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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: TH8B

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 28617

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245621**

2.STATE VENDOR OR MEDICAID NO.
(L2) **154115000**

3. NAME AND ADDRESS OF FACILITY
(L3) **FOLKESTONE**
(L4) **100 PROMENADE AVENUE**
(L5) **WAYZATA, MN** (L6) **55391**

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 **05/16/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **04** (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 **30** (L18)

13.Total Certified Beds **30** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
30				
(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 :
Gayle Lantto, Unit Supervisor — 05/24/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 06/29/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/06/2014
(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.
00325
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/13/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245621

June 29, 2016

Ms. Nichole Pederson, Administrator
Folkestone
100 Promenade Avenue
Wayzata, Minnesota 55391

Dear Ms. Pederson:

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 May 6, 2016 the above facility is certified for:

30 - Skilled Nursing Facility Beds

Your facility's Medicare approved area consists of all 30 skilled nursing facility beds.

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 24, 2016

Ms. Nichole Pederson, Administrator
Folkestone
100 Promenade Avenue
Wayzata, Minnesota 55391

RE: Project Number S5621002

Dear Ms. Pederson:

On April 14, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 31, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On May 16, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 2, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 31, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 6, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 31, 2016, effective May 6, 2016 and therefore remedies outlined in our letter to you dated April 14, 2016, will not be imposed.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245621 Y1	A. Building B. Wing Y2	5/16/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLKESTONE	100 PROMENADE AVENUE WAYZATA, MN 55391

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156	Correction	ID Prefix F0241	Correction	ID Prefix F0246	Correction
Reg. # 483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. # 483.15(a)	Completed	Reg. # 483.15(e)(1)	Completed
LSC	05/06/2016	LSC	05/06/2016	LSC	05/06/2016
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0356	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.30(e)	Completed
LSC	05/06/2016	LSC	05/06/2016	LSC	05/06/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	GL/mm	05/24/2016	15507	05/02/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/31/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245621 Y1	A. Building 01 - FOLKESTONE GABLES NH B. Wing Y2	5/2/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLKESTONE	100 PROMENADE AVENUE WAYZATA, MN 55391

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0022	04/30/2016	LSC K0038	04/30/2016	LSC K0050	04/30/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0052	04/30/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	TL/mm	05/24/2016	27200	05/02/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/30/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TH8B

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 28617

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245621**

2.STATE VENDOR OR MEDICAID NO.
(L2) **154115000**

3. NAME AND ADDRESS OF FACILITY
(L3) **FOLKESTONE**
(L4) **100 PROMENADE AVENUE**
(L5) **WAYZATA, MN** (L6) **55391**

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 **03/31/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **04** (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 **30** (L18)

13.Total Certified Beds **30** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
30				
(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 :
Steven Douglas, HFE NEII 04/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 05/10/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/06/2014
(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.
00325
(L31)

30. REMARKS
Posted 05/13/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 14, 2016

Ms. Nichole Pederson, Administrator
Folkestone
100 Promenade Avenue
Wayzata, Minnesota 55391

RE: Project Number S5621002

Dear Ms. Pederson:

On March 31, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be 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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 10, 2016, 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 July 1, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 1, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245621	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLKESTONE	100 PROMENADE AVENUE WAYZATA, MN 55391

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		5/6/16

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

Electronically Signed | 04/20/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245621	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLKESTONE	100 PROMENADE AVENUE WAYZATA, MN 55391

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F 156	Continued From page 1	F 156		

and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) or uniform denial letter upon termination of all Medicare (MC) Part A skilled services for 2 of 3 residents (R1, R19) reviewed for liability notice and beneficiary appeal rights. Findings include: R1's Admission Record indicated he had been admitted to the facility on 10/13/15, and had received skilled nursing/therapy services. The discharge record verified R1 left the facility on 11/12/15. R1 was issued a Notice of Medicare Non-Coverage (NOMNC) stating currant skilled nursing/therapy services would end 11/11/15. The notice was also signed on 11/11/15 by R1. R1's	F 156	Resident #1 and Resident #19 are both discharged from the facility and did not request a demand bill or a review. The policy was reviewed and is current for Medicare denials all residents currently receiving Medicare were reviewed for appropriate notice and denials forms are current. The facility has added a new process with specific responsibilities for each discipline at the daily IDT meeting. The social worker along with therapy will inform the IDT group of upcoming discharges and the Health Unit Coordinator will be responsible to issue the appropriate denial letter once discharge date is determined. Education was completed with all involved in the Medicare denial process. The Clinical	

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F 156	Continued From page 3 progress notes for the past 30 days were reviewed but lacked mention of explanation for a NOMNC fewer than 48 hours in advance or for beneficiary appeal rights. R19's Discharge Summary/Recapitulation of Stay signed 1/8/16, verified the resident had been admitted to the facility on 10/6/15 and was discharged 1/8/16. Progress notes indicated R19 had received physical and occupational therapy during her stay. The progress notes indicated R19's son was contacted by telephone on 1/4/16, and informed that current skilled nursing/therapy services would end 1/5/16. A 1/4/16 unsigned hand-written note on the NOMNC read, "consent to sign by [R19's son]. Talked to son [name] on 1/4/16 and informed therapy will be done 1/4/16." R19's progress notes for the previous 30 days were reviewed but lacked mention of explanation for a NOMNC fewer than 48 hours in advance or for beneficiary appeal rights. During an interview with the administrator on 3/29/16, at 11:18 a.m. the administrator explained she thought she'd had more correspondence with the families of R1 and R19 regarding the NOMNC and appeal rights. She explained, "mistakes were made" and verified R1 and R19 were not given NOMNC and appeal rights information in a timely manner. The administrator added, "The facility strives to give a 48 hour notice [for NOMNC and appeal rights]. I am the one who issues the notices." The Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123, approved 10/31/11 indicated, "A Medicare provider or health	F 156	Coordinator will conduct monthly audits for all residents receiving medicare, which were initiated 4/4/16, to ensure completion as required in a timely manner. Care Center Administrator and Clinical Administrator are responsible for ongoing compliance.	

