DEPARTMENT OF HEALTH	. –					ICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: VUR3
					TE SURVEY AGENCY	Facility ID: 00973
1. MEDICARE/MEDICAID PROVIDER (L1) 245312	NO.	3. NAME AND AL (L3) CASTLE RI				4. TYPE OF ACTION: $\underline{7}$ (L8)
2.STATE VENDOR OR MEDICAID NO		(L4) 625 PRAIRI	E CENTER D	RIVE		1. Initial2. Recertification3. Termination4. CHOW
(L2) 255342200		(L5) EDEN PRAI	IRIE, MN		(L6) 55344	5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OW	/NERSHIP	7. PROVIDER/SU	PPLIER CATEG	ORY	<u>02</u> (L7)	8. Full Survey After Complaint
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	
6. DATE OF SURVEY 02/23/2	()	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE	09/30
2 AOA 3 Other		04 SINF	08 OF 1/SP	12 KHC	16 HOSPICE	07/50
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED			
From (a):		AS:	anaa With		And/Or Approved Waivers Of	The Following Requirements:
To (b):		A. In Complia Program Re	equirements		2. Technical Personnel	6. Scope of Services Limit
		e	e Based On:		3. 24 Hour RN	7. Medical Director
12.Total Facility Beds	60 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	· _
13.Total Certified Beds	60 (L17)	B. Not in Comp	1	am	5. Life Safety Code	9. Beds/Room
		Requirements	and/or Applied V	Waivers:	* Code: A	(L12)
14. LTC CERTIFIED BED BREAKDOW	N				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
60						
(L37) (L38)	(L39)	(L42)	(L43)			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Gayle Lantto, HFE NEII		0	3/29/2017	(L19)	Mark Meath,	Enforcement Specialist 05/01/2017 (L20)
PART	II - TO BE	COMPLETED I	BY HCFA RE	. /	OFFICE OR SINGLE S	
19. DETERMINATION OF ELIGIBILIT	Y	20. COM	IPLIANCE WITH	I CIVIL		cial Solvency (HCFA-2572)
X 1. Facility is Eligible to Part	icipate	RIGH	ITS ACT:		 Ownership/Contro Both of the Above 	l Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible					5. Dour of the ribove	·
	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	1ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DAT	ГЕ	VOLUNTARY 00	INVOLUNTARY
05/01/1986					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ement 06-Fail to Meet Agreement
	27. ALTERNATI	VE SANCTIONS	. ,		03-Risk of Involuntary Termination	n <u>OTHER</u>
	A. Suspensio	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(1.27)			(L44)			00-Active
(L27)	B. Rescind S	uspension Date:				
			(L45)			
28. TERMINATION DATE:	29	0. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	DETERMINIATION		DATE		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION 02/27/2017	OF APPKUVAL	DALE		
	(L32)	04/2//201/		(L33)	DETERMINATION APPR	ROVAL



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245312

May 1, 2017

Ms. Molly Senske, Administrator Castle Ridge Care Center 625 Prairie Center Drive Eden Prairie, MN 55344

Dear Ms. Senske:

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

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

Effective February 17, 2017 the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 60 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 Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 29, 2017

Ms. Molly Senske, Administrator Castle Ridge Care Center 625 Prairie Center Drive Eden Prairie, Minnesota 55344

RE: Project Number S5312027

Dear Ms. Senske:

On January 23, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 5, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On February 23, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 27, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 5, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 17, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 5, 2017, and therefore remedies outlined in our letter to you dated January 23, 2017, 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 Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

## **POST-CERTIFICATION REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
245312 _{Y1}	B. Wing	Y2	2/23/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
CASTLE RIDGE CARE CENTER		625 PRAIRIE CENTER DRIVE		
		EDEN PRAIRIE, MN 55344		

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).

M	DATE	ITEM		DATE	ITEM		DATE
	Y5	Y4		Y5	Y4		Y5
F0156 483.10(d)(3)(g)(1) (13)(16)-(18)	(4)(5) Correction Completed 01/31/2017	ID Prefix Reg. # LSC	F0280 483.10(c)(2)(i-ii,iv,v) (3),483.21(b)(2)	Correction Completed 02/10/2017	ID Prefix Reg. # LSC	F0323 483.25(d)(1)(2)(n)(1)-(3	Correction Completed 02/10/2017
F0334 483.80(d)(1)(2)	Correction Completed 02/03/2017	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
	Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
	Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
	Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
	REVIEWED BY (INITIALS) GL/mm REVIEWED BY (INITIALS)		7 TITLE CK FOR ANY UNCORRECT	15507 ED DEFICIENCIES			TE 02/23/2017 TE
	F0156 483.10(d)(3)(g)(1) (13)(16)-(18) F0334 483.80(d)(1)(2) 	F0156       Correction         483.10(d)(3)(g)(1)(4)(5)       Completed         (13)(16)-(18)       O1/31/2017         F0334       Correction         483.80(d)(1)(2)       Completed         02/03/2017       Correction         Completed       O2/03/2017         Correction       Completed         Correction       Completed         Correction       Completed         Completed       O2/03/2017         Completed       Correction         Completed       Completed         Output       Correction         Completed       Completed         Completed       Completed <tr< td=""><td>Y5       Y4         F0156       Correction       ID Prefix         483.10(d)(3)(g)(1)(4)(5)       Completed       Reg. #         01/31/2017       LSC         F0334       Correction       ID Prefix         483.80(d)(1)(2)       Completed       Reg. #         02/03/2017       LSC        </td><td>Y5         Y4           F0156         Correction         ID Prefix         F0280           483.10(d)(3)(g)(1)(4)(5)         Completed         Reg. #         483.10(c)(2)(i-i,i,v.v)           (13)(16)-(16)         01/31/2017         LSC         483.10(c)(2)(i-i,i,v.v)           F0334         Correction         ID Prefix         (3),483.21(b)(2)           F0334         Correction         ID Prefix        </td><td>Y6     Y4     Y5       F0156     Correction     ID Prefix     F0280     Correction       483.10(d)(3)(g)(1)(4)(5)     Completed     Reg. #     483.10(c)(2)(-ii,iv,v)     Completed       01/31/2017     LSC     02/10/2017     Correction       F0334     Correction     ID Prefix     Correction       483.80(d)(1)(2)     Correction     Reg. #     Correction       02/03/2017     LSC     Correction     Correction       Correction     Correction     Reg. #     Correction       Correction     ID Prefix     Correction     Correction       Correction     Reg. #     Correction     Correction       Correction     Correction     Reg. #     Correction<td>Y5         Y4         Y5         Y4           F0156         Correction         ID Prefix         F0280         Correction         ID Prefix         Reg. #         483.10(c)(2)(i+i, v, v)         Completed         Reg. #         483.10(c)(2)(i+i, v, v)         Completed         Reg. #         2010/2017         LSC         Correction         ID Prefix         Correction         <td< td=""><td>Y5       Y4       Y5       Y4         F0156       Correction       ID Prefix       F0280       Correction       ID Prefix       F0323         483.10(d)(3)(g)(1)(4)(5)       Completed       Reg. #       483.10(c)(2)(4),iv,v)       Completed       Reg. #       483.25(d)(1)(2)(n)(4)         601312017       LSC      </td></td<></td></td></tr<>	Y5       Y4         F0156       Correction       ID Prefix         483.10(d)(3)(g)(1)(4)(5)       Completed       Reg. #         01/31/2017       LSC         F0334       Correction       ID Prefix         483.80(d)(1)(2)       Completed       Reg. #         02/03/2017       LSC	Y5         Y4           F0156         Correction         ID Prefix         F0280           483.10(d)(3)(g)(1)(4)(5)         Completed         Reg. #         483.10(c)(2)(i-i,i,v.v)           (13)(16)-(16)         01/31/2017         LSC         483.10(c)(2)(i-i,i,v.v)           F0334         Correction         ID Prefix         (3),483.21(b)(2)           F0334         Correction         ID Prefix	Y6     Y4     Y5       F0156     Correction     ID Prefix     F0280     Correction       483.10(d)(3)(g)(1)(4)(5)     Completed     Reg. #     483.10(c)(2)(-ii,iv,v)     Completed       01/31/2017     LSC     02/10/2017     Correction       F0334     Correction     ID Prefix     Correction       483.80(d)(1)(2)     Correction     Reg. #     Correction       02/03/2017     LSC     Correction     Correction       Correction     Correction     Reg. #     Correction       Correction     ID Prefix     Correction     Correction       Correction     Reg. #     Correction     Correction       Correction     Correction     Reg. #     Correction <td>Y5         Y4         Y5         Y4           F0156         Correction         ID Prefix         F0280         Correction         ID Prefix         Reg. #         483.10(c)(2)(i+i, v, v)         Completed         Reg. #         483.10(c)(2)(i+i, v, v)         Completed         Reg. #         2010/2017         LSC         Correction         ID Prefix         Correction         <td< td=""><td>Y5       Y4       Y5       Y4         F0156       Correction       ID Prefix       F0280       Correction       ID Prefix       F0323         483.10(d)(3)(g)(1)(4)(5)       Completed       Reg. #       483.10(c)(2)(4),iv,v)       Completed       Reg. #       483.25(d)(1)(2)(n)(4)         601312017       LSC      </td></td<></td>	Y5         Y4         Y5         Y4           F0156         Correction         ID Prefix         F0280         Correction         ID Prefix         Reg. #         483.10(c)(2)(i+i, v, v)         Completed         Reg. #         483.10(c)(2)(i+i, v, v)         Completed         Reg. #         2010/2017         LSC         Correction         ID Prefix         Correction <td< td=""><td>Y5       Y4       Y5       Y4         F0156       Correction       ID Prefix       F0280       Correction       ID Prefix       F0323         483.10(d)(3)(g)(1)(4)(5)       Completed       Reg. #       483.10(c)(2)(4),iv,v)       Completed       Reg. #       483.25(d)(1)(2)(n)(4)         601312017       LSC      </td></td<>	Y5       Y4       Y5       Y4         F0156       Correction       ID Prefix       F0280       Correction       ID Prefix       F0323         483.10(d)(3)(g)(1)(4)(5)       Completed       Reg. #       483.10(c)(2)(4),iv,v)       Completed       Reg. #       483.25(d)(1)(2)(n)(4)         601312017       LSC

# **POST-CERTIFICATION REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building 01 - MAIN BUILDING 01			
245312 _{Y1}	B. Wing	Y2	2/27/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
CASTLE RIDGE CARE CENTER		625 PRAIRIE CENTER DRIVE		
		EDEN PRAIRIE. MN 55344		

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).

ITE	м	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix Reg. # LSC	NFPA 101 K0353	Correction Completed 02/17/2017	Reg. #	IFPA 101	Correction Completed 02/01/2017	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix - Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Comp <b>l</b> eted
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. #		Correction	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. #		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
REVIEWE STATE AG REVIEWE CMS RO	BENCY X	REVIEWED BY (INITIALS) TL/mm REVIEWED BY (INITIALS)	DATE 03/29/20017 DATE	TITLE		7009	DATE 02/27/20 DATE	)17
FOLLOWUP TO SURVEY COMPLETED ON 1/4/2017		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?						

