen again and never pinched her skin either. -At 7:59 a.m. when LPN-E came out of room she proceeded to close the three ring binder which contained the Medication Administration Record (MAR) before documenting the administration.	2 565	Corrected completion date 2/23/15	

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2 565	Continued From page 3 Surveyor approached and asked LPN-E when she would be documenting and the facility expectation after administering medications. LPN-E indicated she was supposed to document immediately. LPN-E then opened the MAR initiated the MAR and wrote behind the MAR R23 had self-administered insulin. When asked if R23 had an order to self-administer medication (SAM) LPN-E stated she did not think so and verified after going through the MAR. LPN-E asked "I thought residents had the right to give their own medications." R23's diagnoses included schizoaffective, manic depression and diabetes Mellitus obtained from the admission Minimum Data Set (MDS) dated 12/28/14. Review of R23's Physician's Orders dated 1/8/15, revealed R23's orders were as follows: -Lantus injection 100/milliliter (ml) inject 85 units sub-cutaneous (SQ) daily -Novolog injection 18 units SQ three times daily with meals Care plan dated 1/4/15, identified R23 with the potential for complications related to diagnoses of diabetes mellitus and directed the staff to administer medications per orders and to monitor and rotate injection sites. On 1/13/15, at 8:16 a.m. LPN-D supervisor verified R23 did not have an order to self-administer insulin after going through the orders and the undated Self Administration of Medications Assessment which indicated R23 did not wish to keep any medications at bedside and also did not want to self-administer any medications after set up. When asked if R23 was supposed to SAM he stated "Nope."	2 565		

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2 565	Continued From page 4 On 1/13/15, at 10:03 a.m. the director of nursing (DON) stated because of that incident she had the nurses get an order for R23 to SAM as resident had lived in the assisted living next door and thought probably R23 did give herself the insulin there. DON acknowledged the nurse should have told R23 she would give the insulin and stated she did not have an order to SAM and the care plan should have been followed. Self-Administration of Medications policy revised May 2011, indicated if a resident had expressed a desire to self-administer medications an assessment would be done, the facility would require drugs to be administered by the nurse until the interdisciplinary team (IDT) had the opportunity to obtain information necessary to complete an assessment and update the care plan. In addition, the policy indicated nursing would obtain an order from the physician for self-administration of medications. On 1/13/15, at 10:03 a.m. when asked about the Insulin SAM the director of nursing (DON) stated she was not told about the second insulin that the nurse had handed to R23 and because of the incident she had the nurses get an order for R23 to SAM as resident leaved in the assisted living next door and thought probably R23 did give herself the insulin there. DON acknowledged the nurse should have told R23 she would give the insulin and stated she did not have an order to SAM and the care plan should have been followed. Self-Administration of Medications policy revised May 2011, indicated if a resident had expressed a desire to self-administer medications an assessment would be done, the facility would	2 565		

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2 565	Continued From page 5 require drugs to be administered by the nurse until the interdisciplinary team (IDT) had the opportunity to obtain information necessary to complete an assessment and update the care plan. In addition the policy indicated nursing would obtain an order from the physician for self-administration of medications. R63 was observed seated in his room watching television on 1/14/15, at 10:06 a.m. The resident was wearing a short sleeved shirt which exposed left arm dialysis access site observed with cotton and secured with paper tape. R63 stated had been to dialysis the day before and had no report of pain. R63's signed Physician Orders dated 1/13/15, indicated monitor dialysis access site for intact dressing, closed clamp caps, signs and symptoms of infections, bleeding, petechiae, prolonged bleeding with blood draw, bleeding gums, and drop in blood pressure. The staff was to notify the medical doctor (MD) if resident had any bleeding every shift, check access site for bruit thrill every shift, notify MD if there is no bruit or thrill every shift and replace pressure dressing to shunt site as needed (PRN). Staff was directed to use dialysis emergency protocol for access problems or bad weather that may have caused resident to have missed or delay dialysis. Staff was to remove the pressure dressing every Wednesday, Friday and Sunday morning and apply pressure dressing if bleeding persisted. Staff was to check the shunt, palpate and auscultate thrill daily. The nurse was to check bruit/thrill daily every morning on the left antecubital area.	2 565		

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2 565	Continued From page 6 Review of R63's treatment sheet dated 11/9/13, indicated pressure dressing to be removed every Wednesday, Friday and Sunday morning and to apply pressure dressing if bleeding persists. It also indicated nurse was to check bruit/thrill daily every morning on left antecubital area and shunt palpate and auscultate thrill daily. R63's quarterly MDS dated 1/2/15, noted diagnoses including diabetes mellitus (DM), hypertension, dementia, and indicated R63 received dialysis. The resident's Brief Interview for Mental Status (BIMS-tool used to measure cognition) indicated R63 had moderate impaired cognition, and R63 received limited assistance self-performance with one person physical assistance support with cares. The plan of care: renal function/dialysis dated 1/5/15, identified R63 with diagnosis of end stage renal disease (ESRD). The goal was the dialysis access site will be free of infection and remain patent during review period. Interventions were to monitor dialysis access site for intact dressing, closed clamp caps, signs/symptoms of infection, check access site for bruit or thrill every shift and staff may remove dressing to shunt site four hours after return from dialysis. When interviewed on 1/14/15, at 12:40 p.m. a licensed practical nurse (LPN)-A stated what she should do with resident's dialysis dressing. LPN-A stated she had to remove dressing on R63's fistula today and that would be done on her morning shift. If it had still been bleeding she would replace dressing, and would check thrill also. If there had been an emergency and it did not stop bleeding, she would get an order to send R63 to the emergency room (ER).	2 565		

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2 565	Continued From page 7 The dialysis center's registered nurse (RN)-B was interviewed on 1/15/15, at 8:44 a.m. and when asked, reported how the runs are going with R63, RN-B explained they are "going good so far. " When asked what the expectation would be regarding removing the dressing after runs, stated "dialysis center would prefer dressing to be removed three to four hours after, probably by bedtime. " RN-B indicated R63 had come back for the next run with the dressing from the previous time he was at the facility and "we have communicated with the facility several times about this issue. " When asked what the implications would be if the dressing was not removed stated "the site would be warm and it would increase the chances of infection and clotting. " On 1/15/15, at 11:07 a.m. when asked director of nursing (DON) indicated she thought dialysis dressing removal was PRN. Resident Care Policies and Procedures-Skilled Nursing Facility, Health Dimensions Group dated 2013, indicated: " f. Dialysis center's expectation of care to be completed by skilled nursing facility (SNF) (if any) such as: checking thrills/bruit of grafts and fistulas, documented on TAR, when to remove dressing from the access site placed on from the dialysis center, emergency protocol for uncontrolled bleeding from any dialysis site g. A communication tool is utilized to receive a report on the resident to the facility after each dialysis session. A verbal report is accepted and the licensed nurse will document this in the resident's medical record. " A SUGGESTED METHOD FOR CORRECTION: The DON or designee could develop and implement policies and procedures to ensure that	2 565		

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2 565	Continued From page 8 resident care plans are implement; provide staff education; develop monitoring systems or audit to ensure ongoing compliance. Report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) 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 document review, the facility failed to revise the care plan regarding nutritional monitoring for 1 of 3 residents (R86). Finding Include: On 1/13/15, at 3:35 p.m. R86 stated skipping meals "a lot of times" because her stomach was rejecting the food being served. R86 stated being unhappy with the meals because there were times when the menu did not list food choices	2 570	corrected 2/23/15	2/23/15

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2 570	Continued From page 9	2 570		

that were easy to digest and swallow, and during those times boyfriend brought in food for R86. R86 claimed to have given a list of food preferences as well as food that she could not have to "lady who used to work in dietary" but whenever R86 asked for an alternate such as a sandwich, staff would make it with lettuce which she still could not have.

The Care Area Assessments (CAA) dated 9/25/14, indicated R86 was at risk for alteration in nutritional status related to the need of a mechanically altered diet, and weight was over ideal body weight. Care plan considerations noted in the CAA was for monitoring of food intake, tolerance of diet, and weights.

R86's care plan initiated on 9/25/14, directed staff to observe for signs of difficulty chewing and swallowing, to record intake of food and fluids, to observe for need to add nutritional interventions, and to monitor weights and update physician and dietician as needed.

R86's nutritional assessment dated 9/26/14, relevant conditions to include diabetes mellitus, depression and dysphagia (difficulty swallowing). R86 was described to have no chewing and swallowing problems but had food intolerances to include seafood, lactase, and tomato. The treatment record for 12/14, indicated R86 had additional diagnoses including abdominal pain, abnormal weight loss, B-complex deficiency, back ache, and chronic pain.

A review of nutritional progress notes dated 12/30/14, indicated R86 continued to be on mechanically soft diet due to dysphagia, was at 75 to 100% food and fluid intake, and had no swallowing or chewing issues. R86's weight was

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2 570	Continued From page 10 noted as stable within three months. A review of R86's Food and Fluid Intake Record since admission from 9/23/14 to 1/13/15, indicated multiple meal refusals, as follows: 9/14 there were two meals refused and six meals left blank; 10/14 there were 15 meals refused and 50 meals left blank; 11/14 there were 31 meals refused and four meals left blank; 12/14 there were 43 meals refused and two meals left blank; 1/1 through 13/15 there were 21 meals refused and four meals left blank. R86's medical records lacked evidence to show these meal refusals have been thoroughly assessed and addressed. On 1/14/15, at 7:53 a.m. nursing assistant (NA)-B described R86 as "not a breakfast person" and would pick days when she wanted breakfast. -At 8:22 a.m. dietary aide (DA) stated R86 was rarely at the main dining room for meals, and was never down for breakfast. DA denied having heard R86 complain or make any requests about food. -At 8:28 a.m. the dining services director (DSD) denied awareness about R86's problem regarding food choices in the menu. DSD stated residents would be offered to have an alternate such as salad or a sandwich if residents did not want anything from the menu. -At 8:48 a.m. the registered dietician (RD) verified R86's weight refusals since admission were not addressed in her most recent assessment. RD also reviewed R86's weight record and found out that the weight recorded on 1/5/15, was entered in error as 168 instead of 268. RD stated R86 actually had a significant weight gain and not loss. R86's latest weight recorded on 1/12/15, was 267. RD could not explain recent significant weight gain aside from stating that R86's boyfriend was bringing in food from the outside.	2 570		