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F 156	Continued From page 4 plan must give in advance , a completed copy of the NOMNC to beneficiaries/enrollees receiving skilled care--services no later than two days before the termination of services." The Presbyterian Homes and Services SNF Determination on Continued Stay, modified February 2016, indicated their purpose was to remain in compliance with Federal regulations allowing facility participation in the Medicare program, and to communicate with beneficiary/responsible party on determination of Medicare coverage. The procedure of the policy directed staff to issue denials two days before payer source changed.	F 156		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the failed to ensure personal information and care items were maintained in a manner that promoted dignity for 3 of 3 residents (R20, R22, R32) reviewed for dignity. Findings include: R20's room was observed on 3/28/16, at 3:19 p.m. and confidential personal care information was observed posted in the shared room and bathroom which could be easily viewed by others.	F 241	Resident #20 posted signs in room were removed immediately by Administrator. Incontinence products in all resident rooms have been moved to be stored in a private location out of site as well as Resident #22 nebulizer mask and associated medical equipment once identified. All resident rooms were checked for signage and supplies for appropriate storage. All residents that have identified	5/6/16

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F 241	Continued From page 5 A typed message was posted in the bathroom which included R20's name and room number, and explained that R20's family provided incontinent products, therefore staff were not to take "diapers and wipes" from the facility's supply. Another sign, posted on the bulletin board adjacent to R20's bed, also revealed personal information. The sign directed staff to obtain the resident's weight on Monday, Wednesday and Friday on the a.m. (morning) shift, to not take a blood pressure from R20's left arm, to place the resident's left arm in a splint for eight hours, to provide peri care and repositioning every two hours, to abstain from using briefs or incontinent products at night, to "leave the peri area open to air at night," and to have the resident wear her own clothing protector at meal time. On the wall at the head of the bed additional instructions were posted directing staff to lock the bed in the lowest position at night. During interview with the administrator at 8:28 a.m. on 3/30/16, she stated the signs should not have been posted. The administrator acknowledged the posted signs divulged personal information which could have easily beeen visualized by residents and visitors, especially since the room and bathroom were shared. At that time, the administrator removed the postings. R22's incontinent brief was observed left on the bedside table in his room on 3/30/16, at 10:30 a.m. The resident was not receiving incontinence care at the time of the observation. In addition, nebulizer masks and boxes of associated medical equipment were observed to be stored on the counter in the room.	F 241	signs in room were reviewed and/or removed and care plan updated. Policy related to privacy and dignity was reviewed and is current. Staff education initiated on 4/4/16 with all care center staff regarding privacy and dignity including storage of supplies and signage. Random dignity and privacy audits on 10% of residents were initiated on 4/4/16 and will be completed weekly for four weeks by nursing. Results will be reported to the QA Committee and action plans will be developed as needed. The Care Center Administrator and Clinical Administrator are responsible for ongoing compliance.	

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F 241	Continued From page 6	F 241		

The care plan for R22 dated 1/19/16, indicated the resident required extensive assistance with cares. R22's 1/20/16, Minimum Data Set (MDS) indicated the resident was cognitively intact and presented no behavioral issues. The MDS indicated R22 required extensive assistance from staff with toileting and was always incontinent.

R32's cares were observed on 3/30/16, at 7:39 a.m. A package of incontinent briefs was stored on the personal hutch in the entrance alcove to the room the resident shared with a roommate.

The MDS dated 2/10/16, indicated R32 had Alzheimer's disease, required extensive assistance from staff to perform activities of daily living, and was always incontinent.

In an interview with registered nurse (RN)-A, and the corporate director of nursing, on 3/31/16 at approximately 1:00 p.m., RN-A said she had noticed supplies were occassionally being stored inappropriately in resident rooms. The corporate director of nursing said resident supplies should be stored in the residents' bathrooms.

The facility policy, Presbyterian Home and Services Dignity dated 12/14, indicated residents were to be cared for in a manner and in an environment that promoted maintenance and/or enhancement of each resident's quality of life. The policy further indicated the facility was committed to an atmosphere that humanized and individualized each resident and their experiences. The policy noted residents would be informed of their rights and staff would be trained in Resident Rights, Privacy and Dignity upon hire and annually.

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F 246	Continued From page 7	F 246		
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 equipment was available for 2 of 2 residents (R8, R22) who reported equipment was unavailable for their use. Findings include: R8 was interviewed on 3/28/16, at 5:09 p.m. and reported she was missing "a cover for my elbow--a spongy cover. I don't know what happened to it and I should have that. They're trying to replace it but there's no place to look for it...Sometimes they look for things, but don't generally find the missing items and don't offer to replace them." R8 said the item had been missing for about two weeks. Although R8 was in her room in the wheelchair, she did was not using a lap tray. On 3/31/16, at 7:24 a.m. R8 was receiving range of motion (ROM) to her left arm and hand by a nursing assistant (NA)-A. The resident reported her elbow hurt sometimes, and it would feel better if she had her elbow protector. NA-A gave a puzzled look and said she had actually not seen	F 246	The facility initiated immediate correction for Resident #8 missing elbow pad and cover equipment on 3/31/16 by ordering a new one for resident and placed a padded armrest to wheelchair for the interim. Resident # 8 was assessed for appropriate wheelchair and declined other offering.Resident #22 call light was placed within reach immediately upon being notified. All residents care plans were reviewed to ensure appropriate equipment needs are up to date. All resident equipment needs are reviewed quarterly with RAI process. Policy and procedure was reviewed and is current. Staff education initiated with all care center staff on 4/4/16 and will be completed by 4/30/16 on appropriate equipment and following care plan. Random audits initiated on 4/4/16 for 10% of residents and will be completed weekly for four weeks by nursing. Staff education on call light placement	5/6/16

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F 246	Continued From page 8 the device for the last couple weeks, but possibly R8's family had taken it home. R8's 11/3/15, Minimum Data Set assessment revealed the resident was cognitively intact, and had a functional impairment of range of motion on one side of the body. She required extensive assistance from staff for activities of daily living. The care plan dated 7/28/14, for R8 indicated the resident had a history of olecranon process of ulna (fractured elbow) and potential for pain. Interventions included applying a sling as needed, daily passive ROM to upper extremities, and use of a hand splint before bed. It was noted R8 could tell the staff what alleviated the pain and could request medication. On 3/31/16, at 9:40 a.m. a registered nurse (RN)-A reported the facility was working with the resident's family on getting a new elbow protector. RN-A explained the facility had washed the item and it "wasn't able to make it through the laundry." RN-A said the resident's son was visiting last week and they mentioned it, but realized they should tell R8's daughter. RN-A stated, "We're working on i,t but without having it [elbow protector] to know what it looked like, we're having a hard time replacing it." When asked if the occupational therapists might have a book of items that could be ordered RN-A said they cannot be consulted without a physician's order to treat, but said, "Yes, they may have a book we could use." At 10:10 a.m. RN-A said she tried calling R8's family again, but did not reach anyone. RN-A said she told NA-A if she knew it was missing she should have reported it, but she had not worked with R8 for a couple weeks. RN-A said it was brought to her attention "this	F 246	initiated immediately. Random audits on 10% of residents were initiated on 4/4/16 on call light placement will be completed weekly for four weeks by nursing. Results will be reported to the QA Committee and the need for ongoing audits and action plans will be determined as appropriate. The Care Center Administrator and Clinical Administrator will be responsible for ongoing compliance.	