DEPARTMENT OF HEALTH						ICARE & MEDICAID SERVICES		
					AND TRANSMITTAL	ID: VUR3		
					TE SURVEY AGENCY	Facility ID: 00973		
1. MEDICARE/MEDICAID PROVIDER (L1) 245312	R NO.	3. NAME AND AI (L3) CASTLE RI				4. TYPE OF ACTION: $2(L8)$		
2.STATE VENDOR OR MEDICAID NO	)	(L4) 625 PRAIRI	E CENTER D	RIVE		1. Initial2. Recertification3. Termination4. CHOW		
(L2) <b>255342200</b>		(L5) EDEN PRA		-	(L6) <b>55344</b>	3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other		
5. EFFECTIVE DATE CHANGE OF O	WNERSHIP	7. PROVIDER/SU			<u>02</u> (L7)	8. Full Survey After Complaint		
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA			
6. DATE OF SURVEY 01/05/2	. ,	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID				
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complia	ance With		And/Or Approved Waivers Of	The Following Requirements:		
To (b) :			equirements		2. Technical Personnel	6. Scope of Services Limit		
		Compliance	e Based On:		3. 24 Hour RN	7. Medical Director		
12. Total Facility Beds	60 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	F) 8. Patient Room Size		
-	60 (L18) 60 (L17)	<b>X</b> D. Notin Com			5. Life Safety Code	9. Beds/Room		
13.Total Certified Beds	<b>00</b> (L17)	X B. Not in Con Requirements	and/or Applied V	0	* Code: <b>B</b> *	(L12)		
14. LTC CERTIFIED BED BREAKDOW	/N		**		15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	YES (L15)		
60								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Lisa Hakanson, HFE NEII		0	02/02/2017	(L19)	) Mark Meath, Enforcement Specialist 02/27/2017 (L20)			
PAR	T II - TO BE	COMPLETED I	BY HCFA RE		OFFICE OR SINGLE S			
19. DETERMINATION OF ELIGIBILIT	ſΥ	20. COM	IPLIANCE WITH	H CIVIL	21. 1. Statement of Financial Solvency (HCFA-2572)			
X 1. Facility is Eligible to Par	rticipate	RIGI	HTS ACT:		<ol> <li>Ownership/Contro</li> <li>Both of the Above</li> </ol>	l Interest Disclosure Stmt (HCFA-1513)		
2. Facility is not Eligible					5. Dour of the Above	·		
	(L21)							
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION	BEGINNING	6 DATE	ENDING DA	ГЕ	VOLUNTARY 00	INVOLUNTARY		
05/01/1986					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ement 06-Fail to Meet Agreement		
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS	· /		03-Risk of Involuntary Terminatio	n <u>OTHER</u>		
20. 210 2112.010.1 2112.		n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
			(L44)			00-Active		
(L27)	B. Rescind Su	spension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	DETERMINATION	I OF APPROVAL	DATE				
				_				
	(L32)			(L33)	DETERMINATION APPE	ROVAL		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered January 23, 2017

Ms. Molly Senske, Administrator Castle Ridge Care Center 625 Prairie Center Drive Eden Prairie, Minnesota 55344

RE: Project Number S5312027

Dear Ms. Senske:

On January 5, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

#### DEPARTMENT CONTACT

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

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 February 14, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by February 14, 2017 the following remedy will be imposed:

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

#### ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

#### Original deficiencies not corrected

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

#### Original deficiencies not corrected and new deficiencies found during the revisit

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

#### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 5, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 5, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

## INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

CENTERS FOR MEDICARE & MEDICARD SERVICES         OMB NO. 0938-0391           STATEMENT OF DEPICIENCIES         (1) IP POVIEENDEPICENCIA DENTIFICATION NUMBER:         (2) MULTIPLE CONSTRUCTION A BUILDING         (2) DUTE SURVEY COMPLETED ABUILDING         (2) DUTE SURVEY COMPLETED EXAMPLETED EXAMPLETED CASTLE RIDGE CARE CENTER         (2) DUTE SURVEY EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EACH DEPICENCY MUST BE PROCEED BY FULL TAQ         (2) DUTE SURVEY EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EACH DEPICENCY MUST BE PROCEED BY FULL TAQ         (2) DUTE SURVEY EXAMPLETED EXAMPLETED EXAMPLETED EACH DEPICENCY MUST BE PROCEED BY FULL EACH CORRECTIVE ACTION SURVEY EXAMPLETED EXAMPLETED EXAMPLETED EACH DEPICENCY MUST BE PROCEED BY FULL TAQ         (2) DUTE CORE EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EACH DEPICENCY MUST BE PROCEED BY FULL EACH CORRECTIVE ACTION SURVEY EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EACH DEPICENCY MUST BE ENCODED EXAMPLETED TAQ         (2) DUTE CORE EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPLETED EXAMPL			AND HUMAN SERVICES				FORM	APPROVED
AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A BUILDING       COMPLETED         245312       B. WING       STREET ADDRESS, CITY, STATE, ZIP CODE         CASTLE RIDGE CARE CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE       STREET PARKE, MIN 55344         (X41 ID PEERX 100       SUMMARY STATEMENT OF DEPORTORINES PREAM OF CORRECTION RESULATORY OR LSG DENTIFYING INFORMATION       D PICK 100       PROVIDERS PLAN OF CORRECTION RESULATORY OR LSG DENTIFYING INFORMATION         F 000       INITIAL COMMENTS       F 000       F 000       F 000         The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2657 from. Electoric submission of the POC will be used as verification of compliance.       F 000       F 156         SS-DD       RIGHTS, RULES, SERVICES, CHARGES       F 156       1/31/17         G(d)(3) The facility must ensure that each resident remains informed of the name, specially, and way of contacting the physician and cher primary care professionals responsible for his or her care.       \$483.10(g) Information and Communication.	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0		
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       CASTLE RIDGE CARE CENTER     STREET ADDRESS, CITY, STATE, ZIP CODE       OWID TAG     SUMMARY STATELENT OF DEPICIENCIES (EACH DEPICARYCRUST BE PROCEEDED BY FULL RECULATORY OR LSC DENTIFYING INFORMATION)     D PROVIDERS FLANK TAG       F 000     INITIAL COMMENTS     F 000       The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.     F 000       F 156     Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.     F 156       F 156     1/31/17       SS_D     RIGHTS, RULES, SERVICES, CHARGES       G(d)(3) The facility must ensure that each resident remains informed of the name, specially, and way of contacting the physician and other primary care professionals responsibile for his or her care.       S483.10(0) Information and Communication.       (1) The resident has the right to be informed of his or her stay in the facility.       (g)(4) The resident has the right to receive notices orally (maxing specified) and in writing (including Braille) in a format and a language he or she understands, including:       (1) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph ((f)(10) of this <td></td> <td></td> <td></td> <td>. ,</td> <td></td> <td></td> <td colspan="2"></td>				. ,				
CASTLE RIDGE CARE CENTER         625 PRAIRIE CENTER MUE           Image: Care Center         ECASTLE RIDGE CARE CENTER           Image: Care Center         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG         PREFIX PREFIX         PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG         PREFIX PREFIX         PREFIX (EACH CORRECTIVA CONSISTER PRACEDED BY FULL TAG         PREFIX PREFIX         PREFIX (EACH CORRECTIVA CONSISTER)         OCMET           F 000         INITIAL COMMENTS         F 000         Frequence         F 000         PREFIX         F 000           The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 from. Electronic submission of the POC will be used as verification of compliance.         F 000         F 156         1/31/17           F 156         Salo(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF SS-D         F 156         F 156         1/31/17           F 156         IGHTS, RULES, SERVICES, CHARGES         F 156         F 156         1/31/17           (d)(3) The facility must ensure that each resident remains informed of the name, specially, and way of contacting the physician and other primary care professionals responsibile for his or her care.         \$483.10(g) Information and Communication.         1/1 The resident has the right to receive notices orally (meaning specially and may or contacting the physician and a language he or she understands, including: (I) Required notices as specified in a this section. The facility must fur			245312	B. WING			01/	05/2017
CASILE RIDGE CARE CENTER       EDEN PRAIRIE, MN 55344         (PA) ID PHEEK TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATION TO LSC IDENTIFYING INFORMATION)       PROVIDERS PLAN OF CORRECTION (EACH OPERCENCY MUST BE PRECEDED BY FULL REGULATION TO LSC IDENTIFYING INFORMATION)       PREEX TAG       PROVIDERS PLAN OF CORRECTION (EACH OPERCENCY MUST BE PRECEDED BY FULL REGULATION TO LSC IDENTIFYING INFORMATION)       PREEX TAG       PROVIDERS PLAN OF CORRECTION (EACH OPERCENCY MUST BE PRECEDED BY FULL REGULATION TO LSC IDENTIFYING INFORMATION)       OWE THE PREEX TAG       PROVIDERS PLAN OF CORRECTION (EACH OPERCENCY MUST BE PRECEDED BY FULL REGULATION TO LSC IDENTIFYING INFORMATION)       OWE THE PREEX TAG       PROVIDERS PLAN OF CORRECTION (EACH OPERCENCY MUST BE PRECEDED BY FULL REGULATION TO LSC IDENTIFYING INFORMATION)       OWE THE PREEX TAG       PROVIDERS PLAN OF CORRECTION (EACH OPERCENCY MUST BE CHORENOW)       COMENTIFY (EACH OPERCENCY MUST BE CHORENOW)       COMENTIFY (EACH OPERCENCY MUST BE PREEX TAG       F 000         F 000       The facility is enrolled in POC and therefore a signature is not POC will be used as verification of opercing revisit of your facility must ensure that each resident remains informed of the name, specially, and way of contacting the physician and other primary care professionals responsible for his or her care.       F 156       1/31/17         \$483.10(q) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.       F 100       1/31/17         (g) (4	NAME OF I	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PREER/ TAG         CEACH CORPECTIVE ACTION SHOLLD BE ECOLLATORY OR LSC. DENTEYING INFORMATION)         PREER/ TAG         CEACH CORPECTIVE ACTION SHOLLD BE CROSS-REFERENCE TO THE APPROPRIATE         CORPUS- INTERPORT           F 000         INITIAL COMMENTS         F 000         F 000         INITIAL COMMENTS         F 000           The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.         F 000         F 156           Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with your verification.         F 156         F 156           SS=D         R(dHTS, RULES, SERVICES, CHARGES         F 156           (d)(3) The facility must ensure that each resident remains informed of the name, specially, and way of contacting the physician and other primary care professionals responsibile for his or her care.         \$483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rats and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.         (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:         (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this	CASTLE	RIDGE CARE CENTE	R					
The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.         Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.       F 156         F 156       483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF SS=D       F 156         (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.       \$483.10(g) Information and Communication.         (1) The resident has the right to be informed of his or her stay in the facility.       (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braile) in a format and a language he or she understands, including:         (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -         (A) A description of the manner of protecting personal lunds, under paragraph (()(10) of this	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP	) BE	COMPLETION
<ul> <li>signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.</li> <li>Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.</li> <li>F 156 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF SS=D RIGHTS, RULES, SERVICES, CHARGES</li> <li>(d)(3) The facility must ensure that each resident remains informed of the name, specially, and way of contacting the physician and other primary care professionals responsible for his or her care.</li> <li>§483.10(g) Information and Communication.</li> <li>(1) The resident has the right to be informed of his or her rate and regulations governing resident conduct and responsibilities during his or her stay in the facility.</li> <li>(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:</li> <li>(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -</li> <li>(A) A description of the manner of protecting personal funds, under paragraph (()(10) of this</li> </ul>	F 000	INITIAL COMMENT	ſS	F 0	000			
revisit of your facility may be conducted to         validate that substantial compliance with the         regulations has been attained in accordance with         your verification.         F 156         SB=D         RIGHTS, RULES, SERVICES, CHARGES         (d)(3) The facility must ensure that each resident         remains informed of the name, specialty, and way         of contacting the physician and other primary care         professionals responsible for his or her care.         §483.10(g) Information and Communication.         (1) The resident has the right to be informed of         his or her rights and of all rules and regulations         governing resident conduct and responsibilities         during his or her stay in the facility.         (g)(4) The resident has the right to receive         notices orally (meaning spoken) and in writing         (including Braille) in a format and a language he         or she understands, including:         (i) Required notices as specified in this section.         The facility must furnish to each resident a written         description of the manner of protecting         personal funds, under paragraph (f)(10) of this		signature is not req page of the CMS-29 submission of the F	uired at the bottom of the first 567 form. Electronic POC will be used as					
<ul> <li>(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.</li> <li>§483.10(g) Information and Communication.</li> <li>(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.</li> <li>(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:</li> <li>(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -</li> <li>(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this</li> </ul>		revisit of your facilit validate that substa regulations has bee your verification. 483.10(d)(3)(g)(1)(4	y may be conducted to initial compliance with the en attained in accordance with 4)(5)(13)(16)-(18) NOTICE OF	F 1	156			1/31/17
<ul> <li>(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.</li> <li>(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:</li> <li>(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -</li> <li>(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this</li> </ul>	SS=D	(d)(3) The facility m remains informed o of contacting the ph	ust ensure that each resident of the name, specialty, and way hysician and other primary care					
<ul> <li>Notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:</li> <li>(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -</li> <li>(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this</li> </ul>		(1) The resident hat his or her rights and governing resident	s the right to be informed of d of all rules and regulations conduct and responsibilities					
The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this		notices orally (mean (including Braille) in	ning spoken) and in writing a format and a language he					
personal funds, under paragraph (f)(10) of this		The facility must fur	rnish to each resident a written					
		personal funds, und						
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE Electronically Signed 01/31/2017			DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE 01/31/2017