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2 570	Continued From page 11 However, despite RD's knowledge of food being brought from the outside, there was no further assessment to rule out why R86 needed outside food for many times. -At 12:03 p.m. licensed practical nurse (LPN)-A stated she was never aware that R86 had refused meals for so many times. LPN-A acknowledged reasons for refusals should have been known to staff and documented. -At 12:08 p.m. surveyor observed LPN-A inquire about R86's meal refusals and asked R86 to sign a St. Olaf Risk vs. Benefit form regarding refusals of breakfast meals. When LPN-A also asked why there was a stack of four cases ensure (dietary supplement) that was discovered in R86's room, R86 replied, "because I could not eat anything that they have in the menu." LPN-A suggested the alternate food but R86 went on to say, "like now they have spaghetti, I can't have tomato. The alternate is chicken, I can't swallow chicken. Salad? I cannot swallow lettuce. That is why I keep ensure or Glucerna (a diabetic nutritional supplement) so at least I can have something." -At 12:11 p.m. LPN-A stated LPN-A was going to call the doctor to get an order for R86 to have the ensure as an alternate for meal refusals. -At 12:45 p.m. RD came to conference room to inform surveyor that an alternate sauce for R86's spaghetti was offered, so R86 was then happy eating at the ground floor dining room. - At 2:47 p.m. the director of nursing stated she expected staff to document residents' meal refusals to re-evaluate and revise care plan as needed. The facility's care plan policy dated 4/1/08, outlined the procedure on resident's problem identification to include conducting resident and/or family interviews, nursing assessment and history, and any other available information. The	2 570		

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2 570	Continued From page 12 policy directed staff to use results of resident assessments to develop and revise comprehensive care plan and to periodically review and revise the care plan after each assessment. SUGGESTED METHOD OF CORRECTION: The DON or designee could educate all the appropriate staff on the importance of revising each residents' plan of care in a timely manner, and could develop a monitoring system to ensure all care plans are revised to reflect the current status. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: R63 was observed seated in his room watching television on 1/14/15, at 10:06 a.m. The resident	2 830	Corrected by 2/23/15	2/23/15

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2 830	Continued From page 13 was wearing a short sleeved shirt which exposed left arm dialysis access site observed with cotton and secured with paper tape. R63 stated had been to dialysis the day before and had no report of pain. R63's signed Physician Orders dated 1/13/15, indicated monitor dialysis access site for intact dressing, closed clamp caps, signs and symptoms of infections, bleeding, petechiae, prolonged bleeding with blood draw, bleeding gums, and drop in blood pressure. The staff was to notify the medical doctor (MD) if resident had any bleeding every shift, check access site for bruit thrill every shift, notify MD if there is no bruit or thrill every shift and replace pressure dressing to shunt site as needed (PRN). Staff was directed to use dialysis emergency protocol for access problems or bad weather that may have caused resident to have missed or delay dialysis. Staff was to remove the pressure dressing every Wednesday, Friday and Sunday morning and apply pressure dressing if bleeding persisted. Staff was to check the shunt, palpate and auscultate thrill daily. The nurse was to check bruit/thrill daily every morning on the left antecubital area. Review of R63's treatment sheet dated 11/9/13, indicated pressure dressing to be removed every Wednesday, Friday and Sunday morning and to apply pressure dressing if bleeding persists. It also indicated nurse was to check bruit/thrill daily every morning on left antecubital area and shunt palpate and auscultate thrill daily. R63's quarterly MDS dated 1/2/15, noted diagnoses including diabetes mellitus (DM), hypertension, dementia, and indicated R63 received dialysis. The resident's Brief Interview	2 830		

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2 830	Continued From page 14 for Mental Status (BIMS-tool used to measure cognition) indicated R63 had moderate impaired cognition, and R63 received limited assistance self-performance with one person physical assistance support with cares. The plan of care: renal function/dialysis dated 1/5/15, identified R63 with diagnosis of end stage renal disease (ESRD). The goal was the dialysis access site will be free of infection and remain patent during review period. Interventions were to monitor dialysis access site for intact dressing, closed clamp caps, signs/symptoms of infection, check access site for bruit or thrill every shift and staff may remove dressing to shunt site four hours after return from dialysis. When interviewed on 1/14/15, at 12:40 p.m. a licensed practical nurse (LPN)-A stated what she should do with resident's dialysis dressing. LPN-A stated she had to remove dressing on R63's fistula today and that would be done on her morning shift. If it had still been bleeding she would replace dressing, and would check thrill also. If there had been an emergency and it did not stop bleeding, she would get an order to send R63 to the emergency room (ER). The dialysis center's registered nurse (RN)-B was interviewed on 1/15/15, at 8:44 a.m. and when asked, reported how the runs are going with R63, RN-B explained they are "going good so far. " When asked what the expectation would be regarding removing the dressing after runs, stated "dialysis center would prefer dressing to be removed three to four hours after, probably by bedtime. " RN-B indicated R63 had come back for the next run with the dressing from the previous time he was at the facility and "we have communicated with the facility several times	2 830		

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2 830	Continued From page 15 about this issue. " When asked what the implications would be if the dressing was not removed stated "the site would be warm and it would increase the chances of infection and clotting. " On 1/15/15, at 11:07 a.m. when asked director of nursing (DON) indicated she thought dialysis dressing removal was PRN. Resident Care Policies and Procedures-Skilled Nursing Facility, Health Dimensions Group dated 2013, indicated: " f. Dialysis center's expectation of care to be completed by skilled nursing facility (SNF) (if any) such as: checking thrills/bruit of grafts and fistulas, documented on TAR, when to remove dressing from the access site placed on from the dialysis center, emergency protocol for uncontrolled bleeding from any dialysis site g. A communication tool is utilized to receive a report on the resident to the facility after each dialysis session. A verbal report is accepted and the licensed nurse will document this in the resident's medical record. " SUGGESTED METHOD OF CORRECTION: The DON or her designee could develop polices and procedures regarding assessing and monitoring dialysis access sites. The DONor her designee could educate staff on the policies and procedures. The DON or her designee could develop a monitoring system to ensue residents receive the appropriate care. TIME FRAME FOR CORRECTION: Twenty One (21) days.	2 830		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status	2 965		2/23/15

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2 965	Continued From page 16 Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure proper food substitute was offered to 1 of 3 residents (R86) reviewed for nutritional status. Findings include: On 1/13/15, at 3:35 p.m. R86 stated skipping meals " a lot of times " because her stomach was rejecting the food being served. R86 stated being unhappy with the meals because there were times when the menu did not list food choices that were easy to digest and swallow, and during those times boyfriend brought in food for R86. R86 claimed to have given a list of food preferences as well as food that she could not have to "lady who used to work in dietary" but still the food choices provided were things she could not have. R86 added whenever an alternate was asked such as sandwich, the staff would make it with lettuce which she could not have. The Care Area Assessments (CAA) dated 9/25/14, indicated R86 was at risk for alteration in nutritional status related to the need of a mechanically altered diet, and weight was over ideal body weight. Care plan considerations noted	2 965	completed by 2/23/2015	

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2 965	Continued From page 17 in the CAA was for monitoring of food intake, tolerance of diet, and weights. R86's care plan initiated on 9/25/14, directed staff to observe for signs of difficulty chewing and swallowing, to record intake of food and fluids, to observe for need to add nutritional interventions, and to monitor weights and update physician and dietician as needed. R86's nutritional assessment dated 9/26/14, relevant conditions to include diabetes mellitus, depression and dysphagia (difficulty swallowing). R86 was described to have no chewing and swallowing problems but had food intolerances to include seafood, lactase, and tomato. A review of nutritional progress notes dated 12/30/14, indicated R86 continued to be on mechanically soft diet due to dysphagia, was at 75-100% food and fluid intake, and had no swallowing or chewing issues. R86's weight was noted to be stable within three months. A review of R86's Food and Fluid Intake Record since admission from 9/23/14 to 1/13/15, indicated multiple meal refusals, as follows: 9/14 there were two meals refused and six meals left blank; 10/14 there were 15 meals refused and 25 meals left blank; 11/14 there were 31 meals refused and four meals left blank; 12/14 there were 43 meals refused and two meals left blank; 1/1-13/15 there 21 meals refused and four meals left blank. R86's medical records lacked evidence to show these meal refusals have been thoroughly assessed and addressed. On 1/14/15, at 7:53 a.m. nursing assistant (NA)-B described R86 as "not a breakfast person" and would pick days when she wanted breakfast. -At 8:22 a.m. dietary aide (DA)-A stated R86 was	2 965		

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2 965	Continued From page 18 rarely at the main dining room for meals, and was never down for breakfast. DA-A denied having heard R86 complain or make any requests about food. -At 8:28 a.m. the dining services director (DSD) denied awareness about R86's problem regarding food choices in the menu. DSD stated residents would be offered to have an alternate such as salad or a sandwich if residents did not want anything from the menu. -At 8:48 a.m. the registered dietician (RD) verified R86's weight refusals since admission were not dealt with in her most recent assessment. RD also reviewed R86's weight record and found out that the weight recorded on 1/5/15 was entered in error as 168 instead of 268. RD stated R86 actually had a significant weight gain and not loss. R86's latest weight recorded on 1/12/14 was 267. RD could not explain recent significant weight gain aside from stating that R86's boyfriend was bringing in food from the outside. However, despite RD's knowledge of food being brought from the outside, there was no further assessment to rule out why R86 needed outside food for many times. -At 12:03 p.m. licensed practical nurse (LPN)-A stated she was never aware that R86 had refused meals for so many times. LPN-A acknowledged reasons for refusals should have been known to staff and documented. -At 12:08 p.m. LPN-A was observe to ask R86 about the meal refusals and asked R86 to sign a St. Olaf Risk vs. Benefit form regarding refusals of breakfast meals. In addition, LPN-A also asked why there was a stack of four cases Ensure (dietary supplement) that was kept in R86's room. R86 replied, "Because I could not eat anything that they have in the menu." LPN-A suggested the alternate food but R86 went on to say, " like now they have spaghetti, I can't have tomato. The	2 965		

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2 965	Continued From page 19 alternate is chicken, I can't swallow chicken. Salad? I cannot swallow lettuce. That is why I keep ensure or Glucerna [diabetic nutritional supplement] so at least I can have something." -At 12:11 p.m. LPN-A stated LPN-A was to call the doctor to get an order for R86 to have the Ensure as an alternate for meal refusals. -At 12:45 p.m. RD came to conference room to inform surveyor that an alternate sauce for R86's spaghetti was offered, so R86 was then happy eating at the ground floor dining room. On 1/14/15, at 2:47 p.m. the director of nursing stated she expected staff to do ongoing assessments to include residents' meal refusals, in order to address and prevent further problems. SUGGESTED METHOD OF CORRECTION: The registered dietitian with the DON could ensure a system for flagging residents who are nutritionally at risk. A plan could be devised to ensure each residents' nutritional needs are met to the extent possible. Audits could periodically be completed. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 965		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	21015	Corrected	2/23/15

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21015	Continued From page 20	21015		

review, the facility failed to ensure resident food was stored under sanitary conditions in one of two reach-in coolers used for storage in the kitchen where food was prepared for consumption by residents in the facility and 2 of 3 refrigerators on the units. In addition, 3 of 3 refrigerators and 3 of 3 microwaves in the kitchenette area on the units were not maintained in a sanitary manner which had the potential to effect 66 of 68 residents who use the main kitchen or the kitchenettes located on each floor of the facility.