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F 246	Continued From page 9	F 246		

past week," and they were working with R8's daughter to replace it. The occupational therapist said they could assist in finding a replacement elbow protector. At 10:31 a.m. RN-A said she was able to get in touch with R8's daughter, who gave the okay to order a new one. They were able to determine the type of elbow protector R8 had, and a new one was ordered and was to arrive "tomorrow."

R8's 1/16/15, physician's order read, "Encourage pad/pillow to elbow to w/c [wheelchair] armrest on left side to prevent future breakdown." A care conference summary note dated 2/4/16, noted "Make sure left arm rest is on wheelchair." The current (3/16) treatment administration record directed staff to "avoid direct pressure to elbow."

In a follow up interview with R8 on 3/31/16, at 10:40 a.m. she again stated her elbow protector had been missing for a couple weeks and she "really wants it back." R8 speculated it had been accidentally thrown away by staff. The resident said she told someone, but could not remember who she told. She stated [therapist's name] gave her a wheelchair arm rest which she had "used some" and found it helpful. She could not always use it, however, as she could then not get close enough to the table at meals. This was the first observation in four days where R8 was utilizing the arm rest. The arm rest was padded with thick foam, covered in vinyl. R8 also reported she was "quite protective of the elbow since I broke it and it feels more comfortable wearing the elbow protector." When informed her elbow looked a little reddened during ROM she pulled up her shirt sleeve. Although the resident did not fully turn her arm, it appeared the redness was no longer present. When R8 was told it sounded like she

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F 246	Continued From page 10	F 246		

would be getting another elbow protector soon, she replied, "Thank you very much!"

On 3/31/16, at 11:23 a.m. R8's daughter (FM)-A was interviewed via telephone. She offered, "I just got a call this morning" saying the staff was trying to locate R8's elbow protector. FM-A said she believed RN-A found out about it last week. Although RN-A informed her she left her a voicemail, she had not received any messages until "today." FM-A stated, "A week and a half ago or so I think I mentioned it to a nurse that it was missing," and although she wished she could have recalled who she told, she could not remember, but was sure she told someone. FM-A said "for sure my brother" told a staff person it was missing after R8 told him it was missing as well. She stated, "That would've been Tuesday" (3/22/16). FM-A said she was aware her mother had a lap tray, but said, "She herself could not use it," and it would be "up to staff to put it on, and I don't know if she would ask for that, as she is disinclined to make her needs known due to appearing burdensome." FM-A said she brought this up at the last care conference because "I frequently see her poorly positioned and leaning to the left--very slumpy." RN-A had asked FM-A if the family had taken the elbow protector home for any reason, such as to launder it, and she had told her "No," the family would not have taken the elbow protector out of the facility.

On 3/30/16 at 10:30 a.m., R22 was observed to be seated in a wheelchair in his room with the door closed. His call light was observed to be behind him, wrapped several times around the bedside grab bar, so that the resident would not have been physically able to reach for the call

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F 246	Continued From page 11 light. At that time, R22 stated, "the staff leave me without my call light and say we'll be right back, but what does that mean?" When asked how often his call light was out of his reach he replied, "every day." On 3/31/16 at 11:03 a.m., R22 was again observed to be seated in his wheelchair. Although his call light was placed within his reach, when asked again how frequently he was left in his room without his call light he didn't hesitate before stating, "At least once a day." R22 said if he needed something and did not have the light, he had to "holler" for help. However, he added that was difficult sometimes because staff often closed his door. R22's care plan dated 1/19/16, indicated the resident required extensive assistance with cares. Staff were directed to ensure the resident's call light was within his reach at all times. The 1/20/16, MDS revealed the resident had a functional impairment of ROM on one side (toward the call light), required extensive assistance from staff for activities of daily living, and was always incontinent. In addition, the MDS revealed R22 had no cognitive impairment or behavioral issues. During interview with RN-A, and the corporate director of nursing on 3/31/16, at 2::00 p.m. they both verified the resident should have had his call light within reach in accordance with his plan of care.	F 246		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282		5/6/16

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F 282	Continued From page 12 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 ensure the care plan was followed for 1 of 1 resident (R23) with bruising, and for 1 of 2 residents (R22) whose personal equipment was unavailable. Findings include: R23's 8/25/14, care plan indicated the resident had a self-care performance deficit. Approaches included "SKIN INSPECTION: I ask that you observe my skin for redness, open areas, scratches, cuts, bruises and report changes." The 1/13/16, Minimum Data Set (MDS) assessment revealed diagnoses including Alzheimer's disease and moderately impaired cognition. R23 was observed on 3/29/16, at 10:26 a.m. with a large purple bruise on her left hand, approximately 1 1/2 by 2 inches in size. The resident reported she did not know how she'd sustained the bruise, but thought she may have possibly bumped her hand on something. The current care plan for R23, indicated the resident had a self-care performance deficit. Approaches included "SKIN INSPECTION: I ask that you observe my skin for redness, open areas, scratches, cuts, bruises and report changes." The 1/13/16, Minimum Data Set (MDS) assessment revealed diagnoses including Alzheimer's disease and moderately impaired	F 282	Resident #23 was immediately assessed regarding the identification of the bruise and an investigation was initiated as per facility procedure. The care plan was updated to reflect causative factors for risk of bruising an appropriate interventions. Resident #22 was assessed and care plan reviewed related to call light use and is current. All residents care plans were reviewed and were current and/or updated as appropriate. All residents checked to ensure their care plans were being followed. Policy and procedure for care planning was reviewed and is current. All resident care plans are reviewed and updated upon admission, quarterly, significant changes, and annually as a part of the RAI process. Staff education initiated on 4/4/16 and will be completed with all care center staff by 4/30/16 on importance of following care plan. A nurse re-education class was completed with nurses on 4/18/16 on nursing assessments and occurrences by Clinical Administrator and the Education Department. Random audits of 10% of residents on unknown injury and assessment completion were initiated on 4/4/16 and will be completed weekly for four weeks. Results will be reported to the QA Committee to determine further action	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245621	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLKESTONE	100 PROMENADE AVENUE WAYZATA, MN 55391