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

PRINTED: 01/31/2017

		AND HUMAN SERVICES				FORM	01/31/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245312	B. WING			01/(	05/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	ĨR			25 PRAIRIE CENTER DRIVE DEN PRAIRIE, MN 55344		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	Continued From pa	ige 1	F1	156			
	procedures for esta including the right to	the requirements and ablishing eligibility for Medicaid, o request an assessment of ection 1924(c) of the Social					
	email), and telepho State regulatory and resident advocacy of Survey Agency, the State Long-Term Co protection and advo services where stat in long-term care fa agency for informat	addresses (mailing and one numbers of all pertinent d informational agencies, groups such as the State e State licensure office, the are Ombudsman program, the ocacy agency, adult protective te law provides for jurisdiction acilities, the local contact tion about returning to the Medicaid Fraud Control Unit;					
	complaint with the s concerning any sus federal nursing faci not limited to reside exploitation, misapp in the facility, non-c directives requirem	at the resident may file a State Survey Agency spected violation of state or lity regulations, including but ent abuse, neglect, propriation of resident property compliance with the advance ents and requests for ng returning to the community.					
	and local advocacy not limited to the St Long-Term Care Or (established under Americans Act of 19 U.S.C. 3001 et seq	contact information for State organizations including but tate Survey Agency, the State mbudsman program section 712 of the Older 965, as amended 2016 (42 ) and the protection and as designated by the state, and					

Facility ID: 00973

If continuation sheet Page 2 of 28

		AND HUMAN SERVICES				FORM	01/31/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245312	B. WING _			01/(	05/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	R			25 PRAIRIE CENTER DRIVE DEN PRAIRIE, MN 55344		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	as established under Disabilities Assistar 2000 (42 U.S.C. 15 [§483.10(g)(4)(ii) wi November 28, 2017 (iii) Information rega eligibility and covera [§483.10(g)(4)(iii) wi November 28, 2017 (iv) Contact information Disability Resource Section 202(a)(20)( Act); or other No Wi [§483.10(g)(4)(iv) wi November 28, 2017 (v) Contact information Control Unit; and [§483.10(g)(4)(v) wi November 28, 2017 (vi) Information and grievances or comp suspected violation facility regulations, resident abuse, neg misappropriation of facility, non-complia directives requirem information regardin (g)(5) The facility mi manner accessible residents, resident	er the Developmental nce and Bill of Rights Act of 6001 et seq.) ill be implemented beginning 7 (Phase 2)] arding Medicare and Medicaid age; vill be implemented beginning 7 (Phase 2)] ation for the Aging and e Center (established under (B)(iii) of the Older Americans Yrong Door Program; vill be implemented beginning 7 (Phase 2)] tion for the Medicaid Fraud vill be implemented beginning 7 (Phase 2)] tion for the Medicaid Fraud vill be implemented beginning 7 (Phase 2)] d contact information for filing plaints concerning any of state or federal nursing including but not limited to glect, exploitation, i resident property in the ance with the advance ents and requests for ng returning to the community. hust post, in a form and and understandable to	F 15	56			

If continuation sheet Page 3 of 28

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	01/31/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245312	B. WING		01/	05/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	R		625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 156	and telephone num agencies and advoor Survey Agency, the protective services jurisdiction in long-t of the State Long-To program, the protect home and commun and the Medicaid Fit (ii) A statement that complaint with the S concerning any sus federal nursing facil limited to resident a misappropriation of facility, and non-cor directives requirement I) and requests for it to the community. (g)(13) The facility r written information, applicants for admisi information about h Medicare and Media receive refunds for such benefits. (g)(16) The facility r and services to the admission and durin (i) The facility must and in writing in a la understands of his o regulations governing	ge 3 bers of all pertinent State cacy groups, such as the State State licensure office, adult where state law provides for erm care facilities, the Office erm Care Ombudsman ction and advocacy network, ity based service programs, raud Control Unit; and the resident may file a State Survey Agency pected violation of state or lity regulation, including but not abuse, neglect, exploitation, resident property in the mpliance with the advanced ents (42 CFR part 489 subpart information regarding returning must display in the facility and provide to residents and ssion, oral and written ow to apply for and use caid benefits, and how to previous payments covered by must provide a notice of rights resident prior to or upon ng the resident's stay. inform the resident both orally anguage that the resident or her rights and all rules and ng resident conduct and ng the stay in the facility.	F 156	6		

Facility ID: 00973

If continuation sheet Page 4 of 28

	-	AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245312	B. WING _			01/	05/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	:R		-	25 PRAIRIE CENTER DRIVE DEN PRAIRIE, MN 55344		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	Continued From pa	ige 4	F 15	56			
		t also provide the resident with d notice of Medicaid rights and					
		i information, and any must be acknowledged in					
	(g)(17) The facility r	nust					
	writing, at the time of	dicaid-eligible resident, in of admission to the nursing e resident becomes eligible for					
	nursing facility servi	services that are included in ices under the State plan and ent may not be charged;					
	facility offers and fo	ms and services that the or which the resident may be mount of charges for those					
	changes are made	dicaid-eligible resident when to the items and services aphs (g)(17)(i)(A) and (B) of					
	before, or at the tim periodically during t available in the facil services, including a	must inform each resident ne of admission, and the resident's stay, of services lity and of charges for those any charges for services not dicare/ Medicaid or by the ate.					

If continuation sheet Page 5 of 28

PRINTED: 01/31/2017

		AND HUMAN SERVICES & MEDICAID SERVICES			OM	FORM /	01/31/2017 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (		E SURVEY PLETED
		245312	B. WING			01/0	05/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	R			25 PRAIRIE CENTER DRIVE DEN PRAIRIE, MN 55344		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	<ul> <li>(i) Where changes and services covered Medicaid State plan notice to residents of reasonably possible</li> <li>(ii) Where changes items and services facility must inform 60 days prior to imp (iii) If a resident diet transferred and doef facility must refund representative, or e deposit or charges per diem rate, for the resided or reserved facility, regardless of discharge notice refund the resident within of date of discharge free v) The terms of an individual facility must not cor these regulations. This REQUIREMEN by: Based on interview failed to provide the</li> </ul>	in coverage are made to items ad by Medicare and/or by the a, the facility must provide of the change as soon as is are made to charges for other that the facility offers, the the resident in writing at least olementation of the change. Is or is hospitalized or is as not return to the facility, the to the resident, resident state, as applicable, any already paid, less the facility's ne days the resident actually or retained a bed in the of any minimum stay or quirements. It refund to the resident or tive any and all refunds due 80 days from the resident's om the facility. admission contract by or on ual seeking admission to the offlict with the requirements of NT is not met as evidenced and record review, the facility appropriate liability and of 3 residents (R64) whose	F	156	This plan of correction constitutes the facilities written allegation of complia for the deficiencies cited. This submoof this plan of correction is not an admission of/or agreement with the deficiencies or conclusions contained the department inspection report.	ance hission	

Facility ID: 00973

If continuation sheet Page 6 of 28

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/31/2017 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245312	B. WING _			01/0	05/2017
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	R			25 PRAIRIE CENTER DRIVE DEN PRAIRIE, MN 55344		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	Medicare liability an any record for the p notifications. The ac in an interview on 1 stay in the facility w to required skilled s attorney (POA) who Skilled services for R64 did not dischar 10/26/16. R64 was coverage. The AD stated she informed verbally re The AD stated she informed verbally re The AD verified the had been missed at remaining 2 days of had not contacted t billing. The facility provided Services (CMS) for Medicare Non-Cove dated 12/31/2011, a providing NOMNC. provider or health p completed copy of t Non-Coverage (NO beneficiaries/enrolle home health, comp rehabilitation facility later than two days services."	And the Centers for Medicare ministructions for the Notice of Proper written notifications the stay. The POA for R64 he facility to question the facility to question the facility to question the facility to question the facility to question the facility and procedure for facility to question the facility to question the facility to question the facility and procedure for facility to question the facility and procedure for facility to question the facility to question the form read, "A Medicare fan must give an advance, the Notice of Medicare fan must give an advance, the notice of medicare fan must give an advance, the notice of medicare fan must give an advance fan must give an advance fan must give an advance fan must give a	F 1		R64's skilled services ended on 10/ and she discharged back to her Ass Living on 10/26/16. The denial was documented in writing and the billin department was not notified of skille services ending, so R64's care for 10/25/16 was billed to Medicare. Th billing department has now adjusted claim showing her last cover day of 10/24/16. A write off was completed facility for the cost of R64's care for 10/25/16. Systemic changes were made to th process that is followed in regards the Medicare Denials. The Health Infor Manager has been trained and edu in the denial process on 1/19/17. The Health Information Manager began over this process effective 1/23/17. duty being performed by Health Information is consistent with corpo policy. In addition, the RAI coordina the facility has been re-educated or role in notifying Health Information of IDT when a denial needs to be issu The facility will identify other resider having the potential to be affected by conducting a quarterly audit during meetings each quarter. This process help the QA team monitor performar regards to denials. The audits will by continued until 100% compliancy is and QA team can evaluate for frequ of auditing in the future.	sisted not g ed he d the l by the l by the l by the e o mation cated he taking This rate tor for her during ed. hts by the QA is will nce in e met uency	
F 280	483.10(c)(2)(i-ii,iv,v	)(3),483.21(b)(2) RIGHT TO	F 23	80			2/10/17