Findings Include:

On 1/12/15, at 12:30 p.m., a tour of the kitchen with the director of dietary services (O)-E was conducted and the following was observed:
-a walk-in cooler contained a resident's tray with a container of half-eaten fried rice with a white plastic fork inside and had the letters SHFR hand-written indicating the contents of shrimp fried rice, a meat sandwich in a clear plastic bag and a small covered container of spiced apple slices. There was no name or date observed on these food items.
-the facility toaster had old crumbs and debris behind the grates
-the facility stove/oven unit was dirty with baked on debris to one half, the grids and -the back splash were corroded with dries -on food
-the floor fan had dust between the grids on the head of the fan near the blades

At 12:40 p.m. the (O)-E stated the container of half-eaten food looked like Chinese food from a nearby Chinese restaurant. He further stated it was not facility practice to put outside food or resident food in the kitchen area or coolers. O-E stated he was recently hired and was getting

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21015	Continued From page 21	21015		

systems in various areas in place including cleaning of kitchen appliances. He further explained the grids on the toaster needed to be removed to be cleaned and verified this had not been done.

On 1/13/14, at 9:13 a.m. the following was observed in the kitchenette area on the second floor:
-a resident's tray for R73 was inside the microwave
-a resident's tray for R7 was in top of the microwave
-a resident's tray for R70 was on top of the full-size refrigerator
each tray contained a bowl of hot cereal and a breakfast sandwich which consisted of sausage, egg and cheese.
A nursing assistant (NA)-F stated that one of these residents was out of the building at an appointment and the other two come to breakfast at a later time. She further explained that there was not enough room in the refrigerator to hold all the trays of residents who were not at breakfast in a timely manner.

At 3:22 p.m. the microwave in the kitchenette on the second floor had spillage of clear liquid on the bottom, inside of the microwave. A brownish tinged stain was noted to the inside, left back. A moderate amount sugar sprinkles was observed on the top of this same microwave.

At 3:25 p.m. in the refrigerator of the second floor kitchenette NA-E verified the following:
-a meat sandwich with various condiment packages was stored between two styrofoam plates, a vanilla pudding with a dollop of whipped cream was placed on the styrofoam plate and was not covered. It was not identified by a name

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21015	Continued From page 22	21015		

or with a date.
-a covered plate containing a baked potato, green beans and meat sauce. placed on top was a bowl of vanilla pudding with a dollop of whipped cream, uncovered. It was not identified with a name or with a date. NA-E stated did not know who it was for or who placed it there. She stated, We are not suppose to put it in here like this. We should cover and date it."

On 1/14/15, 9:46 a.m. the kitchenette continued to have food splatters and debris and large amount of liquid was spilled inside the microwave. In addition, the freezer compartment of the full-size refrigerator had food particle at the base and food splatters to the back and side walls.

At 2:57 p.m. the director of environmental services/maintenance (M)-A stated the kitchenette areas are checked daily by the housekeepers assigned to that unit. He further explained they are directed to throw away any unmarked food items belonging to staff or residents. He explained a thorough weekly cleaning was done and staff marked off when this task was complete and daily as checked. He would expect housekeeping to wipe down the area for spills and splatters and for staff to wipe down after each use, especially is a spill or splatter occurred. M-A stated the microwaves were "getting old and may need to be replaced".

During a conversation on 1/15/15, at 9:44 a.m. the director of nursing (DON) stated it was unacceptable practice to store resident food of in the refrigerators of the main kitchen area. She further stated all food should be dated, labeled with name and covered when stored. Refrigerators on the units were used for resident

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food storage and all food that was saved for residents who are out of the building or delayed coming to breakfast should be kept in these refrigerators. The DON also explained the kitchenette including the refrigerators and microwaves and kitchen appliances and surfaces should be cleaned daily and after each use.

3rd Floor Kitchenette Microwave
On 1/12/15, at 2:38 p.m. observed the microwave located on the 3rd Floor kitchenette seated on top of a low stand at the end of the kitchenette by the window next to the toaster. On top of the microwave was observed a heavy build-up of sticky dried up liquid and upon opening the microwave it was observed to have yellow food splashes, spattered all over the inside of the microwave and heavy build-up of food debris.
-At 5:37 p.m. the microwave remained the same not been cleaned still.

On 1/15/15, at 9:22 a.m. nursing assistant (NA)-A verified the microwave was not clean. NA-indicated the microwave was used by residents and was cleaned by house-keeping. NA-A further indicated "Right away I will let them know."

First floor kitchenette:
On 1/12/15, at 6:21 p.m. the first kitchenette observed with nursing assistant (NA)-G and the following were observed:
- There was no thermometer in the refrigerator. The refrigerator had two containers of open juice undated. There were two open milk cartons and one of them had not been dated.
- The inside of the microwave was stained brown and had small amount of dried food debris which could have contaminated the food being microwaved. NA-G made no comment about the findings of the lack of a thermometer in the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 24 refrigerator and the dried on food debris in the microwave. On 1/14/15, at 10:02 a.m. the 1st floor microwave remained in the same condition as the observation 1/12/15. The refrigerator freezer had been cleaned and all items in the refrigerator were now dated and labeled. The St. Olaf Policies and Procedures for Refrigerator Cleaning, review date 10/02, directs staff as follows: To maintain clean and sanitary refrigerators on resident floors: -remove any food item that is note labeled with a resident name and date, or are not from dietary for resident consumption, and discard. -remove and discard outdated items -wipe out any spills from interior surfaces and wipe down exterior with disinfectant cleaner. -the refrigerators are to be cleaned in all floors daily The St. Olaf Policies and Procedures for Resident Dining Room and Floors, review date 10/01/02, directed staff as follows: To daily maintain a clean, orderly and attractive dining room / kitchenette -damp wipe with disinfectant cleaner and with a separate cloth: tables, countertops, microwaves (inside and out), refrigerators (inside and out) and ice machines. SUGGESTED METHOD OF CORRECTION: The food service director or designee could review any policies, procedures or facility processes for safe food handling and make any necessary revisions. Appropriate staff could be educated regarding any changes. The food service director or designee could develop a system to monitor	21015		

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21015	Continued From page 25 staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
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 facilitate dental services for 1 of 3 residents (R81) reviewed for dental concerns. Findings include: On 1/12/15, at 3:09 p.m. during general observations R81 was observed lying in bed and was several missing teeth on the lower jaw to the front and some brown teeth with heavy tartar around the teeth. On 1/14/15, at 9:45 a.m. when asked who assisted her with grooming R81 stated she was responsible and would ask when she needed assistance. When asked about her teeth and	21325	corrected	2/23/15

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21325	Continued From page 26 noted missing teeth R81 stated "I don't want to talk about it I have missing teeth and not seen the dentist but don't have problems with chewing." During conversation observed several teeth missing in the lower jaw and some of the visual teeth were black with build-up tartar around them. On 1/14/15, at 1:52 p.m. via a telephone conversation R81's guardian indicated she had not been called or notified by the facility regarding R81 refusing dental care and she would have expected the facility to assess her dental needs and schedule an appointment with dentist and if any problems were arising she would have expected the facility to call her as she was the emergency contact. R81 was admitted to the facility on 6/6/14 with diagnoses including paranoid schizophrenia, vitamin D deficiency, anemia, senile psychosis and acute post hemorrhagic obtained from Resident Admission Record 1/14/15. R81's quarterly Minimum Data Set (MDS) dated 12/10/14, identified R81 was independent with personal hygiene, had no behaviors which included rejection of cares and had intact cognition. In review of admission MDS dated 6/12/14, and two quarterly MDS's dated 9/10/14, and 12/10/14, all three dental sections were left blank of any dental concerns which included but not limited to broken or loosely fitting full or partial denture, no natural teeth or tooth fragments, abnormal mouth tissue, obvious cavity or loose natural teeth, inflamed or bleeding gums, mouth or facial pain, discomfort or difficulty with chewing. In addition, the dental section Care Area Assessment (CAA) did not trigger for CAA	21325		

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21325	Continued From page 27 completed on 6/12/14. R81's ADL functional/rehabilitation care plan dated 6/19/14, identified R81 was independent but required cues with hygiene/dressing. The care plan directed staff to give R81 cues for hygiene, assist with ADL's as needed and encourage R81 to participate in cares. R81's nutritional status care plan dated 6/12/14, identified R81 had potential for alteration in nutrition, had potential for decreased appetite and weight loss. Review of documents revealed the following: -Undated dental Doorstep Healthcare Services Consent For Treatment and Billing Form signed by the guardian indicated R81 had no financial representative and payment was by medical assistance. -Nutritional Re-Assessment dated 9/11/14, and 12/10/14, indicated R81 did not have problems with chewing nor dentition. On 1/14/15, at 10:13 a.m. registered nurse (RN)-A who was the MDS coordinator and completed all the MDS's at the facility, indicated the facility did not have a dental assessment when asked if the facility had a tool. RN-A indicated she did not see anything in the chart or medical record that showed when R81 had seen the dentist last even though the facility had a contracted dentist who came to the facility. -When asked how the staff completed an oral/dental assessment RN-A stated "I believe they do a visual for obvious problems and check for dentures or own teeth." RN-A verified on the Admission Nursing Evaluation dated 6/6/14, had indicated R81 had "Few, some missing and broken teeth."	21325		

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21325	Continued From page 28	21325		

-When asked if she used the information from the assessment to complete the admission MDS dated 6/12/14, she indicated "I guess I never looked at the assessment and missed it" as she pointed to the section. RN-A verified and indicated that was why the dental Care Area Assessment (CAA) had not triggered.

On 1/14/15, at 12:05 p.m. when asked about R81's dental care nursing assistant (NA)-D assigned to R81 stated R81 was responsible for all that and was not aware R81 had any dental problems including missing and discolored teeth.

On 1/14/15, at approximately 10:27 a.m. RN-A approached surveyor provided a copy of the schedule book which indicated R81 had a scheduled appointment scheduled for Thursday January 29th.

On 1/14/15, at 3:28 p.m. health information coordinator (HUC) approached surveyors indicated she had just scheduled the dental appointment the very day 1/14/15, after the concern had been brought to the facility staff attention and provided the number to the clinic.

On 1/15/15, at 10:04 a.m. when asked her expectation regarding assessment and arranging for dental services director of nursing (DON) stated she would have expected a dental consult to have been scheduled for any resident in need of dental needs. When asked about the assessment and care planning DON stated "The assessments and MDS need to be accurate we are human and make mistakes."