(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 282	Continued From page 13 cognition. R23's most recent skin assessment was dated 3/21/16, noted the resident's skin at that time was "intact." R23's nursing notes 3/27/16, reflected she was physically aggressive toward staff three times in the past seven days, and occasional notes showed the resident did not wish to get out of bed, for example on 3/23/16. The resident's medical record did not reflect the identification of the bruise when the record was reviewed on 3/30/16. The presence of bruising was not noted in any progress notes or on the treatment record. However, a progress note was located the following day that was written 3/30/15, at 5:31 p.m. The note lacked "Author" (as other notes included) and read, "Bruise located to left posterior hand occurring when resident states she was reaching for the light on the wall and hit her hand. Resident denies any pain or discomfort and is able to freely move her hand without pain." A note by the clinical administrator dated 3/31/16, indicated the bruise on R23's hand measured 5 by 4 centimeters, and the resident reported she hit it on the wall shutting off the light. On 3/31/16, at approximately 8:00 a.m. a registered nurse (RN)-A was asked about the bruise on R23's hand, and was informed documentation regarding the bruise could not be found in the resident's record. RN-A said she would "have to go look" at the resident's hand. At 9:00 a.m., RN-A said she had visualized the bruise and had asked the resident what had happened. RN-A said the resident had reported she could have hit it on something. RN-A said, she was in bed at the time and reported her light was so bright she'd probably reached out to shut it off, and hit the wall. RN-A said the family had	F 282	plans as appropriate. Staff education on call light placement initiated immediately. Random audits on 10% of residents were initiated on 4/4/16 on call light placement and will be completed weekly for four weeks by nursing. Results will be reported to the QA Committee and the need for ongoing audits and action plans will be determined as appropriate. The Care Center Administrator and Clinical Administrator will be responsible for ongoing compliance.	

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	245621	A. BUILDING _____ B. WING _____	03/31/2016

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F 282	Continued From page 14	F 282		

requested the room arrangement, but she had placed a call to them to see if the room could be rearranged. RN-A explained the resident was sometimes confused, but said no one hurt her. She said the facility protocol was, "If you see something say something," however verified the nursing assistants had failed to report the bruising to the nurse. RN-A said the resident had spent most of Monday (day prior) in bed, and it could have happened Monday after she (RN-A) had left for the day. RN-A initiated an incident report and said the interdisciplinary team had already reviewed it. Furthermore, RN-A said the size of the bruise would be monitored every week with body audits completed on bath days. RN-A also said R23's bath day was Monday and that if R23 was uncooperative with the body audit, it would be performed when the resident would allow it. RN-A verified the surveyor was the first person to inform the nurse of the bruise and again stated, "Staff should have informed the nurse right away."

R22's care plan dated 1/19/16, indicated the resident required extensive assistance with cares. Staff were directed to ensure the resident's call light was within his reach at all times. The 1/20/16, MDS revealed the resident had a functional impairment of ROM on one side (toward the call light), required extensive assistance from staff for activities of daily living, and was always incontinent. In addition, the MDS revealed R22 had no cognitive impairment or behavioral issues.

On 3/30/16 at 10:30 a.m., R22 was observed to be seated in a wheelchair in his room with the door closed. His call light was observed to be behind him, wrapped several times around the

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F 282	Continued From page 15 bedside grab bar, so that the resident would not have been physically able to reach for the call light. At that time, R22 stated, "the staff leave me without my call light and say we'll be right back, but what does that mean?" When asked how often his call light was out of his reach he replied, "every day." On 3/31/16 at 11:03 a.m., R22 was again observed to be seated in his wheelchair. Although his call light was placed within his reach, when asked again how frequently he was left in his room without his call light he didn't hesitate before stating, "At least once a day." R22 said if he needed something and did not have the light, he had to "holler" for help. However, he added that was difficult sometimes because staff often closed his door. During interview with RN-A, and the corporate director of nursing on 3/31/16, at 2::00 p.m. they both verified the resident should have had his call light within reach in accordance with his plan of care.	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 and plan of care. This REQUIREMENT is not met as evidenced by:	F 309		5/6/16

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F 309	Continued From page 16 Based on observation, interview and document review, the facility failed to ensure bruises were identified and reported timely to determine possible causal factors and to provide appropriate monitoring and measures to minimize risk for further injury for 1 of 1 resident (R23) who had unidentified bruising. Findings include: R23 was observed on 3/29/16, at 10:26 a.m. with a large purple bruise on her left hand, approximately 1 1/2 by 2 inches in size. The resident reported she did not know how she'd sustained the bruise, but thought she may have possibly bumped her hand on something. The current care plan for R23, indicated the resident had a self-care performance deficit. Approaches included "SKIN INSPECTION: I ask that you observe my skin for redness, open areas, scratches, cuts, bruises and report changes." The 1/13/16, Minimum Data Set (MDS) assessment revealed diagnoses including Alzheimer's disease and moderately impaired cognition. R23's most recent skin assessment was dated 3/21/16, noted the resident's skin at that time was "intact." R23's nursing notes 3/27/16, reflected she was physically aggressive toward staff three times in the past seven days, and occasional notes showed the resident did not wish to get out of bed, for example on 3/23/16. The resident's medical record did not reflect the identification of the bruise when the record was reviewed on 3/30/16. The presence of bruising was not noted in any progress notes or on the treatment record. However, a progress note was located the	F 309	Resident #23 was immediately assessed regarding the identification of the bruise an investigation was initiated per facility procedure. The care plan was updated to reflect causative factors for risk of bruising an appropriate interventions to prevent further injury. All bruises of unknown origin are investigated immediately upon notification and an incident reported completed. The Administrator is notified of all incidents immediately. All residents with known risk of bruising have been assessed and care plans updated to reflect appropriate interventions. The VA policy and procedure was reviewed and is current. Staff education on identifying bruises and notifying administration initiated immediately. The Clinical Coordinator reviews all progress notes for any indication of bruises or unknown injury. Random audits on 10% of residents were initiated on 4/4/16 and will be completed weekly for four weeks by nursing. Results will be reported to the QA Committee and the need for ongoing audits and action plans will be determined as appropriate. The Care Center Administrator and Clinical Administrator will be responsible for ongoing compliance.	

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F 309	Continued From page 17	F 309		

following day that was written 3/30/15, at 5:31 p.m. The note lacked "Author" (as other notes included) and read, "Bruise located to left posterior hand occurring when resident states she was reaching for the light on the wall and hit her hand. Resident denies any pain or discomfort and is able to freely move her hand without pain." A note by the clinical administrator dated 3/31/16, indicated the bruise on R23's hand measured 5 by 4 centimeters, and the resident reported she hit it on the wall shutting off the light.