Facility ID: 00973

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245312	B. WING			01/(	05/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	R		-	625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280 SS=D	Continued From pa PARTICIPATE PLA 483.10 (c)(2) The right to p and implementation plan of care, includi (i) The right to partic including the right to be included in the p request meetings a revisions to the pers (ii) The right to partic expected goals and amount, frequency, other factors related plan of care. (iv) The right to reco included in the plan (v) The right to see right to sign after sign of care. (c)(3) The facility shr right to participate in shall support the re planning process m (i) Facilitate the incl resident representa (ii) Include an asses strengths and need	Ige 7 NNING CARE-REVISE CP articipate in the development of his or her person-centered ing but not limited to: cipate in the planning process, o identify individuals or roles to planning process, the right to nd the right to request son-centered plan of care. icipate in establishing the d outcomes of care, the type, and duration of care, and any d to the effectiveness of the eive the services and/or items of care. the care plan, including the gnificant changes to the plan hall inform the resident of the n his or her treatment and sident in this right. The nust	F 2		DEFICIENCY)		
	(iii) Incorporate the	resident's personal and					

If continuation sheet Page 8 of 28

PRINTED: 01/31/2017

		AND HUMAN SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	0938-0391 SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COM	PLETED
		245312	B. WING			01/0	05/2017
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE S25 PRAIRIE CENTER DRIVE		
CASTLE	RIDGE CARE CENTE	R			EDEN PRAIRIE, MN 55344		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	cultural preferences	ge 8 in developing goals of care.	F 2	80			
	483.21 (b) Comprehensive	Care Plans					
	(2) A comprehensiv	e care plan must be-					
	(i) Developed within the comprehensive	7 days after completion of assessment.					
	(ii) Prepared by an i includes but is not li	nterdisciplinary team, that imited to					
	(A) The attending p	hysician.					
	(B) A registered nur resident.	se with responsibility for the					
	(C) A nurse aide wit resident.	h responsibility for the					
	(D) A member of for	od and nutrition services staff.					
	the resident and the An explanation mus medical record if the and their resident re	acticable, the participation of e resident's representative(s). It be included in a resident's e participation of the resident epresentative is determined he development of the					
		te staff or professionals in mined by the resident's needs the resident.					
		evised by the interdisciplinary sessment, including both the I quarterly review					

If continuation sheet Page 9 of 28

PRINTED: 01/31/2017

STATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		TIPLE CONSTRUCT		OMB NO. (X3) DATE	SURVEY
IND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG		COMP	PLETED
		245312	B. WING				5/2017
NAME OF	PROVIDER OR SUPPLIER				SS, CITY, STATE, ZIP COD	E	
CASTLE	RIDGE CARE CENTE	R		625 PRAIRIE C EDEN PRAIR	IE, MN 55344		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 280	Continued From pa	ige 9	F 2	80			
	assessments. This REQUIREMEI by:	NT is not met as evidenced					
	Based on interview facility failed to revi minimize the risk for (R84, R59) reviewe Finding include: R84's care plan rev resident had function and/or physical diffi for falls related to h cognition impaired dementia, anxiety, cataracts, bowel ar medicationsBe su and encourage me schedule." The goa	vised 12/22/16, revealed the onal incontinence (cognitive iculty using toilet), "I am at risk istory of falls, impaired mobility, Alzheimer's depression hallucinations, ad bladder incontinence and ure my call light is within reach to use it. Offer toileting per Il was that R84 would be free		facilities w for the def of this plat admission deficiencie the depart R84 fell la in hospice 1/14/17. Falls for F 6 months interventio medical re	of correction constituritten allegation of c ficiencies cited. This n of correction is not of/or agreement wites or conclusions co tment inspection rep ast on 12/11/16. He we and passed away p 859 were reviewed fr and a summary rega ons was documented ecord. The IDT team ons and the care plan	ompliance submission an th the ntained in ort. vas enrolled beacefully on om the last arding fall d in the reviewed	
	included checking a incontinence brief in 4:00 a.m. and offer meals, activities an was also identified decline in activities mobility and balance promote safety pro- and/or injury. The most recent M 12/12/16, identified impaired. He was u required extensive transferring and am had experienced tw	review date. Interventions and changing the resident's ncluding at 10:00 p.m. and toileting before and after d as needed. A risk for falls on the care plan related to a of daily living with limited e problems. Staff were to mote safety and prevent falls inimum Data Set dated R84 was severely cognitively insteady with transferring and assistance from staff for both abulation. The MDS noted R84 vo or more falls without injury lls with minor injury.		The Care be review emphasis revisions. 1:1 educa nursing st Managem included v importanc and root c audits are document reports, pi team shee the audit t	t that time. Plan Policy and Pro- ed with all IDT memi- on timeliness of car Director of Nursing of tion with all schedule aff on the Fall Preve ent Program Policy. verbalized understan te of immediate inter ause analysis. In ad being completed on ation with each fall. rogress notes, care p ets will be reviewed a o ensure all steps in n Policy are completed	bers with e plan completed ed licensed ntion and This ding of ventions dition, fall Incident plans and as part of the Fall	

Facility ID: 00973

If continuation sheet Page 10 of 28

STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES		PLE CONSTRUCTION	(X3) DATE	0938-039
ND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COM	PLETED
		245312	B. WING		01/0	05/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	R		625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 280	Resident Occurren follows: 1) 10/18/16, at 2:40 The report indicate the floor stating he his incontinence bri indicated R84 was was sitting in reclin interdisciplinary tea staff was to assist f after meals. The qu time you observed the last time the res restroom or incontil left blank. The anal the toileting plan wa additional toileting v afternoon. 2) 12/1/16, at 2:50 The report on 12/1/ floor at the bathroo trying to use the toi stated, "I fainted." H bedside, the toilet r tipped over. R84's I was cold and oxyge between 78-91%. W what he was trying replied that he was post fall assessment last been toileted o "What suggestions from occurring aga [resident]further in oxygenation." The in intervention indicate ordered staff check	ce Reports for R84 were as 0 p.m. d the resident was found on needed to use the toilet, and ief was wet. The report also "usually in bed after lunch, er." Although the um (IDT) intervention indicated R84 to the toilet before and uestions "When was the last the resident?" and "When was sident was assisted to the nent pad changed?" were both lysis did not include whether as followed or whether was necessary in the	F 28	<ul> <li>Fall incidents will continue to be redaily at IDT team meetings. Systechanges include access to three computers during this meeting. Our computer is used to update the car with the new fall interventions, one computer is used to update the NA sheets, and the third computer is a write the IDT follow up progress n follow up work for the fall incident completed by the time the IDT me adjourns each day.</li> <li>The facility plans to monitor perfore by completing fall tracking reviews month. This information along with audits will be brought to the QA computering by the QA team.</li> </ul>	emic ne re plan AR team used to ote. All is eting mance s every h the ommittee	

Facility ID: 00973

If continuation sheet Page 11 of 28

		AND HUMAN SERVICES				FORM	01/31/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245312	B. WING	i		01//	05/2017
NAME OF	PROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	R			325 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 280	root cause analysis toileting plan. 3) 12/7/16, at 10:15 The report indicated on the floor on his k The wheelchair was bathroom. R84 stat was doing prior to t was between 76-83 was wet. The IDT fa the NP ordered O2 however, the interver resident's need for was found with a w A quarterly Fall Risl indicated R84 expet the past 180 days, vision, and frequent balance, and use o psychotropic medic on care plan include 100 feet twice daily monitoring medicat effectiveness of inter monitoring resident care]. Resident had 4) 12/11/16, at 2:30 The report indicated when asked what h replied he did not k had been toileted a sustained skin injur [centimeters]. Cove dressing and Tegato	erventions did not include a or revisions to the resident's b p.m. d the resident was observed back during routine rounds. s between the bed and ed, "I don't know'" what he he fall. R84's O2 saturation 9% at room air, and his brief alls follow up form indicated at 2 liters per minute, entions did not address the additional toileting when he et brief. k assessment dated 12/8/16, rienced three or more falls in had poor recall, inadequate t incontinence, poor gait and f non-steroidal pain and ations. "Interventions updated ed ambulating the resident to improve strength and ions for side effects. The erventions read, "Will continue and update POC [plan of I last fall 12/7/16."	F	280			

Facility ID: 00973

If continuation sheet Page 12 of 28

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	01/31/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245312	B. WING	ì		01//	05/2017
NAME OF	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CASTLE	RIDGE CARE CENTE	ĪR			325 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 280	intervention read, "I historically been rel night toileting schee Resident will be offa am." The intervention how the toileting time minimize the risk for R84's current NA cat assist resident to an toileting plan did not toilet R84 to minimi generic and directed the morning and eva activities, and as not incontinence on nig Nursing assistant (I regarding R84's fall stated, "I remember to go to the bathroot the bathroom. He di is the problem." Licensed nurse pra on 1/5/17, at 11:45 on 10/18/16. LPN-A place so that staff a before and after me he was trying to use the NP also added since his saturation some of the falls. T mediations as orde frequently. LPN-A s plan, but that is what R59's care plan dat	Residents falls have lated to toileting. Resident's dule has been updated. ered toileting at 10 pm and 4 on, however, did not address nes had been determined, to or further falls. are guide directed staff to mbulate 100 feet a day. The ot specify times staff was to ize his risk for falls, but was ed staff to toilet the resident in vening, before and after meals, eeded, and check for ght rounds. NA)-A was interviewed ls on 1/4/17, at 7:25 a.m. and er one of the falls he was trying om and fell before he reached does not use the call lightthat actical (LPN)-A was interviewed a.m. about R84's fall occurred A stated, "We put the plan in assist R84 to the bathroom eals. He was falling because e the bathroom." LPN-A stated O2 (since was discontinued) as were low at the time of the staff was also to administer ared and check on R84 stated, "It is not in his care		280			

Facility ID: 00973

If continuation sheet Page 13 of 28

		AND HUMAN SERVICES			FORM	: 01/31/2017 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245312	B. WING		01/	05/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	:R		625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	an antidepressant, weakness, depress mobility and cogniti getting out of bed a Although the reside impaired, interventi my call light is withi use it for assistance wearing appropriate effectiveness of my basis. Follow my to at night, place me in bed related to seizu bed to help me with in an increase of be assessment" R59's Minimum Da indicated the reside cognition and requin staff with bed mobil dressing. R59's 1/17, physicia including delusiona disorder, anoxic bra disease, absence e medication orders i amoxicillin-clavulan (for seizures), Abilif fluoxetine (for majo R59's fall informatio 1) 10/24/16, at 6:29 "Resident noted on When writer intervie not fall. I crawled ou	as well as a seizure disorder, sion, psychosis, impaired ive loss. "I have a history of and crawling on the floor." ent was severely cognitively ons directed staff to "Be sure in reach and encourage me to e as needed. Ensure that I am e footwear. Evaluate v interventions on an ongoing illeting schedule. grippy socks n middle of bed. I use a low ures. I use grab bars on my n repositioning. If acute change ehaviors, complete clinical ta Set (MDS) dated 10/19/16, ent had severely impaired red extensive assistance with lity, transferring, toileting and an orders revealed diagnoses I disorder, major depressive ain damage, chronic kidney epileptic syndrome. R59's	F 280			

If continuation sheet Page 14 of 28

	-	AND HUMAN SERVICES			FORM	01/31/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DAT	E SURVEY IPLETED
		245312	B. WING		01/	05/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	R		625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	[range of motion] per Resident able to mo difficulty. Denied hit after removed from A Resident Occurrer revealed, R59 had toilet at 9:36 p.m. h lacked information toileted between 9:3 time the resident wa The Fall Follow Up "R59 was assisted updated to check a [bedtime] cares, to activities, at 10-11:0 2) 12/15/16, at 11:1 "At 9:35 a.m. res [ref from her w/c in the station. Res stated toilet." It was noted and then fell. Follow and voided and had also noted the care which directed staff AM and HS cares, to activities." The IDT follow up fainterventions were dose will be reviewed 3) 12/30/16, at 6:43 "Resident observed the door sitting. Cra door." When asked	erformed to all extremities. ove extremities w/o [without] tting head." R59 was toileted	F 280			