On 1/15/15, at 11:38 a.m. via telephone the consultant dietician (CD) was interviewed and stated when doing her initial nutritional

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21325	Continued From page 29 assessment she got the information about the Admission Nursing Evaluation assessment. -When asked if she was aware R81 had missing and broken teeth, CD stated she was not sure. -When CD was told R81 had missing and broken teeth which had been indicated on the initial Admission Nursing Evaluation dated 6/6/14, CD stated although she used the form to collect her data she may have "over looked" the missing, broken teeth issues which would have probably been addressed under the dentition section of the nutrition assessments and MDS's dated 6/12/14, 9/10/14, and 12/10/14. Dental Services (General) policy dated April 1, 2008 indicated the facility would provide or obtain from an outside resource, routine and emergency dental services to meet the need of each resident. In addition the policy indicated the facility would assist the resident in making appointments by arranging transportation to and from the dentist's office and promptly refer residents with lost or damaged dentures to a dentist. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure dental services are provided. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21325		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control	21390		2/23/15

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21390	Continued From page 30 Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility did not ensure infection control practices were maintained during dressing change for 1 of 1 resident (R62) reviewed for pressure ulcer. Findings include:	21390	Corrected	

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21390	Continued From page 31 On 1/13/15, at 2:43 p.m. licensed practical nurse (LPN)-A stated she was going to do a scheduled wound dressing change for R62. LPN-A informed R62 about the procedure. While LPN-A prepared the dressing supplies, another nurse, LPN-G stood by as R62 slowly transferred himself to bed. R62 was lying in bed with the head of part elevated at about 60-degree angle. There was a strong odor as LPN-A removed R62's boots. LPN-A placed a pillow lined with a white towel under R62's feet. LPN-A washed her hands, wore a pair of gloves and cut R62's old Unna boots (a compression bandage that contains zinc oxide impregnated into the rolled gauze used to treat edema and leg ulcers) with a pair of scissors. LPN-A removed the old 2x2 gauze dressing on R62's left foot. There was a strong odor and a moderate amount of yellowish drainage observed on the old dressing. LPN-A stated the wound was at Stage II (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). The wound base was beefy red. LPN-A slowly put R62's left leg down. The wound was on the left sole which was directly pressed against the bed's foot board. LPN-A washed hands, wore a new pair of gloves, took a soapy wash cloth and scrubbed R62's left leg from below the knee down to the foot but did not touch left plantar area's wound. LPN-A flipped the soapy wash cloth then went to scrub the right leg from below the knee to the foot. LPN-A flipped the soapy wash cloth again then finally wiped the left foot plantar wound. Throughout the soap washing procedure, LPN-A used one soapy wash cloth. There was minimal bleeding observed as LPN-A washed the wound. LPN-A put the soapy wash cloth aside and was observed to have small amount of bloody stain. LPN-A then took another	21390		

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21390	Continued From page 32	21390		

white wash cloth which was wet with tap water, wiped R62's left leg, flipped the wash cloth, wiped the right leg then went back to wash the left plantar wound. R62 re-acted with discomfort as the R62 ' s face had a grimaced look during the procedure. LPN-A assured R62 by explaining what she was doing. LPN-A left the wet wash cloth pressed against R62's wound, between the left sole and the bed's foot board. There was one wash cloth used to rinse.

LPN-A took a dry towel and used it to dry R62's legs then wiped starting from left leg to right leg and back to left plantar wound using the same towel. LPN-A put down R62's left leg where the wound was again pressing against the bed's foot board. When surveyor commented about wound touching the bed's foot board, LPN-A instructed R62 to move himself up from the bed but R62 stated he could not do it, instead suggested that left foot be elevated more using one more pillow. LPN-E took one pillow from R62's left side and placed it under the R62's legs. The wound was no longer touching the bed's foot board. LPN-A measured the wound as 4.3centimeters (cm) X 0.5cm X 0.05cm, with minimal bleeding. LPN-A put a new 2X2 gauze dressing over the wound and wrapped the leg with Unna boots.

On 1/3/15, at 3:30 p.m. when asked to review the process of R62's wound dressing that was just concluded, both LPN-A and LPN-G stated washing started from the " clean " area going towards the " dirty " area referring to the wound. Both licensed practical nurses confirmed R62's lower legs were washed first before washing the wound. LPN-A also confirmed using one wash cloth for the soap, one wash cloth for the rinse and one towel to dry.

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21390	Continued From page 33 The Resident Admission Record indicated R62 was admitted to facility on 8/2/13 with diagnoses including diabetes type II, dementia, and lower extremity venous ulcer. R86's current treatment record dated 1/15, directed staff to cleanse bilateral legs with soap and water; pat dry; apply 2X2 gauze to open area on left foot; apply bilateral Unna boot cover with Coban (a self-adhesive wrap used to treat wounds); change every 5 days and PRN; off-load shoe on left foot. On 1/14/15, at 7:29 a.m. the wound doctor clarified R62's wound was a diabetic ulcer and stated nurses were expected to wash " starting from the wound outwards and not the other way." LPN-A was present when the wound doctor made the clarifications. LPN-A admitted she washed the wound from the outside and towards the wound and stated she would wash wounds starting from the wound outwards from then on. During interview with the director of nursing (DON) on 1/14/15, at 2:47 p.m. she stated expectations that nurses wash wounds following infection control measures, that was to wash from the wound to the outside and also not to let an open wound be in contact with any surface. The facility's undated Policy for Wound Care and Documentation included procedure for clean dressing technique which directed staff to use "no-touch" technique; do not directly touch any item that would be in contact with the wound; and wash from the center of the wound to the periphery. SUGGESTED METHOD OF CORRECTION: The administrator or director of nursing could	21390		

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21390	Continued From page 34 in-service all employees on the basics of infection control practices to reduce and prevent the spread of infection. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
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 interview and document review, the facility failed to ensure tuberculosis (TB) tuberculin skin test (TST) was completed within 72 hours from admission for 2 of 5 residents	21426	corrected	2/23/15

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21426	Continued From page 35 (R29, R72). In addition, failed to complete Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents for TB screening for 5 of 5 residents (R4, R72, R98, R14, R29). Also the facility failed to document results of the TST that was given for 4 of 5 residents (R72, R98, R14, R29) reviewed for TB screening. Findings include: TST not given within 72 hours of admission: R29 was admitted to the facility on 8/14/14, per the Minimum Data Set (MDS) entry tracking record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed. The Medication Administration record (MAR) for August 2014 revealed R29 was to be given the first step TST on 8/25/14, and it was not administered until 10/1/14. R72 was admitted to the facility on 8/4/14, per the MDS entry tracking record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed as R72 did not have a second TST. The medical record revealed R72 had received the first step TST on 8/5/14, was read on 8/8/14, no result, 0 induration was documented. A second step TST was not documented as given. Screening: R4 was admitted to the facility on 9/11/14, per the MDS entry tracking record. R4's Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed for TB screening. R72 was admitted to the facility on 8/4/14, per the MDS entry tracking record. The Baseline TB	21426		

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21426	Continued From page 36 Screening Tool for Nursing Home and Boarding Care Home Residents was not completed for TB screening. R98 was admitted to the facility on 9/29/14, per the MDS entry tracking record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed for TB screening. R14 was admitted to the facility on 12/22/14, per the MDS entry tracking record. Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed for TB screening. R29 was admitted to the facility on 8/14/14. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed for TB screening. Lack of induration documentation: R72 was admitted to the facility on 8/4/14, per the MDS entry tracking record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed. R72's first TST lacked documentation for the millimeters (mm) for the first TST reading which given on 8/5/14. R98 was admitted to the facility on 9/29/14, per the MDS entry tracking record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed. The medical record revealed R98 had received the first step TST on 9/30/14, was read on 10/1/14. A second step TST was given on 10/8/14, was read on 10/10/14. Both readings lacked documentation for the mm.	21426		

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21426	Continued From page 37 R14 was admitted to the facility on 12/22/14, per the MDS entry tracking record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed. The medical record revealed R14 had received the first step TST on 12/23/14, was read on 12/25/14. A second step TST was given on 1/9/15, was read on 1/11/15. Both readings lacked documentation for the mm. R29 was admitted to the facility on 8/14/14. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed for TB screening. The medical record revealed R29 had received the first step TST on 10/1/14, was read on 10/3/14. A second step TST was given on 10/17/14, was read on 10/19/14. Both readings lacked documentation for the mm. On 1/15/15, at 10:15 a.m. additional information was requested from DON and was not provided in respect to TB screening for residents. Tuberculosis (TB) Prevention & Control Policy and Procedure, The Ecumen: TB Control Plan dated 6/11 directed "All residents will receive baseline TB screening within 72 hours of admission or within 3 months prior to admission. Baseline TB screening consists of three components: (1) assessing the resident's risk factors for TB, (2) assessing for current symptoms of active TB disease; and 3) testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test." SUGGESTED METHOD OF CORRECTION: The DON could designate one staff to be in charge of ensuring TST tuberculin skin test are completed for employees upon hire. The DON	21426		

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21426	Continued From page 38 could complete random audits to ensure continued compliance. In addition the director of nursing could review/revise the tuberculosis treatment and prevention plan to include annual staff training on all aspects of tuberculosis care, management, and prevention. The DON or designee could provide the education and monitor staff participation in the programs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is	21530		2/23/15

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21530	Continued From page 39 being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility consultant pharmacist failed to identify medications irregularity regarding adequate monitoring for 3 of 5 residents (R23, R58, R14) who used antidepressants and antipsychotics. Findings include: On 1/13/15, at 7:14 a.m. R23 room door was observed shut upon opening the door R23 was observed lying in bed lights were on in the room and R23 was observed wearing a mask around her mouth and nose, eyes were closed and was asleep. On 1/14/15, at 7:52 a.m. to 7:57 a.m. licensed practical nurse (LPN)-E was observed prep R23's two insulins and R23 self-administered the insulins. When asked how she had slept R23 indicated she had slept well "thanks for asking." R23 appeared calm and with a flat affect.	21530	Corrected	

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21530	Continued From page 40 R23's diagnoses included schizoaffective, manic depression and diabetes Mellitus obtained from the admission Minimum Data Set (MDS) dated 12/28/14. In addition the MDS indicated R23's cognition was intact, had indicated having trouble falling or staying asleep or sleeping too much and was feeling or had little energy. The MDS also indicated R23 had no behaviors but received daily both an antipsychotic and an antidepressant. Psychotropic drug use Care Area Assessment (CAA) dated 1/2/15, indicated R23 received psychotropic medications related to bipolar disorder, schizoaffective disorder. Monitor and administer medications per order. Psychotropic Drug use care plan dated 1/4/15, identified R23 was at risk for adverse consequences related to receiving antipsychotic medications for treatment of schizophrenia and bipolar disorder and also received an antidepressant. The care plan directed staff to administer medications per orders, monitor resident behavior and response to medications and assess/record effectiveness of drug treatment. Review of R23's Physician's Orders dated 1/8/15, revealed R23's orders were as follows: -Olanzapine (atypical antipsychotic used currently in the treatment of schizophrenia and bipolar illness) 20 milligrams (mg) 1 tablet orally every bedtime. -Escitalopram (medication used for treating depression and generalized anxiety disorder) 20 mg 1 tablet orally daily. Review of the Medication Administration Records (MAR's) and Treatment Administration Records (TAR's) from 12/22/14, through January 15th 2015, revealed R23 lack behavior tracking/monitoring, no orthostatic blood pressures had been completed since admission	21530		