On 3/31/16, at approximately 8:00 a.m. a registered nurse (RN)-A was asked about the bruise on R23's hand, and was informed documentation regarding the bruise could not be found in the resident's record. RN-A said she would "have to go look" at the resident's hand. At 9:00 a.m., RN-A said she had visualized the bruise and had asked the resident what had happened. RN-A said the resident had reported she could have hit it on something. RN-A said, she was in bed at the time and reported her light was so bright she'd probably reached out to shut it off, and hit the wall. RN-A said the family had requested the room arrangement, but she had placed a call to them to see if the room could be rearranged. RN-A explained the resident was sometimes confused, but said no one hurt her. She said the facility protocol was, "If you see something say something," however verified the nursing assistants had failed to report the bruising to the nurse. RN-A said the resident had spent most of Monday (day prior) in bed, and it could have happened Monday after she (RN-A) had left for the day. RN-A initiated an incident report and said the interdisciplinary team had already reviewed it. Furthermore, RN-A said the size of the bruise would be monitored every week with

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F 309	Continued From page 18 body audits completed on bath days. RN-A also said R23's bath day was Monday and that if R23 was uncooperative with the body audit, it would be performed when the resident would allow it. RN-A verified the surveyor was the first person to inform the nurse of the bruise and again stated, "Staff should have informed the nurse right away" as indicated on the plan of care.	F 309		
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	F 356		5/6/16

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F 356	Continued From page 19 staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post the actual hours worked for nursing staff directly responsible for resident care per shift. This had the potential to affect visitors and all 25 residents residing in the facility. Findings include: During observation at 12:00 p.m. on Monday 3/28/16, the facility's Posted Nursing Staff Hours were noted to be dated for Friday 3/25/16. The posted document also indicated a trained medication aide was working, however that was inaccuarate, and a licensed practical nurse was working instead which was not listed. A registered nurse (RN)-A and the corporate director of nursing were interviewed on 3/31/16, at 8:35 a.m. They explained their Nursing Staff Postings were printed in advance for the weekend, and a nurse on duty during the weekend was supposed to pull out the new one and cross off any information that had changed, such as the census or staffing patterns. RN-A said the staff had been reminded to record the changes. RN-A acknowledged the nurses could not print the information during the weekend because the printer was broken, which was why the postings had been pre-printed on Friday. RN-A said the problem had likely occured because a pool nurse had worked on the weekend. RN-A said it was either her	F 356	The Clinical Coordinator posted the corrected hours when informed posting was not correct. The process and procedure of posted daily hours in the care center was reviewed and updated on 4/4/16 by the Administrator. The care center staffer will be responsible to post daily hours updates will be made by the charge nurse as needed on each shift. Audits will be completed by the Administrator daily for four weeks and results reported to QA. The Care Center Administrator and Clinical Administrator will be responsible for ongoing compliance by May 6th, 2016.	

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F 356	Continued From page 20 responsibility, or the director of nursing's, to see that the correct information was posted.	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245621	A. BUILDING 01 - FOLKESTONE GABLES NH B. WING	03/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Folkestone Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/20/2016

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

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	245621	A. BUILDING **01 - FOLKESTONE GABLES NH** B. WING _____	**03/30/2016**

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

By e-mail to both:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

This 5-story building with a basement was constructed in 2014 and determined to be Type II (222) construction. The building contains independent living, assisted living and skilled nursing beds. Folkstone is located on the fourth floor south wing and is separated from other occupancies on the same floor by a 3-hour fire wall. The three egress stairs and elevators serving Folkstone are surveyed as part of the certification.

The building is fire sprinkler protected throughout. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.

The facility has a capacity of 30 beds and had a census of 25 at the time of the survey.

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	245621	A. BUILDING **01 - FOLKESTONE GABLES NH** B. WING _____	**03/30/2016**

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 022 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to properly identify 1 of several non-required exit doors leading to the exterior that do not lead to the public way in accordance with NFPA Life Safety Code 101 (2000 edition), Sec. 7.10.1.7 and 7.10.8.1 This deficient practice could affect 25 of 25 residents, as well as an undetermined number of staff, and visitors, by causing confusion in locating an exit from the building to the public way in the event of an emergency. Findings include: On facility tour between 2:00 PM to 5:00 PM on 03/30/2016, observations revealed that the doors leading to the TO the rooftop patio is not marked as "NO EXIT". These doors are not part of a required exits for the facility and need to display a sign that reads as follows: NO EXIT. The word "NO" shall be in letters 2 inches in height and with a stroke width of 3/8 inch, and the word "EXIT" in letters 1 inch in height located directly below the word "NO".	K 022	Doors leading from the which are not required fire exits and are not used as fire exits will labeled as required by the NFPA 101 Life Safety Code (00) with NO EXIT signage. The PHS Regional Engineering Manager assigned to this site will ensure that all doors requiring this labeling have the proper signage.	4/30/16

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	245621	A. BUILDING **01 - FOLKESTONE GABLES NH** B. WING _____	**03/30/2016**

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K 022	Continued From page 3 This deficient condition was verified by the Maintenance Supervisor.	K 022		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a means of egress in accordance with the following requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 18.2.1 and 7.2.1.5.1 and the 2007 MN State Fire Code, Appendix I. This deficient practice could affect 25 of 25 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 2:00 PM to 5:00 PM on 03/30/2016, Observation revealed that the doors to exit stairwells have a coded keypad used to unlock the doors to the stairwells, but did not have the current code or instructions on how to open the door posted at the location of the keypad. This deficient condition was verified by the Maintenance Supervisor.	K 038	The path of egress doors to stairwells or other exit passageways which are locked and utilize a keypad to exit will have the signage as required by the NFPA 101 LSC(00) posted at the door on the locked side of the door by the keypad which includes instructions on how to open the door. The PHS Regional Engineering Manager assigned to this site will ensure completion of the required signage.	4/30/16
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established	K 050		4/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245621	A. BUILDING **01 - FOLKESTONE GABLES NH** B. WING _____	**03/30/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLKESTONE	**100 PROMENADE AVENUE WAYZATA, MN 55391**

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K 050	Continued From page 4 routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101 (2000 edition), section 18.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire and could affect 25 of 25 residents, as well as an undetermined number of staff, and visitors in the event of a fire. Findings include: On facility tour between 2:00 PM to 5:00 PM on 03/30/2016, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed that the facility had he following deficient conditions were found affecting the facility's fire drills: 1. the facility could not provide documentation for 2 overnight shift fire drill in the 2nd and 3rd calendar quarter. 2. the facility could not provide documentation for 2 day shift fire drill in the 2nd and 3rd calendar quarter. 3. the facility could not provide documentation for 2 evening shift fire drill in the 2nd and 3rd calendar quarter.	K 050	1. Fire drills at intervals as required by the NFPA LSC (00) for night shifts will be scheduled into the electronic work order scheduling system to automatically generate a work ticket. The fire drill scheduled will also be entered into the Campus Administrators calendar. The safety committee will review fire drills semiannually to ensure compliance; the campus Environmental Services Director will be responsible for the timely completion of fire drills. The Campus Administrator will ensure that these drills are conducted as required. 2. Fire drills at intervals as required by the NFPA 101 LSC (00)for day shifts will be scheduled into the electronic work order scheduling system to automatically generate a work ticket. The fire drill scheduled will also be entered into the Campus Administrators calendar. The safety committee will review fire drills semiannually to ensure compliance; the campus Environmental Services Director will be responsible for the timely completion of fire drills. The Campus Administrator will ensure that these drills are conducted as required. 3. Fire drills at intervals as required by the NFPA 101 LSC (00)for evening shifts will	