If continuation sheet Page 15 of 28

		AND HUMAN SERVICES			FORM	01/31/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245312	B. WING		01/	05/2017
NAME OF !	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	ĨR		625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 280	the head against ok floor and in her brie to bed." The fall hud last time the reside a.m. A progress note dat discussed and deci resident's medication the reason for frequ BMs a day)." A progress note dat pharmacist called b medication and said tabs twice daily was stools and the write practitioner. During an interview 9:00 a.m. LPN-A ex had been reviewed had not been admin medication. The NF thought the residen magnesium oxide, facility had not com as to potential caus revised plan develo The facility's 9/15, F Management Progr determine the resid establish appropria related to fall risk in personnel in deliver careMembers of responsible for ass	bject. Loose stool noted on the efbrief changed and put back ddle review form revealed the nt had been changed was 4:45 ted on 12/30/16, read "IDT ided to ask pharmacy to review ons and give consultation on uent bowel movements (2-3 ted on 12/30/16, indicated the back after reviewing resident's d that only magnesium oxide 2 s a concern related to loose er planned to update the nurse of n 1/4/16, at approximately kplained R59's medication use and it was concluded they nistering the laxative P was updated and she at's loose stools were not from however, LPN-A verified the upleted a further assessment sal factors for falls and a oped. Fall Prevention and ram policy directed staff to lent's risk for falls and to te intervention the care plan in the plan of care. "Supervising ring safe and personalized the interdisciplinary team are	F 280			

Facility ID: 00973

If continuation sheet Page 16 of 28

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245312	B. WING			01/0	05/2017
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	R			5 PRAIRIE CENTER DRIVE DEN PRAIRIE, MN 55344		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280 F 323	Continued From pa resident falls."	-	F 2				2/10/17
F 323 SS=D	HAZARDS/SUPER	I)-(3) FREE OF ACCIDENT VISION/DEVICES	гэ	23			2/10/17
	(d) Accidents. The facility must en	sure that -					
		vironment remains as free rds as is possible; and					
		eceives adequate supervision ices to prevent accidents.					
	appropriate alternat bed rail. If a bed or must ensure correc	e facility must attempt to use tives prior to installing a side or side rail is used, the facility it installation, use, and d rails, including but not limited ments.					
	(1) Assess the resid from bed rails prior	dent for risk of entrapment to installation.					
	. ,	s and benefits of bed rails with dent representative and obtain rior to installation.					
	appropriate for the	bed's dimensions are resident's size and weight. NT is not met as evidenced					
	Based on observat review, the facility fa services to minimize	ion, interview and document ailed to provide care and e the risk for falls for 2 of 5 9) reviewed for falls.			This plan of correction constitutes the facilities written allegation of compli- for the deficiencies cited. This submost this plan of correction is not an	ance nission	
	Finding include:				admission of/or agreement with the deficiencies or conclusions contained the department inspection report.		

Facility ID: 00973

If continuation sheet Page 17 of 28

PRINTED: 01/31/2017

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	COM	IPLETED	
		245312	B. WING		01/	05/2017	
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIF	P CODE		
CASTLE	RIDGE CARE CENTE	ER		625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 323	Continued From pa	age 17	E S	323			
	R84 was observed seated in his wheel the resident did not At 9:41 a.m. license assisted R84 to be light. He was not as toilet. The bathroor the light was on. Ou in bed with his eyes within reach, and th ajar and the light w A 9/9/16, Fall Profil R84's admission re assistance to move had problems inclu with diagnoses incl psychotic disorder mental status. A fa (CAA) dated 9/20/1 maintaining sitting	on 1/4/17, at 7:18 a.m. while lchair. When asked about falls t recall experiencing any falls. ed practical nurse (LPN)-A d and was provided his call sked if he needed to use the n door was slightly ajar and n 1/5/17, at 8:11 a.m. R84 was s closed. His call light was he bathroom door was slightly as on. e Checklist at the time of evealed R84 required hands on e from place to place. He also ding difficulty walking and falls uding Alzheimer's disease, with hallucinations and altered all Care Area Assessment 6, indicated R84 had difficulty balance and had impaired histions.		R84 fell last on 12/11/16. in hospice and passed aw 1/14/17. Falls for R59 were review 6 months and a summary interventions was docume medical record. The IDT t interventions and the care updated at that time. Occu therapy orders were obtai was fitted for a broda chai positioning, and safety. Re made to R64's toileting so sleep log for overnight wa monitor R64's night scheo conducted a medication re side effects to medication loose stools. NP was notif no changes were made. E were monitored and loose since resolved.	vay peacefully on ed from the last regarding fall ented in the eam reviewed e plan was upational ned and R59 ir for comfort, evisions were shedule and a s initiated to dule. Pharmacy eview to assess s related to fied of this and Bowel patterns		
	12/12/16, identified impaired. He was u required extensive transferring and an had experienced tw and two or more fa R84's care plan rev resident had function and/or physical diff for falls related to h cognition impaired dementia, anxiety, cataracts, bowel an	inimum Data Set dated R84 was severely cognitively insteady with transferring and assistance from staff for both abulation. The MDS noted R84 wo or more falls without injury lls with minor injury. <i>v</i> ised 12/22/16, revealed the onal incontinence (cognitive iculty using toilet), "I am at risk history of falls, impaired mobility, Alzheimer's depression hallucinations, and bladder incontinence and ure my call light is within reach		Director of Nursing compl education with all schedul nursing staff on the Fall P Management Program Po- included verbalized under importance of immediate and root cause analysis. I audits are being complete documentation with each reports, progress notes, c team sheets will be review the audit to ensure all step Prevention Policy are com NAR team sheets were re revisions were made to er	ed licensed revention and olicy. This standing of interventions n addition, ed on fall fall. Incident are plans and wed as part of os in the Fall opleted well. eviewed and		

Facility ID: 00973

	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION		0938-039 E SURVEY		
	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			NG		COMPLETED		
		245312	B. WING _			01/05/2017		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP (	CODE			
CASTLE RIDGE CARE CENTER				625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIOI DATE		
F 323	and encourage me schedule." The goa of falls through the included checking a incontinence brief i 4:00 a.m. and offer meals, activities an was also identified decline in activities mobility and baland promote safety pro and/or injury. Resident Occurren follows: 1) 10/18/16, at 2:40 The report indicate the floor stating he his incontinence br indicated R84 was was sitting in reclin interdisciplinary tea staff was to assist a after meals. The qu time you observed the last time the rear restroom or inconti left blank. The anal the toileting plan wa additional toileting afternoon. 2) 12/1/16, at 2:50 The report on 12/17 floor at the bathroo trying to use the toi stated, "I fainted." H	to use it. Offer toileting per al was that R84 would be free review date. Interventions and changing the resident's ncluding at 10:00 p.m. and toileting before and after ad as needed. A risk for falls on the care plan related to a of daily living with limited as problems. Staff were to mote safety and prevent falls ce Reports for R84 were as 0 p.m. d the resident was found on needed to use the toilet, and ief was wet. The report also "usually in bed after lunch, er." Although the um (IDT) intervention indicated R84 to the toilet before and uestions "When was the last the resident?" and "When was sident was assisted to the nent pad changed?" were both lysis did not include whether as followed or whether was necessary in the	F 32	Preferences and safety interproperly communicated to a new format/tool to communicated to a new format/tool to communicate the sheet of the sheet	the line staff. A dicate night on initiated. to be reviewed . Systemic three ting. One the care plan ns, one the NAR team uter is used to press note. All cident is DT meeting r performance reviews every ong with the A committee ance has been			

If continuation sheet Page 19 of 28

		AND HUMAN SERVICES				FORM	01/31/2017 APPROVED 0938-0391			
				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
245312		B. WING			01/05/2017					
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE					
CASTLE RIDGE CARE CENTER			625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
	between 78-91%. V what he was trying replied that he was post fall assessmer last been toileted or "What suggestions from occurring agai [resident]further in oxygenation." The i intervention indicate ordered staff check oxygen (O2) levels with the results. Inter root cause analysis toileting plan. 3) 12/7/16, at 10:15 The report indicated on the floor on his b The wheelchair was bathroom. R84 stat was doing prior to the was between 76-83 was wet. The IDT fa the NP ordered O2 however, the interver resident's need for was found with a we A quarterly Fall Risk indicated R84 expet the past 180 days, I vision, and frequent balance, and use of psychotropic medic on care plan include 100 feet twice daily	The fall R84's O2 saturation registered When the resident was asked to do at the time of the fall he tying to use the toilet. The nt indicated the resident had r brief changed at midnight. do you have to prevent this in? Clip call light to Res nvestigation re: [regarding] interdisciplinary team (IDT) ed the nurse practitioner (NP) to R84's vital signs including his every shift and update the NP erventions did not include a to or revisions to the resident's 5 p.m. d the resident was observed back during routine rounds. s between the bed and ted, "I don't know!" what he he fall. R84's O2 saturation 8% at room air, and his brief alls follow up form indicated at 2 liters per minute, entions did not address the additional toileting when he	F3	323						

Facility ID: 00973

If continuation sheet Page 20 of 28

	-	AND HUMAN SERVICES			FORM	01/31/2017 APPROVED 0938-0391			
STATEMENT	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,		(X3) DATE	E SURVEY PLETED			
	245312		B. WING		01/05/2017				
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE					
CASTLE RIDGE CARE CENTER			625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE			
F 323	effectiveness of intermonitoring resident care]. Resident had 4) 12/11/16, at 2:30 The report indicated when asked what h replied he did not k had been toileted a sustained skin injur [centimeters]. Cove dressing and Tegac dressing]." The IDT intervention read, "I historically been rel night toileting scheo Resident will be offe am." The intervention how the toileting tim minimize the risk fo R84's current NA ca assist resident to an toileting plan did no toilet R84 to minimi generic and directe the morning and ev activities, and as ne incontinence on nig Nursing assistant (I regarding R84's fall stated, "I remembe to go to the bathroo the bathroom. He d is the problem."	erventions read, "Will continue and update POC [plan of d last fall 12/7/16." a.m. d R84 fell in his room and he was doing prior to the fall he now. The report indicated R84 t 1:45 a.m. prior this fall. He y "measuring 4.0 cm x 0.7 cm ered with non-adherent derm film [protective team falls follow up Residents falls have lated to toileting. Resident's dule has been updated. ered toileting at 10 pm and 4 on, however, did not address hes had been determined, to or further falls. are guide directed staff to mbulate 100 feet a day. The ot specify times staff was to ize his risk for falls, but was id staff to toilet the resident in vening, before and after meals, beded, and check for	F 323	3					

If continuation sheet Page 21 of 28

		AND HUMAN SERVICES			FORM	01/31/2017 APPROVED 0938-0391				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
245312		B. WING			01/05/2017					
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE					
CASTLE RIDGE CARE CENTER			625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 323	place so that staff a before and after me he was trying to use the NP also added since his saturation some of the falls. T mediations as orde frequently. LPN-A s plan, but that is what R59 was observed in a wheelchair and On 1/4/17 at 7:30 a NA-D was with prov- resident to dress fo surveyor the reside was at the edge of cares and NA-D sta- aide to help. [R59] if fighting." NA-D left NA-E. R59 assisted resident, and to trans to the toilet. At 8:08 room and assisted bathroom and then wheelchair to the di- weak and drowsy. R59's care plan data resident was at risk an antidepressant, weakness, depress mobility and cogniti getting out of bed a Although the reside impaired, interventi- my call light is withi	A stated, "We put the plan in assist R84 to the bathroom eals. He was falling because e the bathroom." LPN-A stated O2 (since was discontinued) is were low at the time of "he staff was also to administer ired and check on R84 stated, "It is not in his care		323						