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21530	Continued From page 41 and no side effects monitoring had been initiated despite R23 was receiving both an antidepressant and antipsychotic. Merwin Long Term Care Pharmacy Record of Medication Regimen Review completed monthly by the consultant pharmacist revealed the review was last done 1/13/15, and behavior tracking, orthostatic blood pressures and side effects monitoring were not identified as missing in the medical record. On 1/14/15, at 8:35 a.m. registered nurse (RN)-A verified R23 did not have both behavior monitoring, mood monitoring, orthostatic blood pressure and side effects for the antidepressant and antipsychotic. RN-A went through the TAR and verified all the required monitoring were missing and stated she would ask the nurse who checked the MAR and TAR sheets during end of month change over to see what happened. RN-A went through the TAR and showed surveyor how the behavior, mood and side effects sheets would look like as they were printed from the pharmacy. RN-A further stated the admission nurse would check to make sure this was all in place when a resident was admitted. -At 9:31 a.m. RN-A approached surveyor indicated the behavior monitoring sheets for December 2014, were in the chart to the back which R23 was transferred with from the assisted living next door. She verified again the behavior, side effects, orthostatic and mood monitoring were missing in the TAR and MAR for January 2015. On 1/13/14, at 10:03 a.m. the director of nursing (DON) stated "These sheets do not have the month they cannot possibly be for December as resident was admitted to the facility on 12/22/14."	21530		

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21530	Continued From page 42 DON verified after going through the entire chart orthostatic blood pressures, side effects and behavior monitoring were all lacking and indicated "they should have been in place. I have put a list of medications with side effects which were supposed to be attached to the care plan and I guess it's not there." R58 was observed and interviewed on 1/14/15, at 10:45 a.m. R58 sat at the edge of the bed, had a flat affect and was calm. R58 stated she had the total parenteral nutrition going all night long, she didn't feel like eating breakfast since she was a late riser. R58 had no concerns or a question, her mood was "Ok", and stated "I can tell staff if I need something." The undated Resident Admission Record indicated R58 was admitted to the facility on 3/7/14, with most recent admission to the facility on 12/11/14. R58's quarterly MDS completed on 12/4/14, indicated R58 had intact cognition, and had no behaviors, hallucinations or delusions. The MDS also indicated R58 had depression and anxiety. The current physician's order dated 12/12/14, indicated resident took the following medications including: - Citalopram (antidepressant medication) 20 milligram (mg) 1 tablet daily - Zyprexa (anti-psychotic medication) 5 mg 1 tablet at bedtime - Mitrazapine (antidepressant medication) 7.5 mg at bedtime Review of R58's medication administration and	21530		

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21530	Continued From page 43 treatment record from July 2014 to present indicated R58 took the Zyprexa continuously; however, there was no anti-psychotic medication side effect monitoring (including monthly orthostatic blood pressure) completed. The Record of Medication Regimen Review indicated the consultant pharmacist reviewed R58's medication regimen on 7/10/14, 8/14/14, 9/16/14, 10/14/14, 11/18/14, 12/16/14, and 1/13/15. There were notes written for nursing on 8/14/14, 9/16/14 and 10/14/14, however, only the one dated 8/14/14, was provided by the facility for review, which addressed possible gradual dose reduction. There were no irregularities identified regarding lack of psychotropic medication side effect monitoring. The DON was interviewed on 1/15/15, at 8:44 a.m. and stated she expected staff to monitor the anti-psychotic medication side effects, which included orthostatic blood pressure monitoring. The DON reviewed R58's medical record and confirmed the lack of side effect monitoring. The consultant pharmacist was contacted via phone call on 1/15/15, at 8:37 a.m. but was not available for an interview. R14 was observed on 1/15/15, at 11:03 a.m. seated in a wheelchair in her room watching the television (TV). R14 had a flat affect and was calm. She was asked if she knew what medications (meds) she was on, and she said, "Some of them." She further indicated her mood was "good." During an additional interview, R14 indicated she had no symptoms of feeling tired, down, or depressed. She indicated she was at the facility for rehabilitation following a leg	21530		

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21530	Continued From page 44 fracture, and was hoping to go home soon. R14's chart was reviewed for: - A review of Nurse's Notes at the time of admission going forward to 1/15/15, indicated BPs were taken however, they were not orthostatic blood pressures (OBPs, a condition in which a person's blood pressure drops significantly when changing positions from lying down or sitting to standing up. When stood up after sitting or lying down, blood pools in the legs. The direct cause of orthostatic hypotension is failure of the body to react quickly to the position change by shunting blood from the legs back to the heart. With not enough blood to be pumped out of the heart, blood pressure drops. A person with orthostatic hypotension usually becomes dizzy or falls down when standing up too fast). The facility did not monitor the side effects of the psychotropic medication in relationship to the identified falls risk. - The MAR noted R14 was ordered Abilify on 12/22/14, Nortriptyline on 12/22/14, Zoloft on 12/22/14, and Klonopin on 12/30/14. - One Nurse's Note dated 12/22/14, at 4:30 p.m. indicated "...no behavior problems noted @ this time." The medical record lacked evidence of ongoing monitoring of behavior or mood symptoms nor was any OBPs noted in the Nurse's Notes. - R14's MDS dated 12/28/14, indicated R14 had diagnoses which included depression and anxiety. The MDS also depicted R14 as being cognitively intact, as displaying mood symptoms such feeling down, depressed or hopeless, poor appetite or overeating, and feeling bad about yourself, displaying no behaviors as of admission, and as having fallen at least once in the last month which resulted in a fracture within the last six months. The facility identified R14 as taking	21530		

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21530	Continued From page 45 antipsychotics, antidepressants, antianxiety, and diuretic medication in the last seven days. - The CAA for falls dated 12/28/14, indicated the facility's analysis identified the resident as being at risk for falls due to mobility and history of fall with fracture. The interventions were for staff to assist with transfers, physical therapy/occupational therapy per orders and wheelchair for locomotion. The facility was to proceed to care plan. The analysis lacked evidence of how the facility was going to intervene for falls regarding the resident's psychotropic medication and diuretic use. The CAA for psychotropic medication dated 12/28/14, noted the analysis section indicated, "resident receives Psychotropic r/t [related to] Dx [diagnosis] Anxiety and Depression. See Admission H&P [history and physical] for psychiatric documentation. Proceed with cp [care plan]." The CAA lacked evidence of how the facility intended to implement interventions and monitor the use of the psychotropic medication for adverse side effects and efficacy in relationship to the identified falls risk. The CAAs for mood and behavior did not trigger from the facility findings. - No behaviors were monitored for the month of December 2014 when R14 was admitted. The medical record lacked evidence of justification and appropriate behavior monitoring as the facility identified R14 as being monitored for "altered mental status" on the January 2015 TAR sheets. The inappropriate behavior monitoring was started during the survey process. The medical record lacked evidence of the facility staff monitoring specific behavioral symptoms due to mania or psychosis such as auditory, visual, or other hallucinations, delusions, paranoia and/or grandiosity. - A "Psychotropic Drug Use" care plan dated	21530		

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21530	Continued From page 46 1/3/15 indicated R14 was using medications for depression and anxiety and had a history of alcoholism. Goal: "R14 will result in maintenance of functional status..." The care plan directed the administration of meds per orders, Dyskinesia Identification System: Condensed User Scale (DISCUS) on admission and quarterly, monitor for effectiveness and side effects of medications and pharmacy consult review. - A "Behavioral Symptoms" care plan dated 1/15/15, identified R14 had a history of treatment noncompliance, diagnoses that affect her behavior included depression, anxiety, and persistent mental disorder. In addition the care plan indicated R14 had a history of alcohol abuse and attended weekly Alcoholics Anonymous meetings..."Goal: will accept cares." The care plan directed staff to reapproach later as needed, use a calm, gentle approach with R14, explain steps of cares as they were being performed. - A review of the January 2015 TAR sheets revealed orthostatic blood pressures OBPs had not been done for the months of December 2014 and January 2015 to determine if R14 displayed any low blood pressure related to medication. The medical record lacked evidence of justification and appropriate mood monitoring as the facility identified R14 as being monitored for "mood changes" on the January 2015 TAR sheets even though the facility identified mood symptoms on the 12/28/14 MDS. The inappropriate mood monitoring was started during the survey process. On 1/15/15, at 10:32 a.m. an interview was conducted with LPN-D. LPN-D indicated he was unable to find records of monitoring of medication side effects (SE) or monitoring of OBPs prior to the survey process. LPN-D expected the SE and OBP monitoring to be found in the treatment	21530		

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21530	Continued From page 47	21530		

book, however, he verified no specific SE or OBP monitoring was being completed as of 1/15/15. LPN-D showed the surveyor the "Behavior Monitoring Record," for R14's medication Nortriptyline, an antidepressant med. The record indicated monitoring by check-off box for nonspecific "mood changes," and the Behavior Monitoring Record for R14's Abilify, an antipsychotic med indicated monitoring by check-off box for nonspecific "altered mental status." No specific behaviors at all were identified for monitoring. Both sheets were started on 1/13/15, however that contradicted LPN-D's above interview which noted no evidence of SE monitoring could be located in the medical record. LPN-D indicated they would do vital signs (VS) which would include blood pressures every shift and all should be charted in the Nurse's Notes. He added there was no graphic chart for VS, which included OPBs.