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K 050	Continued From page 5 This deficient condition was verified by the Maintenance Supervisor.	K 050	be scheduled into the electronic work order scheduling system to automatically generate a work ticket. The fire drill scheduled will also be entered into the Campus Administrators calendar. The safety committee will review fire drills semiannually to ensure compliance; the campus Environmental Services Director will be responsible for the timely completion of fire drills. The Campus Administrator will ensure that these drills are conducted as required.	
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 18.3.4., 18.3.6.3.2, 18.3.6.3.3, and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 25 of 25 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 2:00 PM to 5:00 PM on	K 052	The DACT will be tested at least monthly as required by the NFPA 101 LSC (00). This test will be completed as part of the monthly fire drill routine if possible, otherwise a separate test will be conducted. This test of the DACT will be entered as a recurring task in the electronic work order system and as such a task will be generated monthly to ensure compliance. The Environmental Services Director will be responsible for the timely completion of this routine and documenting the completion of the test. The safety committee will review the documentation of this test semiannually to ensure compliance.	4/30/16

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K 052	Continued From page 6 03/30/2016, observations revealed that during the review of all available fire drill reports and fire alarm maintenance/testing documentation for the last 12 months and an interview with the Maintenance Supervisor, it was revealed that the facility failed to document and/or verify 8 of 12 monthly tests of the digital alarm communicator transmitter (DACT). This deficient condition was verified by the Maintenance Supervisor.	K 052		

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 14, 2016

Ms. Nichole Pederson, Administrator
Folkestone
100 Promenade Avenue
Wayzata, Minnesota 55391

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5621002

Dear Ms. Pederson:

The above facility was surveyed on March 28, 2016 through March 31, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order.

This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Gayle Lantto at (651) 201-3794 or email: gayle.lantto@state.mn.us**.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28617	A. BUILDING: _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLKESTONE	100 PROMENADE AVENUE WAYZATA, MN 55391

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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: 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	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On March 28, 29, 30 and 31, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan was followed for 1 of 1 resident (R23) with bruising, and for 1 of 2 residents (R22) whose personal equipment was unavailable. Findings include: R23's 8/25/14, care plan indicated the resident had a self-care performance deficit. Approaches included "SKIN INSPECTION: I ask that you observe my skin for redness, open areas, scratches, cuts, bruises and report changes." The 1/13/16, Minimum Data Set (MDS) assessment revealed diagnoses including Alzheimer's disease and moderately impaired cognition. R23 was observed on 3/29/16, at 10:26 a.m. with a large purple bruise on her left hand, approximately 1 1/2 by 2 inches in size. The resident reported she did not know how she'd sustained the bruise, but thought she may have	2 565	Resident #23 was immediately assessed regarding the identification of the bruise and an investigation was initiated as per facility procedure. The care plan was updated to reflect causative factors for risk of bruising an appropriate interventions. Resident #22 was assessed and care plan reviewed related to call light use and is current. All residents care plans were reviewed and were current and/or updated as appropriate. All residents checked to ensure their care plans were being followed. Policy and procedure for care planning was reviewed and is current. All resident care plans are reviewed and updated upon admission, quarterly, significant changes, and annually as a part of the RAI process. Staff education initiated on 4/4/16 and will be completed with all care center staff by 4/30/16 on importance of following care	5/6/16

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2 565	Continued From page 3 possibly bumped her hand on something. The current care plan for R23, indicated the resident had a self-care performance deficit. Approaches included "SKIN INSPECTION: I ask that you observe my skin for redness, open areas, scratches, cuts, bruises and report changes." The 1/13/16, Minimum Data Set (MDS) assessment revealed diagnoses including Alzheimer's disease and moderately impaired cognition. R23's most recent skin assessment was dated 3/21/16, noted the resident's skin at that time was "intact." R23's nursing notes 3/27/16, reflected she was physically aggressive toward staff three times in the past seven days, and occasional notes showed the resident did not wish to get out of bed, for example on 3/23/16. The resident's medical record did not reflect the identification of the bruise when the record was reviewed on 3/30/16. The presence of bruising was not noted in any progress notes or on the treatment record. However, a progress note was located the following day that was written 3/30/15, at 5:31 p.m. The note lacked "Author" (as other notes included) and read, "Bruise located to left posterior hand occurring when resident states she was reaching for the light on the wall and hit her hand. Resident denies any pain or discomfort and is able to freely move her hand without pain." A note by the clinical administrator dated 3/31/16, indicated the bruise on R23's hand measured 5 by 4 centimeters, and the resident reported she hit it on the wall shutting off the light. On 3/31/16, at approximately 8:00 a.m. a registered nurse (RN)-A was asked about the bruise on R23's hand, and was informed documentation regarding the bruise could not be	2 565	plan. A nurse re-education class was completed with nurses on 4/18/16 on nursing assessments and occurrences by Clinical Administrator and the Education Department. Random audits of 10% of residents on unknown injury and assessment completion were initiated on 4/4/16 and will be completed weekly for four weeks. Results will be reported to the QA Committee to determine further action plans as appropriate. Staff education on call light placement initiated immediately. Random audits on 10% of residents were initiated on 4/4/16 on call light placement and will be completed weekly for four weeks by nursing. Results will be reported to the QA Committee and the need for ongoing audits and action plans will be determined as appropriate. The Care Center Administrator and Clinical Administrator will be responsible for ongoing compliance.	

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2 565	Continued From page 4	2 565		

found in the resident's record. RN-A said she would "have to go look" at the resident's hand. At 9:00 a.m., RN-A said she had visualized the bruise and had asked the resident what had happened. RN-A said the resident had reported she could have hit it on something. RN-A said, she was in bed at the time and reported her light was so bright she'd probably reached out to shut it off, and hit the wall. RN-A said the family had requested the room arrangement, but she had placed a call to them to see if the room could be rearranged. RN-A explained the resident was sometimes confused, but said no one hurt her. She said the facility protocol was, "If you see something say something," however verified the nursing assistants had failed to report the bruising to the nurse. RN-A said the resident had spent most of Monday (day prior) in bed, and it could have happened Monday after she (RN-A) had left for the day. RN-A initiated an incident report and said the interdisciplinary team had already reviewed it. Furthermore, RN-A said the size of the bruise would be monitored every week with body audits completed on bath days. RN-A also said R23's bath day was Monday and that if R23 was uncooperative with the body audit, it would be performed when the resident would allow it. RN-A verified the surveyor was the first person to inform the nurse of the bruise and again stated, "Staff should have informed the nurse right away" as indicated by the plan of care.