Facility ID: 00973

If continuation sheet Page 22 of 28

	-	AND HUMAN SERVICES				FORM	01/31/2017 APPROVED 0938-0391		
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245312	B. WING			01/	05/2017		
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE				
CASTLE RIDGE CARE CENTER			625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 323	<ul> <li>wearing appropriate effectiveness of my basis. Follow my to at night, place me in bed related to seizu bed to help me with in an increase of be assessment"</li> <li>A Care Area Assess revealed "Will care RT [related to] phys medication. Has im of sit to stand lift for requires staff suppor daily living], use of Has cognitive loss I also noted the reside cognition and requi staff with bed mobil dressing.</li> <li>R59's 1/17, physicia including delusiona disorder, anoxic bra disease, absence e medication orders i amoxicillin-clavulan (for seizures), Abilif fluoxetine (for majo</li> <li>R59's fall information 1) 10/24/16, at 6:29 "Resident noted on</li> </ul>	e footwear. Evaluate v interventions on an ongoing ileting schedule. grippy socks n middle of bed. I use a low ures. I use grab bars on my n repositioning. If acute change ehaviors, complete clinical sment (CAAs) dated 4/27/16, plan for falls. Is at risk for falls sical, cognitive status & use of paired mobility, requires use r transfer, unable to walk, ort for daily ADLs [activities of W/C [wheelchair] for mobility. RT anoxic brain injury." It was dent utilized medication to treat ion, and seizures. R59's most ata Set (MDS) dated 10/19/16, ent had severely impaired red extensive assistance with lity, transferring, toileting and an orders revealed diagnoses I disorder, major depressive ain damage, chronic kidney epileptic syndrome. R59's	F	323					

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	01/31/2017 APPROVED 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				E CONSTRUCTION	(X3) DATE	E SURVEY PLETED			
		245312	B. WING			01/	05/2017		
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE	-			
CASTLE RIDGE CARE CENTER			625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE		
F 323	not fall. I crawled or denied pain, abrasi [range of motion] pr Resident able to me difficulty. Denied hit after removed from A Resident Occurrer revealed, R59 had toilet at 9:36 p.m. h lacked information toileted between 9:: time the resident w The Fall Follow Up "R59 was assisted updated to check a [bedtime] cares, to activities, at 10-11:0 2) 12/15/16, at 11:1 "At 9:35 a.m. res [rof from her w/c in the station. Res stated toilet." It was noted and then fell. Follow and voided and had also noted the care which directed staff AM and HS cares, activities." The IDT follow up f interventions were dose will be review 3) 12/30/16, at 6:43 "Resident observed	ut of my bedis dirty.' Resident ions noted to right knee. ROM erformed to all extremities. ove extremities w/o [without] tting head." R59 was toileted	F 3	\$23					

If continuation sheet Page 24 of 28

		AND HUMAN SERVICES				FORM	01/31/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245312	B. WING	i		01/(	05/2017
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	ĨR			25 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	door." When asked do not know.' Was the head against ok floor and in her brie to bed." The fall hud last time the resider a.m. A progress note dat discussed and deci resident's medication the reason for frequ BMs a day)." A progress note dat pharmacist called b medication and said tabs twice daily was stools and the write practitioner. During an interview 9:00 a.m. LPN-A ex had been reviewed had not been admir medication. The NF thought the residen magnesium oxide, f facility had not com as to potential caus revised plan develo The facility's 9/15, F Management Progr determine the resid establish appropria related to fall risk in personnel in deliver	I what was trying to do, said 'I very agitated. Denied hitting oject. Loose stool noted on the efbrief changed and put back ddle review form revealed the nt had been changed was 4:45 ted on 12/30/16, read "IDT ided to ask pharmacy to review ons and give consultation on uent bowel movements (2-3 ted on 12/30/16, indicated the back after reviewing resident's d that only magnesium oxide 2 is a concern related to loose er planned to update the nurse of 1/4/16, at approximately consistering the laxative P was updated and she at's loose stools were not from however, LPN-A verified the opleted a further assessment sal factors for falls and a oped.		323			

	-	AND HUMAN SERVICES					FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRU			(X3) DATE	E SURVEY IPLETED
		245312	B. WING _				01//	05/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STATE	, ZIP CODE		
CASTLE	RIDGE CARE CENTE	R			E CENTER DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN ( CH CORRECTIVE A SS-REFERENCED T DEFICIE	OTHE APPROPE	BE	(X5) COMPLETION DATE
F 323 F 334	responsible for assi implementing strate resident falls."	isting, treating and egies for the prevention of	F 32 F 33					2/2/17
F 334 SS=D	PNEUMÓCÔĆCAL		F 33	4				2/3/17
	(1) Influenza. The fa and procedures to e	acility must develop policies ensure that-						
	each resident or the receives education	ne influenza immunization, e resident's representative regarding the benefits and ts of the immunization;						
	immunization Octob annually, unless the	offered an influenza per 1 through March 31 e immunization is medically he resident has already been his time period;						
	( )	the resident's representative to refuse immunization; and						
		nedical record includes indicates, at a minimum, the						
		nt or resident's representative ation regarding the benefits offects of influenza						
	immunization or did	nt either received the influenza I not receive the influenza o medical contraindications or						

If continuation sheet Page 26 of 28

PRINTED: 01/31/2017

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM /	01/31/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	SURVEY PLETED
		245312	B. WING			01/0	05/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	R			25 PRAIRIE CENTER DRIVE DEN PRAIRIE, MN 55344		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334	Continued From pa	ge 26	F 3	34			
		disease. The facility must d procedures to ensure that-					
	representative rece	ne pneumococcal resident or the resident's ives education regarding the ial side effects of the					
	immunization, unles	offered a pneumococcal so the immunization is icated or the resident has nized;					
		the resident's representative to refuse immunization; and					
		nedical record includes indicates, at a minimum, the					
	was provided educa	nt or resident's representative ation regarding the benefits ffects of pneumococcal					
	pneumococcal imm the pneumococcal i contraindication or This REQUIREMEN by:	NT is not met as evidenced					
	facility failed to ensu pneumococcal imm evidence of the vac	and document review, the ure each resident received a unization, or had documented cination being contraindicated (R65) in the sample reviewed			This plan of correction constitutes the facilities written allegation of compliant for the deficiencies cited. This submost this plan of correction is not an admission of/or agreement with the deficiencies or conclusions contained	ance lission	

Facility ID: 00973

If continuation sheet Page 27 of 28

PRINTED: 01/31/2017

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/31/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	SURVEY PLETED
		245312	B. WING			01/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	R		-	25 PRAIRIE CENTER DRIVE DEN PRAIRIE, MN 55344		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 334	Continued From pa	ge 27	FS	334	the department inspection report.		
	Findings include:						
	R65 was an 86 yea facility on 8/19/16. I R65 had not receive immunization. On 1/5/17, at 8:52 a (DON) stated R65 f pneumococcal vaco The DON explained received a Pneumo by R65 on 12/8/16, vaccine. The DON and administration been completed at 8/16. She did not kn resident had not be said she would add The facility's 5/16, F Policy indicated, "E immunization status admission or soon a	a.m. the director of nursing had not received cination "due to an oversight." I that although they had coccal Vaccinations Consent they failed to administer the further stated both the consent of the vaccination should have the time of R65's admission in now why consent from the en obtained until 12/8/16, but ress the situation immediately. Pneumococcal Vaccination ach resident's pneumococcal s will be determined upon afterwards; vaccination date (if accination) will be documented			R64's immunization record from MIC was reviewed and the information wa documented in the facility's Point Cli Care system. R65 received the pneumococcal immunization per pol 1/24/17. All current residents historical immunization records were reviewed using the MICC system and Point Cl Care was updated to reflect this. Con forms for receiving immunizations is included in the admission paperwork all residents. The systematic process reviewed by the Director of Nursing of 1/23/17. Through this review, the He Information Manager was re-educate the policy to ensure that timely immunizations are completed. The facility plans to monitor its performance by running immunization reports weekly until 100% compliant information will be included in the inf control section of the QA meetings e quarter.	d licy on lick nsent k for s was on ealth ed on on t. This fection	

Facility ID: 00973

If continuation sheet Page 28 of 28

		AND HUMAN SERVICES & MEDICAID SERVICES		1	F67,2077	FORM	02/03/2017 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COM	E SURVEY PLETED
	X	245312	B. WING			01/0	04/2017
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CASTLEI	RIDGE CARE CENTE	R			25 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344		
(X4) ID PREFIX T <b>A</b> G	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000		rs	ĸ	000			
	FIRE SAFETY						
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.					
	ONSITE REVISIT ( CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.			2		
	Minnesota Departm Fire Marshal Division the time of this survives was found not in correquirements for par Medicare/Medicaid 483.70(a), Life Safe of National Fire Pro- 101, Life Safety Co	articipation in at 42 CFR, Subpart ety from Fire, the 2012 edition otection Association (NFPA) de (LSC), Chapter 19 Existing e 2012 edition of NFPA 99,					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K- Healthcare Fire Ins State Fire Marshal 445 Minnesota St., St. Paul, MN 55101	R THE FIRE SAFETY -TAGS) TO: pections Division Suite 145			EPOC		
	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE 02/01/2017

**Electronically Signed** 

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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/03/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMI	E SURVEY PLETED
		245312	B. WING			01/0	04/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	R			25 PRAIRIE CENTER DRIVE DEN PRAIRIE, MN 55344		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa	ige 1	K 0	00			
	By email to: Marian.Whitney@s Angela.Kappenmar						
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
	1. A description of v to correct the defici	what has been, or will be, done ency.					
	2. The actual, or pro	oposed, completion date.					
		r title of the person ection and monitoring to ence of the deficiency.					
	with no basement. at three different tin constructed in 1983 Type V (111) constr was constructed an Type V (111) constr was constructed an V (111) construction building and the two construction type al the facility was surv building is fully prot sprinkler system an smoke detection in open to the corridor automatic fire depa	Center is a 1-story building The building was constructed nes. The original building was and was determined to be of fuction. In 1987, an addition of was determined to be of fuction. In 1997, an addition of was determined to be Type n. Because the original of additions meet the llowed for existing buildings, veyed as one building. The fected by an automatic fire and has a fire alarm system with the corridors and spaces rs that is monitored for rtment notification. The facility 0 beds and had a census of 54 y.					