- During an interview on 1/15/15, at 10:55 a.m. LPN-C indicated he would expect OBPs to be documented on the pharmacology sheet in the chart. LPN-C looked in R14's chart and verified, "No, they're not in there." LPN-C added SEs should be found on side effects documentation sheets in the TAR, but on 1/15/15, at 10:56 a.m. LPN-C verified he could find no SE sheet in the TAR for R14.
- At 10:44 a.m., the MDS nurse, RN-A was asked to show where the monitoring of orthostatic blood pressures and side effects for psychotropic meds could be found. She indicated she could not locate the information and they should have been in R14's chart. It was her expectation they were to be done on admission and quarterly.
- On 1/15/15, at 12:15 p.m., the consulting pharmacist was interviewed. When he was asked what he would expect to see for monitoring of OBPs and SE he stated, "I don't look for anything

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21530	Continued From page 48 to be ordered every week, unless they're having falling or other issues. I don't expect even one a month unless there's a doctor's order." On 1/15/15, 12:15 p.m. when asked her expectation about the facility doing orthostatic blood pressures for residents who were on psychotics the consultant pharmacist stated "I don't look for anything to be ordered every week, unless they're having falls or other issues and I don't expect even every one month unless there a doctor's order." -When asked about behavior tracking and side effects monitoring the consultant pharmacist stated she expected the facility to have this in place specific to what the resident was currently taking and there were sheets generated. -When asked what her expectation was regarding the facility monitoring for bruising when resident was on Lovenox the consultant pharmacist stated "I would look in skin checks, nursing notes, to see if concerns for bruising during my reviews." - When asked if the facility needed to have bruising and risk of bleeding care planned as resident was at risk for bruising and bleeding, the consultant pharmacist stated she would have expected that to be in place. SUGGESTED METHOD OF CORRECTION: The administrator, DON and Consulting Pharmacist could review and revise policies and procedures for assuring medications had indications for use, parameters and proper monitoring of medication usage. Staff could be educated as necessary. The DON or designee could monitor medications on a regular basis to ensure compliance with state and federal regulations. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21530		

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21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 3 of 5 residents (R23, R58, R14) who took antidepressants and antipsychotics medications had adequate monitoring. In addition, failed to ensure monitor for side effects for the use of Lovenox (an anticoagulant medication) for 1 of 3 residents (R103) reviewed for anticoagulant medication use.	21535	corrected	2/23/15

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21535	Continued From page 50 Findings include: Psychotropic use: R23 was observed on 1/13/15, at 7:14 a.m. as R23 was observed lying in bed lights were on in the room and R23 was observed wearing a mask around her mouth and nose, eyes were closed and was asleep. On 1/14/15, at 7:52 a.m. to 7:57 a.m. licensed practical nurse (LPN)-E was observed prep R23's two insulins and R23 self-administered the insulins. When asked how she had slept R23 indicated she had slept well "thanks for asking." R23 appeared calm and with a flat affect. R23's diagnoses included schizoaffective, manic depression and diabetes Mellitus obtained from the admission Minimum Data Set (MDS) dated 12/28/14. In addition the MDS indicated R23's cognition was intact, had indicated having trouble falling or staying asleep or sleeping too much and was feeling or had little energy. The MDS also indicated R23 had no behaviors but received daily both an antipsychotic and an antidepressant. Psychotropic drug use Care Area Assessment (CAA) dated 1/2/15, indicated R23 received psychotropic medications related to bipolar disorder, schizoaffective disorder. Monitor and administer medications per order. Psychotropic Drug use care plan dated 1/4/15, identified R23 was at risk for adverse consequences related to receiving antipsychotic medications for treatment of schizophrenia and bipolar disorder and also received an antidepressant. The care plan directed staff to administer medications per orders, monitor resident behavior and response to medications and assess/record effectiveness of drug treatment.	21535		

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Review of R23's Physician's Orders dated 1/8/15, revealed R23's orders were as follows:
-Olanzapine (atypical antipsychotic used currently in the treatment of schizophrenia and bipolar illness) 20 milligrams (mg) 1 tablet orally every bedtime.
-Escitalopram (medication used for treating depression and generalized anxiety disorder) 20 mg 1 tablet orally daily.

Review of the Medication Administration Records (MAR's) and Treatment Administration Records (TAR's) from 12/22/14, through January 15th 2015, revealed R23 lack behavior tracking/monitoring, no orthostatic blood pressures had been completed since admission and no side effects monitoring had been initiated despite R23 was receiving both an antidepressant and antipsychotic.

On 1/14/15, at 8:35 a.m. registered nurse (RN)-A verified R23 did not have both behavior monitoring, mood monitoring, orthostatic blood pressure and side effects for the antidepressant and antipsychotic. RN-A went through the TAR and verified all the required monitoring were missing and stated she would ask the nurse who checked the MAR and TAR sheets during end of month change over to see what happened. RN-A went through the TAR and showed surveyor how the behavior, mood and side effects sheets would look like as they were printed from the pharmacy. RN-A further stated the admission nurse would check to make sure this was all in place when a resident was admitted.
-At 9:31 a.m. RN-A approached surveyor indicated the behavior monitoring sheets for December 2014, were in the chart to the back which R23 was transferred with from the assisted living next door. She verified again the behavior,

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21535	Continued From page 52 side effects, orthostatic and mood monitoring were missing in the TAR and MAR for January 2015. On 1/13/14, at 10:03 a.m. the director of nursing (DON) stated "These sheets do not have the month they cannot possibly be for December as resident was admitted to the facility on 12/22/14." DON verified after going through the entire chart orthostatic blood pressures, side effects and behavior monitoring were all lacking and indicated "they should have been in place. I have put a list of medications with side effects which were supposed to be attached to the care plan and I guess it's not there." R58 was observed and interviewed on 1/14/15, at 10:45 a.m. R58 sat at the edge of the bed, had a flat affect and was calm. R58 stated she had the total parenteral nutrition going all night long, she didn't feel like eating breakfast since she was a late riser. R58 had no concerns or a question, her mood was "Ok", and stated "I can tell staff if I need something." The undated Resident Admission Record indicated R58 was admitted to the facility on 3/7/14, with most recent admission to the facility on 12/11/14. R58's quarterly MDS completed on 12/4/14, indicated R58 had intact cognition, and had no behaviors, hallucinations or delusions. The MDS also indicated R58 had depression and anxiety. The current physician's order dated 12/12/14, indicated resident took the following medications including: - Citalopram (antidepressant medication) 20	21535		

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milligram (mg) 1 tablet daily
- Zyprexa (anti-psychotic medication) 5 mg 1 tablet at bedtime
- Mitrazapine (antidepressant medication) 7.5 mg at bedtime

Review of R58's medication administration and treatment record from July 2014 to present indicated R58 took the Zyprexa continuously; however there was no anti-psychotic medication side effect monitoring (including monthly orthostatic blood pressure) completed.

The DON was interviewed on 1/15/15, at 8:44 a.m. and stated she expected staff to monitor the anti-psychotic medication side effects, which included orthostatic blood pressure monitoring. The DON reviewed R58's medical record and confirmed the lack of side effect monitoring.

R14 was observed on 1/15/15, at 11:03 a.m. seated in a wheelchair in her room watching the television (TV). R14 had a flat affect and was calm. She was asked if she knew what medications (meds) she was on, and she said, "Some of them." She further indicated her mood was "good." During an additional interview, R14 indicated she had no symptoms of feeling tired, down, or depressed. She indicated she was at the facility for rehabilitation following a leg fracture, and was hoping to go home soon.

R14's chart was reviewed for:
- A review of Nurse's Notes at the time of admission going forward to 1/15/15, indicated BPs were taken however, they were not orthostatic blood pressures (OBPs, a condition in which a person's blood pressure drops significantly when changing positions from lying

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down or sitting to standing up. When stood up after sitting or lying down, blood pools in the legs. The direct cause of orthostatic hypotension is failure of the body to react quickly to the position change by shunting blood from the legs back to the heart. With not enough blood to be pumped out of the heart, blood pressure drops. A person with orthostatic hypotension usually becomes dizzy or falls down when standing up too fast). The facility did not monitor the side effects of the psychotropic medication in relationship to the identified falls risk.
- The MAR noted R14 was ordered Abilify on 12/22/14, Nortriptyline on 12/22/14, Zoloft on 12/22/14, and Klonopin on 12/30/14.
- One Nurse's Note dated 12/22/14, at 4:30 p.m. indicated "...no behavior problems noted @ this time." The medical record lacked evidence of ongoing monitoring of behavior or mood symptoms nor was any OBPs noted in the Nurse's Notes.
- R14's MDS dated 12/28/14, indicated R14 had diagnoses which included depression and anxiety. The MDS also depicted R14 as being cognitively intact, as displaying mood symptoms such feeling down, depressed or hopeless, poor appetite or overeating, and feeling bad about yourself, displaying no behaviors as of admission, and as having fallen at least once in the last month which resulted in a fracture within the last six months. The facility identified R14 as taking antipsychotics, antidepressants, antianxiety, and diuretic medication in the last seven days.
- The CAA for falls dated 12/28/14, indicated the facility's analysis identified the resident as being at risk for falls due to mobility and history of fall with fracture. The interventions were for staff to assist with transfers, physical therapy/occupational therapy per orders and wheelchair for locomotion. The facility was to

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21535	Continued From page 55 proceed to care plan. The analysis lacked evidence of how the facility was going to intervene for falls regarding the resident's psychotropic medication and diuretic use. The CAA for psychotropic medication dated 12/28/14, noted the analysis section indicated, "resident receives Psychotropic r/t [related to] Dx [diagnosis] Anxiety and Depression. See Admission H&P [history and physical] for psychiatric documentation. Proceed with cp [care plan]." The CAA lacked evidence of how the facility intended to implement interventions and monitor the use of the psychotropic medication for adverse side effects and efficacy in relationship to the identified falls risk. The CAAs for mood and behavior did not trigger from the facility findings. - No behaviors were monitored for the month of December 2014 when R14 was admitted. The medical record lacked evidence of justification and appropriate behavior monitoring as the facility identified R14 as being monitored for "altered mental status" on the January 2015 TAR sheets. The inappropriate behavior monitoring was started during the survey process. The medical record lacked evidence of the facility staff monitoring specific behavioral symptoms due to mania or psychosis such as auditory, visual, or other hallucinations, delusions, paranoia and/or grandiosity. - A "Psychotropic Drug Use" CP dated 1/3/15, indicated R14 was using medications for depression and anxiety and had a history of alcoholism. Goal: "R14 will result in maintenance of functional status..." The CP directed the administration of meds per orders, Dyskinesia Identification System: Condensed User Scale (DISCUS) on admission and quarterly, monitor for effectiveness and side effects of medications and pharmacy consult review.	21535		

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21535	Continued From page 56 - A "Behavioral Symptoms" CP dated 1/15/15, identified R14 had a history of treatment noncompliance, diagnoses that affect her behavior included depression, anxiety, and persistent mental disorder. In addition the CP indicated R14 had a history of alcohol abuse and attended weekly Alcoholics Anonymous meetings..."Goal: will accept cares." The CP directed staff to reapproach later as needed, use a calm, gentle approach with R14, explain steps of cares as they were being performed. - A review of the January 2015 TAR sheets revealed orthostatic blood pressures had not been done for the months of December 2014 and January 2015 to determine if R14 displayed any low blood pressure related to medication. In addition, the medical record lacked evidence of justification and appropriate mood monitoring as the facility identified R14 as being monitored for "mood changes" on the January 2015 TAR sheets even though the facility identified mood symptoms on the 12/28/14, MDS. The "mood changes" monitoring was started during the survey process. On 1/15/15, at 10:32 a.m. an interview was conducted with LPN-D. LPN-D indicated he was unable to find records of monitoring of medication side effects (SE) or monitoring of OBPs prior to the survey process. LPN-D expected the SE and OBP monitoring to be found in the treatment book, however, he verified no specific SE or OBP monitoring was being completed as of 1/15/15. LPN-D showed the surveyor the "Behavior Monitoring Record," for R14's medication Nortriptyline, an antidepressant med. The record indicated monitoring by check-off box for nonspecific "mood changes," and the Behavior Monitoring Record for R14's Abilify, an antipsychotic med indicated monitoring by	21535		

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check-off box for nonspecific "altered mental status." No specific behaviors at all were identified for monitoring. Both sheets were started on 1/13/15, however that contradicted LPN-D's above interview which noted no evidence of SE monitoring could be located in the medical record. LPN-D indicated they would do vital signs (VS) which would include blood pressures every shift and all should be charted in the Nurse's Notes. He added there was no graphic chart for VS, which included OPBs.
- During an interview on 1/15/15, at 10:55 a.m. LPN-C indicated he would expect OBPs to be documented on the pharmacology sheet in the chart. LPN-C looked in R14's chart and verified, "No, they're not in there." LPN-C added SEs should be found on side effects documentation sheets in the TAR, but on 1/15/15, at 10:56 a.m. LPN-C verified he could find no SE sheet in the TAR for R14.
- At 10:44 a.m. the MDS nurse, RN-A was asked to show where the monitoring of orthostatic blood pressures and side effects for psychotropic meds could be found. She indicated she could not locate the information and they should have been in R14's chart. It was her expectation they were to be done on admission and quarterly.