R22's care plan dated 1/19/16, indicated the resident required extensive assistance with cares. Staff were directed to ensure the resident's call light was within his reach at all times. The 1/20/16, MDS revealed the resident had a functional impairment of ROM on one side (toward the call light), required extensive assistance from staff for activities of daily living,

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2 565	Continued From page 5 and was always incontinent. In addition, the MDS revealed R22 had no cognitive impairment or behavioral issues. On 3/30/16 at 10:30 a.m., R22 was observed to be seated in a wheelchair in his room with the door closed. His call light was observed to be behind him, wrapped several times around the bedside grab bar, so that the resident would not have been physically able to reach for the call light. At that time, R22 stated, "the staff leave me without my call light and say we'll be right back, but what does that mean?" When asked how often his call light was out of his reach he replied, "every day." On 3/31/16 at 11:03 a.m., R22 was again observed to be seated in his wheelchair. Although his call light was placed within his reach, when asked again how frequently he was left in his room without his call light he didn't hesitate before stating, "At least once a day." R22 said if he needed something and did not have the light, he had to "holler" for help. However, he added that was difficult sometimes because staff often closed his door. During interview with RN-A, and the corporate director of nursing on 3/31/16, at 2::00 p.m. they both verified the resident should have had his call light within reach in accordance with his plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. A system could developed to educate staff and develop a monitoring system to ensure staff are providing care as directed by the	2 565		

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2 565	Continued From page 6 written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure bruises were identified and reported timely to determine possible causal factors and to provide appropriate monitoring and measures to minimize risk for further injury for 1 of 1 resident (R23) who had unidentified bruising. Findings include: R23 was observed on 3/29/16, at 10:26 a.m. with a large purple bruise on her left hand, approximately 1 1/2 by 2 inches in size. The resident reported she did not know how she'd	2 830	Resident #23 was immediately assessed regarding the identification of the bruise an investigation was initiated per facility procedure. The care plan was updated to reflect causative factors for risk of bruising an appropriate interventions to prevent further injury. All bruises of unknown origin are investigated immediately upon notification and an incident reported completed. The Administrator is notified of all incidents immediately. All residents with known risk of bruising have been assessed and care plans updated to reflect appropriate interventions. The VA	5/6/16

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 7 sustained the bruise, but thought she may have possibly bumped her hand on something. The current care plan for R23, indicated the resident had a self-care performance deficit. Approaches included "SKIN INSPECTION: I ask that you observe my skin for redness, open areas, scratches, cuts, bruises and report changes." The 1/13/16, Minimum Data Set (MDS) assessment revealed diagnoses including Alzheimer's disease and moderately impaired cognition. R23's most recent skin assessment was dated 3/21/16, noted the resident's skin at that time was "intact." R23's nursing notes 3/27/16, reflected she was physically aggressive toward staff three times in the past seven days, and occasional notes showed the resident did not wish to get out of bed, for example on 3/23/16. The resident's medical record did not reflect the identification of the bruise when the record was reviewed on 3/30/16. The presence of bruising was not noted in any progress notes or on the treatment record. However, a progress note was located the following day that was written 3/30/15, at 5:31 p.m. The note lacked "Author" (as other notes included) and read, "Bruise located to left posterior hand occurring when resident states she was reaching for the light on the wall and hit her hand. Resident denies any pain or discomfort and is able to freely move her hand without pain." A note by the clinical administrator dated 3/31/16, indicated the bruise on R23's hand measured 5 by 4 centimeters, and the resident reported she hit it on the wall shutting off the light. On 3/31/16, at approximately 8:00 a.m. a registered nurse (RN)-A was asked about the bruise on R23's hand, and was informed	2 830	policy and procedure was reviewed and is current. Staff education on identifying bruises and notifying administration initiated immediately. The Clinical Coordinator reviews all progress notes for any indication of bruises or unknown injury. Random audits on 10% of residents were initiated on 4/4/16 and will be completed weekly for four weeks by nursing. Results will be reported to the QA Committee and the need for ongoing audits and action plans will be determined as appropriate. The Care Center Administrator and Clinical Administrator will be responsible for ongoing compliance.	

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	28617	A. BUILDING: _____ B. WING _____	03/31/2016

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2 830	Continued From page 8 documentation regarding the bruise could not be found in the resident's record. RN-A said she would "have to go look" at the resident's hand. At 9:00 a.m., RN-A said she had visualized the bruise and had asked the resident what had happened. RN-A said the resident had reported she could have hit it on something. RN-A said, she was in bed at the time and reported her light was so bright she'd probably reached out to shut it off, and hit the wall. RN-A said the family had requested the room arrangement, but she had placed a call to them to see if the room could be rearranged. RN-A explained the resident was sometimes confused, but said no one hurt her. She said the facility protocol was, "If you see something say something," however verified the nursing assistants had failed to report the bruising to the nurse. RN-A said the resident had spent most of Monday (day prior) in bed, and it could have happened Monday after she (RN-A) had left for the day. RN-A initiated an incident report and said the interdisciplinary team had already reviewed it. Furthermore, RN-A said the size of the bruise would be monitored every week with body audits completed on bath days. RN-A also said R23's bath day was Monday and that if R23 was uncooperative with the body audit, it would be performed when the resident would allow it. RN-A verified the surveyor was the first person to inform the nurse of the bruise and again stated, "Staff should have informed the nurse right away" as indicated on the plan of care. SUGGESTED METHOD OF CORRECTION: The facility could review their policies/procedures, make any needed changes, and provide staff education to ensure residents' skin is monitored regularly, and new bruising is identified/ reported/ investigated, and then documented on until resolved. Audits could be conducted and the	2 830		

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2 830	Continued From page 9 results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 830		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.	21800		5/6/16