 ${\mathcal H}^{(i)}_{i}$ 

If continuation sheet Page 2 of 5

ATEMAENIT				PLE CONSTRUCTION		E SURVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	G 01 - MAIN BUILDING 01		PLETED
		245312	B. WING		01/0	04/2017
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ASTLE	RIDGE CARE CENT	ER		625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIC DATE
K 000		42 CFR, Subpart 483.70(a) is	K 000	D		
	NOT MET as evide NFPA 101 Sprinkle Testing	r System - Maintenance and	K 35:	3		2/17/17
	Automatic sprinkle inspected, tested, a with NFPA 25, Star Testing, and Mainta Protection Systems maintenance, inspe- maintained in a sec available.	Maintenance and Testing r and standpipe systems are and maintained in accordance ndard for the Inspection, aining of Water-based Fire s. Records of system design, ection and testing are cure location and readily system last checked				
	b) Who provided c) Water system s			×		
	any non-required or system. 9.7.5, 9.7.7, 9.7.8, This STANDARD is Based on observa facility did not main fire sprinkler system and the 2012 LSC This deficient praction residents. Findings include: On a facility tour be	is not met as evidenced by: tion and document review, the ntain and test their automatic m in accordance with NFPA 25 NFPA 101. 9.7.5, 9.7.7, 9.7.8. tice could effect all 54		The sprinkler system internal obst piping inspection will be completed 2/17/2017. In accordance with NFF (2011) and NFPA 101 (2012) all re- fire systems inspections will be en- into the electronic work order syste the ESD at the proper intervals in o generate a work order when the inspection is due. The Environmen Services Director (ESD) will ensure	I by PA 25 quired tered em by order to ntal e these	
	1630 on January 0 that the five year, a	4, 2017, observation revealed automatic fire sprinkler system a investigation was due but was		inspections are completed in a tim manner. The records of the inspec will be kept available for review by	ely tions	

Event ID: VUR321

Facility ID: 00973

If continuation sheet Page 3 of 5

	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		G 01 - MAIN BUILDING 01		PLETED	
		245312	B. WING		01/0	)4/2017	
AME OF F	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP COL	DE		
CASTLE	RIDGE CARE CENT	ER		625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
K 353		age 3 e last internal obstruction conducted on September 19,	K 35	3 CMS safety inspector or the s marshal's representative in th office.			
K 712 SS=C	of environmental s inspection. NFPA 101 Fire Dri Fire Drills Fire drills include t signal and simulat conditions. Fire dri times under varyir on each shift. The and is aware that routine. Responsil conducting drills is persons who are of Where drills are c 6:00 AM, a coded instead of audible 18.7.1.4 through 1 19.7.1.7 This STANDARD Based on docum	he transmission of a fire alarm ion of emergency fire ills are held at unexpected ig conditions, at least quarterly staff is familiar with procedures drills are part of established bility for planning and a assigned only to competent qualified to exercise leadership. bonducted between 9:00 PM and announcement may be used	K 71	Fire drills will be conducted a by NFPA 101 (2012. A fire dri		2/1/17	
	documentation tha once per shift per varying times and NFPA 101, Section	at fire drills were conducted quarter for all staff under conditions as required by 2012 n 19.7.1.4. through 19.7.1.7. stice could affect all 54		will be entered into the electro order system by the ESD at t intervals to generate a work of the fire drill is due. The ESD will conduct the fire drill in a t manner. Fire drill reports will by the QA committee quarter committee annually to ensure The Campus Administrator w	onic work he required order when or his proxy imely be reviewed ly and safety compliance.		

Event ID: VUR321

Facility ID: 00973

If continuation sheet Page 4 of 5

		AND HUMAN SERVICES				FORM	02/03/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMI	E SURVEY PLETED
		245312	B. WING			01/0	04/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	R			25 PRAIRIE CENTER DRIVE DEN PRAIRIE, MN 55344		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	that the facility coul for conducting fire of third quarter of 201 second quarter of 2 the second quarter This deficient pract	4, 2017, observation revealed d not provide documentation drill for the first shift during the 6, the second shift during the 2016 and the third shift during	K	712			

Facility ID: 00973

If continuation sheet Page 5 of 5



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered January 23, 2017

Ms. Molly Senske, Administrator Castle Ridge Care Center 625 Prairie Center Drive Eden Prairie, Minnesota 55344

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5312027

Dear Ms. Senske:

The above facility was surveyed on January 3, 2017 through January 5, 2017 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 <u>only a suggestion</u> 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Castle Ridge Care Center January 23, 2017 Page 2

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 meeth

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

Minnesc	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00973	B. WING		01/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	R	RIE CENTEF AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided that the Department with notice of assessme	hearing on any assessments n non-compliance with these a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to	
	epartment of Health Y DIRECTOR'S OR PROVIE	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE

Electronically Signed

If continuation sheet 1 of 24

STATEME	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00973	B. WING		01/0	5/2017
		625 PBAII	DRESS, CITY, RIE CENTEI	STATE, ZIP CODE <b>R DRIVE</b>		
JASILE	RIDGE CARE CENTE	EDEN PR	AIRIE, MN	55344		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th corrected prior to e Minnesota Departm On 1/3/17, 1/4/17 a Department's staff, the following correct Please indicate in y correction that you and identify the dat Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag m column entitled "IE statute/rule out of co "Summary Stateme and replaces the "T correction order. Th findings which are in after the statement evidence by." Follo are the Suggested Time period for Con PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	and 1/5/17 surveyors of this visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, e when they will be completed. hent of Health is documenting correction Orders using ag numbers have been sota state statutes/rules for humber appears in the far left o Prefix Tag." The state compliance is listed in the ent of Deficiencies" column to Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and		The assigned tag number ap far left column entitled "ID Pr The state statute/rule out of collisted in the "Summary Stater Deficiencies" column and rep Comply" portion of the correct This column also includes the which are in violation of the s after the statement, "This Rul as evidence by." Following th findings are the Suggested M Correction and Time period for PLEASE DISREGARD THE IT THE FOURTH COLUMN WH STATES, "PROVIDER'S PLA CORRECTION." THIS APPL FEDERAL DEFICIENCIES O WILL APPEAR ON EACH PA THERE IS NO REQUIREMEN SUBMIT A PLAN OF CORREC VIOLATIONS OF MINNESOT STATUTES/RULES.	efix Tag." ompliance is nent of laces the "To tion order. e findings tate statute e is not met e surveyors lethod of or Correction. HEADING OF IICH N OF IES TO NLY. THIS GE. NT TO CCTION FOR	

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPL	EIED
		00973	B. WING		01/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	B	RIE CENTEF AIRIE, MN 5			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 570	MN Rule 4658.0409 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			2/10/17
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p participation of the guardian or chosen quarterly and within	resident, the resident's legal representative at least seven days of the revision of resident assessment required				
	by: Based on interview facility failed to revis	ent is not met as evidenced and document review, the se care plan interventions to r falls for 2 of 5 residents d for falls.		Corrected		
	Finding include:					
	resident had function and/or physical diffi for falls related to h cognition impaired dementia, anxiety, of cataracts, bowel and	ised 12/22/16, revealed the onal incontinence (cognitive culty using toilet), "I am at risk istory of falls, impaired mobility, Alzheimer's depression hallucinations, d bladder incontinence and ure my call light is within reach				

	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		00973	B. WING	B. WING		05/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	B	RIE CENTER AIRIE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 570	and encourage me schedule." The goa of falls through the included checking a incontinence brief in 4:00 a.m. and offer meals, activities and was also identified decline in activities mobility and balanc promote safety pror and/or injury. The most recent Mi 12/12/16, identified impaired. He was u required extensive a transferring and am had experienced tw and two or more fal Resident Occurrent follows: 1) 10/18/16, at 2:40 The report indicated the floor stating he his incontinence bri indicated R84 was was sitting in recline interdisciplinary tea staff was to assist F after meals. The qu time you observed to the last time the res restroom or incontin left blank. The analy the toileting plan was	to use it. Offer toileting per I was that R84 would be free review date. Interventions and changing the resident's ncluding at 10:00 p.m. and toileting before and after d as needed. A risk for falls on the care plan related to a of daily living with limited e problems. Staff were to mote safety and prevent falls nimum Data Set dated R84 was severely cognitively nsteady with transferring and assistance from staff for both ibulation. The MDS noted R84 to or more falls without injury Is with minor injury. ce Reports for R84 were as p.m. d the resident was found on needed to use the toilet, and ef was wet. The report also 'usually in bed after lunch,				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00973	B. WING	WING		01/05/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
CASTLE	RIDGE CARE CENTI	FR	RIE CENTER AIRIE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 570	floor at the bathroot trying to use the to stated, "I fainted." I bedside, the toilet of tipped over. R84's was cold and oxyg between 78-91%. A what he was trying replied that he was post fall assessme last been toileted of "What suggestions from occurring aga [resident]further i oxygenation." The intervention indicat ordered staff check oxygen (O2) levels with the results. Int root cause analysis toileting plan. 3) 12/7/16, at 10:19 The report indicate on the floor on his The wheelchair wa bathroom. R84 sta was doing prior to was between 76-83 was wet. The IDT f the NP ordered O2 however, the interv	a.m. /16 revealed R84 was found on om entrance, and stated he was ilet. When asked how he fell he His wheelchair was at his riser and wastebasket were brief was wet and his, finger en saturation registered When the resident was asked to do at the time of the fall he 6 tying to use the toilet. The nt indicated the resident had or brief changed at midnight. 6 do you have to prevent this in? Clip call light to Res nvestigation re: [regarding] interdisciplinary team (IDT) ed the nurse practitioner (NP) k R84's vital signs including his every shift and update the NP erventions did not include a s or revisions to the resident's 5 p.m. d the resident was observed back during routine rounds. s between the bed and ted, "I don't know!" what he the fall. R84's O2 saturation 3% at room air, and his brief falls follow up form indicated e at 2 liters per minute, ventions did not address the additional toileting when he					
	indicated R84 expe	k assessment dated 12/8/16, erienced three or more falls in had poor recall, inadequate					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00973	B. WING		01/05/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CASTLE	RIDGE CARE CENTI	FR	IRIE CENTER RAIRIE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 5	2 570			
	balance, and use of psychotropic media on care plan includ 100 feet twice daily monitoring medica effectiveness of int	nt incontinence, poor gait and of non-steroidal pain and cations. "Interventions updated led ambulating the resident y to improve strength and tions for side effects. The terventions read, "Will continue t and update POC [plan of d last fall 12/7/16."				
	when asked what h replied he did not k had been toileted a sustained skin inju [centimeters]. Cove dressing and Tega dressing]." The IDT intervention read, " historically been re night toileting sche Resident will be off am." The intervention	ed R84 fell in his room and he was doing prior to the fall he know. The report indicated R84 at 1:45 a.m. prior this fall. He ry "measuring 4.0 cm x 0.7 cm ered with non-adherent derm film [protective Γ team falls follow up 'Residents falls have lated to toileting. Resident's dule has been updated. fered toileting at 10 pm and 4 ion, however, did not address mes had been determined, to				
	assist resident to a toileting plan did no toilet R84 to minim generic and directe the morning and ev	are guide directed staff to imbulate 100 feet a day. The ot specify times staff was to ize his risk for falls, but was ed staff to toilet the resident in vening, before and after meals, eeded, and check for ght rounds.	,			
	regarding R84's fa stated, "I remembe	NA)-A was interviewed lls on 1/4/17, at 7:25 a.m. and er one of the falls he was trying om and fell before he reached				