Anticoagulant use:
R103 was observed on 1/14/15, at 9:57 a.m. lying in the bed. R103 had an approximately 2 inch by 1 inch large dark blue bruise on the right lateral wrist (above thumb), and an approximately quarter sized bruise in the right elbow. When interviewed R103 stated the wrist and elbow bruises were from the hospital needles. R103 also stated she had the abdominal bruises from the twice daily Lovenox (anticoagulant medication) injections. R103 lifted her shirt up

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21535	Continued From page 58 and two dime sized bruises were observed on her abdomen. Review of the Resident Admission Record dated 1/9/15, indicated R103 was admitted to the facility on 1/9/15, (only five days ago) with diagnoses including knee joint replacement and major depression. The current Physician's Orders dated 1/12/15, indicated order for Enoxaparin (also called Lovenox) inject 0.3 ml (milliliter)/30 mg (milligram) subcutaneously every 12 hours for 14 days. Review of the Nurses notes dated 1/9/15, indicated staff identified bruises upon admission on the top of bilateral hands, right inner wrist and "Two pin point red area noted to R abd [right abdomen]." Review of R103's treatment and medication administration record for January 2015 revealed lack of anticoagulant side effect monitoring including risk for bleeding. Review of the care plan dated 1/9/15, indicated R103 was not identified with potential for bruising related to anticoagulation therapy. During interview on 1/14/15, at 1:49 p.m. the DON stated the facility used the temporary care plans from the day of admission until the comprehensive care plan was written by day 21. The DON also explained the purple temporary care plan included multiple areas, and it was individualized by completing it upon admission. The DON also stated residents needed to be monitored for high risk for bleeding when there was anticoagulant medication used, and this had to be identified on the temporary care plan. The	21535		

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21535	Continued From page 59 DON reviewed R103's medical record and verified R103 used Lovenox injections, however the side effects were not monitored, and the DON stated staff should have identified risk of bleeding/bruising as side effect, care plan it and monitor it. The Anti-Coagulant Use policy and procedure dated revised on March 1, 2014, was provided by the facility for review. The policy indicated: - "Residents who require anticoagulation therapy will receive appropriate monitoring to ensure safety.' - "Anti-coagulant is addressed on plan of care as indicated." - "Signs of bruising and bleeding are monitored routinely. Examples of common signs of bleeding include: black-tarry or red-looking stool, dark orange or red discolored urine, excessive bleeding from the gums or teeth, uncontrollable nose bleed, cuts or scratches that continue to bleed despite pressure/bandages, sudden change in cognition or mental status, and excessive bruising of the skin and extremities."	21535		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to determine the practice	21565	corrected	2/23/15

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21565	Continued From page 60 of self-administration of Lantus (a long-acting insulin) and Novolog (a fast-acting insulin) was safe for 1 of 1 resident (R23) observed to self-administer medications during a medication administration observation. Findings include: On 1/14/15, at 7:52 a.m. licensed practical nurse (LPN)-E was observed prep R23's insulins outside the hallway across from R23's room. -At 7:54 a.m. LPN-E entered the room with a Novolog Flex pen dialed up to 18 units and a drawn up syringe of Lantus 85 units. -At 7:55 a.m. LPN-E was observed don a pair of gloves at R23's bedside as R23 was seated on the wheelchair. Then set the Novolog Flex pen on the night stand and then as she approached R23 to give the Lantus insulin R23 grabbed the insulin from LPN-E and was observed to jab the needle to her left lower abdomen without pinching the skin prior and during administration. -At 7:57 a.m. LPN-E picked the Novolog Flex pen from the night stand indicated to R23 it was dialed up already and handed it to R23 and instructed her to pinch the skin and R23 was observed give herself the insulin again to the left lower abdomen again and never pinched her skin. -At 7:59 a.m. when LPN-E came out of room she proceeded to close the three ring binder which contained the Medication Administration Record (MAR) before documenting the administration. Surveyor approached and asked LPN-E when she would be documenting and the facility expectation after administering medications. LPN-E indicated she was supposed to document immediately. LPN-E then opened the MAR initiated the MAR and wrote behind the MAR R23 had self-administered insulin. When asked if R23	21565		

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21565	Continued From page 61 had an order to self-administer medication (SAM) LPN-E stated she did not think so and verified after going through the MAR. LPN-E asked "I thought residents had the right to give their own medications." R23's diagnoses included schizoaffective, manic depression and diabetes mellitus obtained from the admission Minimum Data Set (MDS) dated 12/28/14. Review of R23's Physician's Orders dated 1/8/15, revealed R23's orders were as follows: -Lantus injection 100/milliliter (ml) inject 85 units sub-cutaneous (SQ) daily -Novolog injection 18 units SQ three times daily with meals Care plan dated 1/4/15, identified R23 with the potential for complications related to diagnoses of diabetes mellitus and directed the staff to administer medications per orders and to monitor and rotate injection sites. On 1/13/15, at 8:16 a.m. LPN-D supervisor verified R23 did not have an order to self-administer insulin after going through the orders and the undated Self Administration of Medications Assessment which indicated R23 did not wish to keep any medications at bedside and also did not want to self-administer any medications after set up. When asked if R23 was supposed to SAM he stated "Nope." A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents, who request self-administration of medications, are appropriately assessed and have a physician's	21565		

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21565	Continued From page 62 order to do so; educate staff as needed; then develop monitoring systems and audit to ensure ongoing compliance. Report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21565		
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, interview and document review, the facility failed to ensure a sanitary and comfortable environment was provided, and resident equipment was in good repair. This had the potential to affect 6 of 35 residents in the sample which included (R72, R36, R58, R98, R33, R29). Findings include: An environmental tour was conducted on 1/14/15, with personnel from the Environmental Services (ES) department: maintenance person (M)-A (the environmental services and housekeeping director), and M-B (the maintenance assistant), who were present starting at 11:35 a.m. Joining the tour after 12:14 p.m. were the director of	21685	corrected	2/23/15

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21685	Continued From page 63 nursing (DON) and the administrator. The following were observed: 1. Room 208-1: Observation on 1/12/15, at 2:52 p.m., two oxygen tubing were observed on the floor. On 1/15/15, at 12:24 p.m. when informed the findings on 1/12/15, at 2:52 p.m. the DON indicated she would expect oxygen tubing would be kept off the floor. 2. Room 218-1: R72 was in her room, 218-1 and pointed out a small area of loose debris and dust between two dressers. M-A noted it and indicated he had "not known about it," and would have Housekeeping clean it. 3. Room 224-1: There were black scuffs observed on a wall on the left side of the room. M-A revealed, "We would normally catch this when we [ES] do rounds of all rooms every month, and would patch and repaint." 4. Room 303-1: The bathroom's toilet bowl had brown streaks on its outside, and also inside the bowl. Further, in the deepest part of the interior bowl, in the narrow flush passage was visible a black area of discoloration, and the toilet had missing caulk in a section around the base at floor level. M-A confirmed these problems were not acceptable and stated on 1/15/15, at 12:51 p.m. "We were not notified of this, and we will put it on our repair list - a housekeeper should have caught this." M-A also repeated what he had said several times during the tour, "We fix things as soon as we hear about them." 5. Room 304-2: Observation noted a yellowish, smeared/gritty-looking area on the floor tiling between the wall and the rear of the toilet, below the toilet's exit pipe to the wall. On 1/15/15, at 12:53 p.m. M-A indicated that was "not reported." M-A identified the discolored area under the pipe as lime deposits, and said, "We will have to change the cleaner to make sure we get that off."	21685		

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21685	Continued From page 64 6. Room 319-1: Observation noted unpainted white plaster patches on the wall. In addition, observation of the bathroom doorway revealed scuffing off of paint at the bottom. M-A stated at 12:57 p.m. "We found this on monthly rounds. That's something we do, patch first, let the patch dry well, and come back to paint, and this one is just between steps of that process." M-B, however, admitted he had patched the wall areas about two weeks before, and had not yet gotten to painting it over. He added he would normally follow up as soon as possible, but cosmetic issues could be delayed by prioritizing repairs of call lights and other safety issues. 7. Room 330-1: Observation of a stuffed chair was noted to have a seat cushion stained: the chair was covered in light brown fabric and the stain was a larger, darker irregular outline on the cushion. M-A indicated ES was "not notified," adding they would shampoo the area. The DON stated, "Any staff should have reported this, nursing, housekeeping..." A three-ring binder titled "Environmental Services Requisition Communication Log" was observed on 1/15/15, at 1:21 p.m. after the room tour. It contained pages titled, "Environmental Services Requisitions (ESR)," which were filled out specific to each of the three units. The ES director, M-A indicated the most current pages were still on the units. Copies of these from August, 2013 to the present were provided and reviewed. M-A's indicated ES had not been notified of the problems observed during the tour as facility staff who may have observed environmental problems did not follow the protocol/policy for reporting identified environmental concerns. The log sheets included column headings for "Reported by," whose boxes below were almost	21685		

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always completed; and for Priorty [sic] level," which were rarely completed; and headings for "Response or (Follow-up) [sic]," which had written entries which were seen to indicate either the response, or in some cases a note on what the problem actually was, without a notation of the response. Most responses were simply written as "Done," with no specifics on what/how the repair was done. There were also seen headings for "Date Complete," which had dates indicated for August and September of 2014, but rarely in more recent months; and there were headings for "Completed by," and a similar pattern was observed in these columns. The entries may have indicated a problem-logging system that was only sporadically and incompletely being followed.

Two documents titled, "St. Olaf Residence Policies and Procedures...Environmental Services," each with a last review date of 10/2/02 , was observed. One was subtitled "Spot Cleaning of Walls," and included the following: "Procedure...4. Report any wallpaper tears, cracks or chips in paint or plaster by writing it in the maintenance books at each nursing station." The other document included the subheading, "Resident Room Cleaning (General)," and included, "Procedure...9. Write any damaged items, such as...nurse call cords, etc., repairs needed or unsafe conditions, in the maintenance books at each nursing station."