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21800	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) or uniform denial letter upon termination of all Medicare (MC) Part A skilled services for 2 of 3 residents (R1, R19) reviewed for liability notice and beneficiary appeal rights. Findings include: R1's Admission Record indicated he had been admitted to the facility on 10/13/15, and had received skilled nursing/therapy services. The discharge record verified R1 left the facility on 11/12/15. R1 was issued a Notice of Medicare Non-Coverage (NOMNC) stating currant skilled nursing/therapy services would end 11/11/15. The notice was also signed on 11/11/15 by R1. R1's progress notes for the past 30 days were reviewed but lacked mention of explanation for a NOMNC fewer than 48 hours in advance or for beneficiary appeal rights. R19's Discharge Summary/Recapitulation of Stay signed 1/8/16, verified the resident had been admitted to the facility on 10/6/15 and was discharged 1/8/16. Progress notes indicated R19 had received physical and occupational therapy during her stay. The progress notes indicated R19's son was contacted by telephone on 1/4/16, and informed that current skilled nursing/therapy services would end 1/5/16. A 1/4/16 unsigned hand-written note on the NOMNC read, "consent to sign by [R19's son]. Talked to son [name] on 1/4/16 and	21800	Resident #1 and Resident #19 are both discharged from the facility and did not request a demand bill or a review. The policy was reviewed and is current for Medicare denials all residents currently receiving Medicare were reviewed for appropriate notice and denials forms are current. The facility has added a new process with specific responsibilities for each discipline at the daily IDT meeting. The social worker along with therapy will inform the IDT group of upcoming discharges and the Health Unit Coordinator will be responsible to issue the appropriate denial letter once discharge date is determined. Education was completed with all involved in the Medicare denial process. The Clinical Coordinator will conduct monthly audits for all resident receiving medicare, which were initiated 4/4/16, to ensure completion as required in a timely manner. Care Center Administrator and Clinical Administrator are responsible for ongoing compliance.	

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21800	Continued From page 11	21800		

informed therapy will be done 1/4/16." R19's progress notes for the previous 30 days were reviewed but lacked mention of explanation for a NOMNC fewer than 48 hours in advance or for beneficiary appeal rights.

During an interview with the administrator on 3/29/16, at 11:18 a.m. the administrator explained she thought she'd had more correspondence with the families of R1 and R19 regarding the NOMNC and appeal rights. She explained, "mistakes were made" and verified R1 and R19 were not given NOMNC and appeal rights information in a timely manner. The administrator added, "The facility strives to give a 48 hour notice [for NOMNC and appeal rights]. I am the one who issues the notices."

The Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123, approved 10/31/11 indicated, "A Medicare provider or health plan must give in advance , a completed copy of the NOMNC to beneficiaries/enrollees receiving skilled care--services no later than two days before the termination of services."

The Presbyterian Homes and Services SNF Determination on Continued Stay, modified February 2016, indicated their purpose was to remain in compliance with Federal regulations allowing facility participation in the Medicare program, and to communicate with beneficiary/responsible party on determination of Medicare coverage. The procedure of the policy directed staff to issue denials two days before payer source changed.

SUGGESTED METHOD OF CORRECTION: The facility could review its policy/procedure, make any needed changes, and provide staff

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21800	Continued From page 12 education to ensure liability/appeal notices are appropriately issued. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21800		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the failed to ensure personal information and care items were maintained in a manner that promoted dignity for 3 of 3 residents (R20, R22, R32) reviewed for dignity. Findings include: R20's room was observed on 3/28/16, at 3:19 p.m. and confidential personal care information was observed posted in the shared room and bathroom which could be easily viewed by others. A typed message was posted in the bathroom which included R20's name and room number, and explained that R20's family provided incontinent products, therefore staff were not to take "diapers and wipes" from the facility's supply. Another sign, posted on the bulletin board	21805	Resident #20 posted signs in room were removed immediately by Administrator. Incontinence products in all resident rooms have been moved to be stored in a private location out of site as well as Resident #32 and Resident #22 nebulizer mask and associated medical equipment once identified. All resident rooms were checked for signage and supplies for appropriate storage. All residents that have identified signs in room were reviewed and/or removed and care plan updated. Policy related to privacy and dignity was reviewed and is current. Staff education initiated on 4/4/16 with all care center staff regarding privacy and	5/6/16

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21805	Continued From page 13 adjacent to R20's bed, also revealed personal information. The sign directed staff to obtain the resident's weight on Monday, Wednesday and Friday on the a.m. (morning) shift, to not take a blood pressure from R20's left arm, to place the resident's left arm in a splint for eight hours, to provide peri care and repositioning every two hours, to abstain from using briefs or incontinent products at night, to "leave the peri area open to air at night," and to have the resident wear her own clothing protector at meal time. On the wall at the head of the bed additional instructions were posted directing staff to lock the bed in the lowest position at night. During interview with the administrator at 8:28 a.m. on 3/30/16, she stated the signs should not have been posted. The administrator acknowledged the posted signs divulged personal information which could have easily beeen visualized by residents and visitors, especially since the room and bathroom were shared. At that time, the administrator removed the postings. R22's incontinent brief was observed left on the bedside table in his room on 3/30/16, at 10:30 a.m. The resident was not receiving incontinence care at the time of the observation. In addition, nebulizer masks and boxes of associated medical equipment were observed to be stored on the counter in the room. The care plan for R22 dated 1/19/16, indicated the resident required extensive assistance with cares. R22's 1/20/16, Minimum Data Set (MDS) indicated the resident was cognitively intact and presented no behavioral issues. The MDS indicated R22 required extensive assistance from staff with toileting and was always incontinent.	21805	dignity including storage of supplies and signage. Random dignity and privacy audits on 10% of residents were initiated on 4/4/16 and will be completed weekly for four weeks by nursing. Results will be reported to the QA Committee and action plans will be developed as needed. The Care Center Administrator and Clinical Administrator are responsible for ongoing compliance.	

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21805	Continued From page 14 R32's cares were observed on 3/30/16, at 7:39 a.m. A package of incontinent briefs was stored on the personal hutch in the entrance alcove to the room the resident shared with a roommate. The MDS dated 2/10/16, indicated R32 had Alzheimer's disease, required extensive assistance from staff to perform activities of daily living, and was always incontinent. In an interview with registered nurse (RN)-A, and the corporate director of nursing, on 3/31/16 at approximately 1:00 p.m., RN-A said she had noticed supplies were occassionally being stored inappropriately in resident rooms. The corporate director of nursing said resident supplies should be stored in the residents' bathrooms. The facility policy, Presbyterian Home and Services Dignity dated 12/14, indicated residents were to be cared for in a manner and in an environment that promoted maintenance and/or enhancement of each resident's quality of life. The policy further indicated the facility was committed to an atmosphere that humanized and individualized each resident and their experiences. The policy noted residents would be informed of their rights and staff would be trained in Resident Rights, Privacy and Dignity upon hire and annually. SUGGESTED METHOD OF CORRECTION: The facility could review policy/procedure, make any needed changes, and provide staff education to ensure personal information about residents and their care is communicated to staff by other means than public display, and personal supplies be stored in a dignified manner. Audits could be conducted and the results brought to the quality	21805		

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21805	Continued From page 15 committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21805		