An interview was conducted on 1/14/15, at 1:59 p.m. with the ES director to ask about department staffing, because of the indication of delayed or prolonged responses to problems known to the ES department, despite repeated assertions that they would respond to problems as soon as they were known, and because of repeated responses during the tour which indicated the ES

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21685	Continued From page 66 department had not been informed of problems observed by ES while on the tour with the surveyor. When M-A was asked about staffing in the department: he stated, "There are only two of us to do all this place. We are down two employees. They are waiting for the census to come up to replace the positions."	21685		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 3 of 4 residents (R31, R76, R32) call lights were readily accessible reviewed for falls. Findings include: R31's call light was observed on 1/12/15, at 7:00 p.m. hanging on the wall around the call light button. On 1/13/14, at 8:07 a.m. during interview, when asked if he used the call light R31 stated "Yap" when asked if he was able to reach the call light where it was hanging on the wall at the time he	21810	corrected	2/23/15

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21810	Continued From page 67 stated "No." On 1/13/15, at 8:21 a.m. nursing assistant (NA)-E verified the call light was hanging on the wall indicated R31 was capable of using the call light. NA-E further stated when R31 was lying in bed the call light would be put at reach close to his strong hand. When asked if the call light was supposed to be at reach when R31 was seated on his wheelchair NA-E indicated "Yes." On 1/13/15, at 9:22 a.m. to 9:47 a.m. R31 was observed in his room seated on his wheelchair call light still hanging on the wall not accessible R31 watching television. On 1/13/15, at 3:29 p.m. NA-F verified the call light was not at reach and indicated "When he is in his room it is supposed to be at reach" as she got the call light off the wall and wrapped it around R31's wheelchair. R31's activity of daily living functional/rehabilitation care plan dated 10/16/14, identified R31 at risk for falls related to right sided weakness. Although the care plan directed staff to give R31 verbal reminders not to ambulate/transfer without assistance, the care plan did not direct R31's call light to be within reach even after indicating R31 was at risk for falls. Review of Resident Incident Reports revealed R31 had falls on 10/5/14, 11/20/14, and 12/26/14, and on two out of the three incident reports it was indicated interventions implemented to prevent further incidents included "Told resident to put call light for help @ [at] all times. Resident understands to ask for help when transferring."	21810		

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21810	Continued From page 68 R76 was observed on 1/12/15, at 3:57 p.m. lying in his bed. The call light was at the head of his bed beyond his pillow. R76 had a brace on his right upper extremity and another on his right lower extremity. At 4:05 p.m. a NA-H stated R76 was able to use his call light appropriately if the call light was placed within his reach. She then verified R76 would be unable to use the call light when it was in the current spot, placed at the head of his bed beyond his pillow. NA-H further explained that R76 cannot use his right upper extremity to functionalize the call light. She stated he required his left hand to turn the call light on. NA-H then placed the call light across the chest of R76 and within reach of his left hand. On 1/13/15, at 9:41 a.m. R76 was observed in his room sitting in his wheelchair. One call lights was hanging on the far wall and another call light was lying on the floor near the far wall. Both call lights approximately five feet from R76 and to his back. When asked if he could reach either call light R76 shook his head to indicate he could not reach the call lights. The comprehensive Minimum Data Set (MDS) dated 12/5/14, identified R76's diagnoses as dementia with behavioral disturbances, hemiparesis (weakness of the entire left or right side of the body) and chronic obstructive pulmonary disease (COPD). The MDS further revealed R76 was totally dependent on staff for locomotion, bed mobility, transferring, toileting and dressing and he was nonambulatory.	21810		

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21810	Continued From page 69 The care plan (CP) dated 12/12/14, identified R76 to be at risk for falls related to immobility and right sided hemiparesis and directs staff to give verbal reminders not to self-transfer and to keep the call light within reach. The Fall Risk Assessment dated 6/3/14, identified R76 as a high risk for falls noted no falls were noted in past six months. The Fall Risk Assessment dated 12/4/14, not completed. R32 was observed on 1/13/15, at 8:58 a.m. sitting in her wheelchair in her room. The call light was on the bed near the wall on the far side. -At 9:12 a.m. R32 was in her chair and the call light was on the bed near the far wall. -At 9:25 a.m. R32 was in her chair and the call light was on the bed near the far wall. On 1/15/15, at 2:15 p.m. a licensed practical nurse (LPN)-D stated R32 was capable of using her call light appropriately and staff should always place it within her reach when she was in her room. The comprehensive MDS dated 12/11/14, identified R32's diagnoses as followed Alzheimer's disease, macular degeneration, dementia with behavior disturbances, hypotension and osteoarthritis. The MDS further revealed R32 was totally dependent on staff for locomotion, bed mobility, transferring, toileting and dressing and was nonambulatory. The CP dated 12/19/14, identified R32 at risk for falls related to immobility and directs staff to keep the call light within reach. The Fall Risk Assessments dated 6/8/14 and	21810		

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21810	Continued From page 70 9/5/14, identified R32 as being at low risk for falls. No falls were noted in past six months. On 1/15/15, at 8:25 a.m. the DON stated, "I would expect call lights to be in reach of the resident." She indicated further that the nursing staff would generally be responsible for that, but that any and all staff can see if a resident has a call light and offer it to them. She added she, or other staff she designated performed random audits of call light function and placement. She indicated she kept records of these audits. The DON also indicated if a resident cannot use the usual call light because they cannot push the button, they offered a soft touch call device. She went on to say for residents who just cannot use a light for whatever reason, "We check on them, bring the resident into staff view, offer diversions, stimulation; this would be for the severely aphasic or demented residents." On 1/15/15, at 8:47 a.m. the director of Environmental Services (M)-A was interviewed and said, "I'd expect to see, if the resident was in bed or in a chair that the call light would be in reach." He added if it was someone in a wheelchair the light should be where they could wheel over and reach it easily. He indicated they did audits, "Every month, in every room, we check that the bedside call light plungers (buttons) work, and that the call light indicator lights above the doors do light up." He added they would check the bathrooms in the same way, "The wall switch string and the light going off." On 1/15/15, at 9:50 a.m. with the director of nursing (DON) stated she would definitely expect call light to be within reach for residents who are capable of using them. She further indicated that	21810		

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21810	Continued From page 71 R76 and R32 are able to appropriately use their call lights Review of the Resident Call System Policy (Health Dimensions Group 2008) directed all residents to have call system access while in bed or while at their bedside or in the bathroom. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop and implement policies and procedures to ensure residents call lights are within reach; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21810		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal privacy was provided to 1 of 2 residents (R104)	21855	corrected	2/23/15

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21855	Continued From page 72 observed during blood glucose testing. Findings include: On 1/12/15, at 6:10 p.m. R104 was observed sitting in the dining room waiting for dinner. There were four other residents sitting at the same table (including R58), and four more residents in the dining room sitting at other tables. On 1/12/15, at 6:12 p.m. the licensed practical nurse (LPN)-F walked into the dining room, poked R104's finger and checked her blood sugar. After the procedure was completed LPN-F requested R104 to hold the cotton ball in place till the bleeding stopped. On 1/12/15, at 7:10 p.m. attempted to interview resident, R104 did not speak English. On 1/13/15, at 9:55 a.m. a family of four members visited resident, when attempted to talk to them, the male visitor stated he was R104's son, however declined interview. On 1/14/15, and 1/15/15, LPN-F was not available for an interview. R58 (who sat at the table next to R104 during dinner on 1/12/15) was interviewed on 1/14/15, at 10:10 a.m., and stated "I noticed the nurse checking the other lady's blood sugar at the table", "they do that all the time, and staff also used to give insulin to the residents in the dining." R58 further stated "I thought blood sugar checks and giving insulin supposed to be done in resident's rooms for privacy." Review of the undated Resident Admission Record indicated R104 was admitted to the	21855		

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21855	Continued From page 73 facility on 1/6/15, with diagnoses including anemia, pneumonia and Parkinson's disease; and R104 spoke an "Asian" language. The social service progress note dated 1/8/15, indicated "resident speaks Hmong, family is available to assist" with communication. During interview on 1/14/15, at 10:13 a.m. the director of nursing (DON) stated it was the facility's policy and common nurse practice to provide residents privacy during treatments, by either bringing them into their rooms, or to a location where residents were not visible to others. The DON further stated it was expected from staff to provide privacy during blood sugar checks. The facility's Privacy policy dated reviewed and revised on May 2011, indicated "To provide privacy and protect the dignity of all residents", privacy curtains and/or window treatments will be closed when the resident is receiving personal care including "during treatments." SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies relating to the privacy and confidentiality provided to all residents and provide inservice for all staff regarding privacy and confidentiality. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21855		
22060	MN Rule 4658.4005 Approval Of Plans; New Construction Preliminary plans and final working drawings and specifications for proposed construction must be	22060		2/23/15

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22060	Continued From page 74 submitted to the commissioner of health for review and approval. Preliminary plans must be approved before the preparation of final working drawings is undertaken. Final working drawings and specifications must be approved before construction is begun. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed ensure 1 of 1 resident (R8) rooms (room 107) which had a toilet in the room met the applicable codes/ regulations. Findings include: On 1/12/15, at 12:15 a.m. during entrance conference the interim administrator stated he was not aware the facility had a bedroom which had a toilet in the room, and for which the facility needed to apply for a waiver. The administrator further stated he was the interim administrator and started working only six weeks ago. The director of the nursing (DON) stated she was aware there was a room in the facility that had a toilet in the room, but was not aware the facility had a waiver for it, and that they needed to renew that waiver. Review of R8's current physician's orders dated 1/1/15 indicated diagnoses including traumatic amputation of leg and morbid obesity. The quarterly minimum data set (MDS) dated 11/5/14 indicated R8 needed limited assistance of one staff with toileting. On 1/14/15, at 9:40 a.m. R8's room was toured with the interim administrator. The bathroom was observed immediately to the right of the entry way	22060	corrected	

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22060	Continued From page 75 with a toilet covered with a big brown carton box, and a folded wheel chair in front of it. The room was observed, there was a bed in the left side of the room against the wall. On the right side there was the toilet and the sink (closer to the window). The door sign indicated R8 lived in the room. On 1/14/15, at 2:45 PM R8 was observed and interviewed in the room. R8 stated he just finished using the toilet, and it was a great idea to have the toilet in the room for easier access during transfers. R8 did not want to answer any additional questions. On 1/15/15, at 10.00 a.m. the administrator provided the room 107 waiver dated October 14, 2013, for review, and stated he will apply for a waiver renewal. Review of the waiver revealed the following information "This waiver will remain in effect until October 31, 2014 or until the resident currently assigned to room 107 was assigned to a different bedroom or departs the facility, whichever occurs first. Please be advised that all waivers are subject to review as deemed necessary by the Department. Please remember that all alternative measures of conditions attached to a variance or waiver shall have the force and effect of a licensure." SUGGESTED METHOD OF CORRECTION: The administrator of designee could apply for a waiver for room 107. The administrator or designee could review and revise policies relating to room 107 and provide inservice for all staff regarding privacy and confidentiality. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	22060		