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 01/05/2017	
		00973	B. WING			
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE	• • • •	
ASTLE	RIDGE CARE CENTE	-R	IRIE CENTER			
	1	EDEN PH	RAIRIE, MN 55		0000000101	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 6	2 570			
	the bathroom. He c is the problem."	loes not use the call lightthat				
	on 1/5/17, at 11:45 on 10/18/16. LPN-/ place so that staff a before and after me he was trying to us the NP also added since his saturation some of the falls. T mediations as order	actical (LPN)-A was interviewed a.m. about R84's fall occurred A stated, "We put the plan in assist R84 to the bathroom eals. He was falling because e the bathroom." LPN-A stated O2 (since was discontinued) as were low at the time of The staff was also to administer ored and check on R84 stated, "It is not in his care at we have done."				
	resident was at risk an antidepressant, weakness, depress mobility and cogniti getting out of bed a Although the reside impaired, interventi my call light is withi use it for assistanc wearing appropriate effectiveness of my basis. Follow my to at night, place me i bed related to seize bed to help me with	ted 10/24/16, indicated the k for falling related to the use of as well as a seizure disorder, sion, psychosis, impaired tive loss. "I have a history of and crawling on the floor." ent was severely cognitively ions directed staff to "Be sure in reach and encourage me to e as needed. Ensure that I am e footwear. Evaluate y interventions on an ongoing bileting schedule. grippy socks n middle of bed. I use a low ures. I use grab bars on my n repositioning. If acute change ehaviors, complete clinical				
	indicated the reside cognition and requi	ta Set (MDS) dated 10/19/16, ent had severely impaired ired extensive assistance with lity, transferring, toileting and				

STATEMEN	DT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00973	B. WING	B. WING		05/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
CASTLE	RIDGE CARE CENTI	FR	IRIE CENTER RAIRIE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 7	2 570			
	including delusiona disorder, anoxic br disease, absence of medication orders amoxicillin-clavular (for seizures), Abili fluoxetine (for majo R59's fall informati 1) 10/24/16, at 6:29 "Resident noted or When writer intervi not fall. I crawled of denied pain, abras [range of motion] p Resident able to m difficulty. Denied hi after removed from A Resident Occurro revealed, R59 had toilet at 9:36 p.m. h lacked information	hate (antibiotic), levtiracetam fy (antipsychotic), and or depressive disorder). on revealed the following: 9 a.m. progress note: n floor around 0340 [3:40 a.m.] weed, resident stated, 'I did ut of my bedis dirty.' Residen ions noted to right knee. ROM performed to all extremities. Nove extremities w/o [without] itting head." R59 was toileted				
	The Fall Follow Up "R59 was assisted updated to check a [bedtime] cares, to	vas found on the floor). Intervention on 10/25/16, read to the bathroom. Care Plan and assist to toilet AM and HS and from meals, naps and 00 p.m. and 4-5 a.m. daily."				
	2) 12/15/16, at 11: "At 9:35 a.m. res [r from her w/c in the station. Res stated	11 a.m. progress note: resident] had a witnessed fall common area near nursing that she wanted to use the I she stood up, walked forward	,			

If continuation sheet 8 of 24

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00973	B. WING		01/05/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
CASTLE	RIDGE CARE CENT	FR	IRIE CENTER RAIRIE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 570	Continued From pa	age 8	2 570			
	and voided and had also noted the care which directed staf AM and HS cares, activities." The IDT follow up f interventions were dose will be review 3) 12/30/16, at 6:43 "Resident observed the door sitting. Cra door." When asked do not know.' Was the head against of floor and in her brie to bed." The fall hu last time the reside a.m.	wing the fall R59 was toileted d a bowel movement. It was e plan was already in place f to "check and assist to toilet to and from meals, naps and fall on 12/16/16, indicated for "Bowel review and laxative red and make changes PRN." 3 a.m. progress note: d on the floor of her room by awled from her bed to the d what was trying to do, said 'I very agitated. Denied hitting bject. Loose stool noted on the efbrief changed and put back iddle review form revealed the ent had been changed was 4:45				
	discussed and dec resident's medicati	ted on 12/30/16, read "IDT ided to ask pharmacy to review ons and give consultation on uent bowel movements (2-3				
	pharmacist called to medication and sai tabs twice daily wa	tted on 12/30/16, indicated the back after reviewing resident's id that only magnesium oxide 2 s a concern related to loose er planned to update the nurse				
	9:00 a.m. LPN-A ex had been reviewed had not been admi	v on 1/4/16, at approximately xplained R59's medication use I and it was concluded they nistering the laxative P was updated and she				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00973	B. WING		01/	05/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	-8	IRIE CENTER RAIRIE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 570	Continued From pa	age 9	2 570			
	magnesium oxide, facility had not com	nt's loose stools were not from however, LPN-A verified the apleted a further assessment sal factors for falls and a oped.				
	Management Prog determine the resid establish appropria related to fall risk ir personnel in delive careMembers of responsible for ass	Fall Prevention and ram policy directed staff to dent's risk for falls and to te intervention the care plan in the plan of care. "Supervising ring safe and personalized the interdisciplinary team are isting, treating and egies for the prevention of				
	The director of nurs develop and impler related to care plan designee, could pro staff related to the revisions. The qual	THOD OF CORRECTION: sing (DON) or designee, could ment policies and procedures a revisions. The DON or ovide training for all nursing timeliness of care plan ity assessment and assurance erform random audits to				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			2/10/17
	receive nursing car custodial care, and individual needs an the comprehensive	general. A resident must re and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and				

VUR311

If continuation sheet 10 of 24

STATEMEN	It of Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00973	B. WING		01/05/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	FR	RIE CENTEI AIRIE, MN 🗄			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 10	2 830			
	of bed as much as written order from t	ing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident n bed.				
	by: Based on observat review, the facility f services to minimiz	ent is not met as evidenced ion, interview and document failed to provide care and the risk for falls for 2 of 5 9) reviewed for falls.		Corrected		
	Finding include:					
	seated in his wheel the resident did not At 9:41 a.m. license assisted R84 to be light. He was not as toilet. The bathroor the light was on. Of in bed with his eyes	on 1/4/17, at 7:18 a.m. while lchair. When asked about falls t recall experiencing any falls. ed practical nurse (LPN)-A d and was provided his call sked if he needed to use the m door was slightly ajar and n 1/5/17, at 8:11 a.m. R84 was s closed. His call light was he bathroom door was slightly ras on.				
	R84's admission re assistance to move had problems inclu with diagnoses incl psychotic disorder mental status. A fa (CAA) dated 9/20/1	e Checklist at the time of evealed R84 required hands on e from place to place. He also iding difficulty walking and falls uding Alzheimer's disease, with hallucinations and altered all Care Area Assessment 6, indicated R84 had difficulty balance and had impaired nsitions.				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
		00973	B. WING		01/	01/05/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
CASTLE	RIDGE CARE CENTI	FR	IRIE CENTER RAIRIE, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 11	2 830				
	12/12/16, identified impaired. He was u required extensive transferring and an had experienced tw and two or more fa R84's care plan rev resident had function and/or physical diff for falls related to h cognition impaired dementia, anxiety, cataracts, bowel ar medicationsBe st and encourage me schedule." The goa of falls through the included checking a incontinence brief i 4:00 a.m. and offer meals, activities ar was also identified decline in activities mobility and baland promote safety pro and/or injury. Resident Occurrent follows: 1) 10/18/16, at 2:40 The report indicate the floor stating he his incontinence br indicated R84 was was sitting in reclina interdisciplinary tea	d the resident was found on needed to use the toilet, and ief was wet. The report also "usually in bed after lunch,					

Minnesota Department of Health STATE FORM

6899

VUR311

If continuation sheet 12 of 24

	ta Department of He IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN	OF CORRECTION	DENTIFICATION NUMBER:				PLETED
		00973	B. WING		01/05/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		625 PRAI	RIE CENTER	DRIVE		
CASILE	RIDGE CARE CENTE	EDEN PR	AIRIE, MN 55	5344		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ge 12	2 830			
	after meals. The qu time you observed the last time the res restroom or incontin left blank. The anal the toileting plan wa additional toileting v afternoon. 2) 12/1/16, at 2:50 a The report on 12/1/ floor at the bathrood trying to use the toi stated, "I fainted." H bedside, the toilet r tipped over. R84's H was cold and oxyge between 78-91%. V what he was trying replied that he was post fall assessmen last been toileted ou "What suggestions from occurring agai [resident]further in oxygenation." The i intervention indicate ordered staff check oxygen (O2) levels with the results. Inter root cause analysis toileting plan. 3) 12/7/16, at 10:15 The report indicated on the floor on his k The wheelchair was bathroom. R84 stat	restions "When was the last the resident?" and "When was sident was assisted to the nent pad changed?" were both ysis did not include whether as followed or whether was necessary in the a.m. 16 revealed R84 was found on m entrance, and stated he was let. When asked how he fell he dis wheelchair was at his iser and wastebasket were prief was wet and his, finger en saturation registered When the resident was asked to do at the time of the fall he tying to use the toilet. The nt indicated the resident had r brief changed at midnight. do you have to prevent this in? Clip call light to Res nvestigation re: [regarding] nterdisciplinary team (IDT) ed the nurse practitioner (NP) . R84's vital signs including his every shift and update the NP erventions did not include a or revisions to the resident's				
		3% at room air, and his brief				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00973	B. WING		01/05/20 ⁻	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		00/2011
ASTI F	RIDGE CARE CENTE	ER 625 PRA	IRIE CENTER	DRIVE		
JASTLL		EDEN PF	RAIRIE, MN 55	5344		-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 13	2 830			
	the NP ordered O2 however, the interv	alls follow up form indicated at 2 liters per minute, rentions did not address the additional toileting when he ret brief.				
	indicated R84 expe the past 180 days, vision, and frequen balance, and use o psychotropic medic on care plan includ 100 feet twice daily monitoring medicat effectiveness of int	k assessment dated 12/8/16, erienced three or more falls in had poor recall, inadequate it incontinence, poor gait and of non-steroidal pain and cations. "Interventions updated led ambulating the resident or to improve strength and tions for side effects. The erventions read, "Will continue t and update POC [plan of d last fall 12/7/16."				
	when asked what h replied he did not k had been toileted a sustained skin injun [centimeters]. Cove dressing and Tegac dressing]." The IDT intervention read, " historically been re night toileting schee Resident will be off am." The interventi	d R84 fell in his room and he was doing prior to the fall he know. The report indicated R84 at 1:45 a.m. prior this fall. He ry "measuring 4.0 cm x 0.7 cm ered with non-adherent derm film [protective T team falls follow up Residents falls have lated to toileting. Resident's dule has been updated. Fered toileting at 10 pm and 4 ion, however, did not address nes had been determined, to				
	assist resident to a toileting plan did no	are guide directed staff to mbulate 100 feet a day. The ot specify times staff was to ize his risk for falls, but was				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/05/2017	
		00973	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		- D 625 PRA	<b>RIE CENTER</b>	DRIVE		
CASILE	RIDGE CARE CENTE	EDEN PF	AIRIE, MN 5	5344		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 14	2 830			
	generic and directe the morning and ev	ed staff to toilet the resident in vening, before and after meals, eeded, and check for				
	regarding R84's fal stated, "I remembe to go to the bathroo	NA)-A was interviewed Is on 1/4/17, at 7:25 a.m. and or one of the falls he was trying om and fell before he reached does not use the call lightthat				
	on 1/5/17, at 11:45 on 10/18/16. LPN-4 place so that staff a before and after me he was trying to us the NP also added since his saturation some of the falls. T mediations as order	actical (LPN)-A was interviewed a.m. about R84's fall occurred A stated, "We put the plan in assist R84 to the bathroom eals. He was falling because e the bathroom." LPN-A stated O2 (since was discontinued) as were low at the time of The staff was also to administer ared and check on R84 stated, "It is not in his care at we have done."				
	in a wheelchair and On 1/4/17 at 7:30 a NA-D was with pro- resident to dress for surveyor the reside was at the edge of cares and NA-D sta aide to help. [R59] fighting." NA-D left NA-E. R59 assisted	on 1/3/17, at 7:21 p.m. seated d participating in music activity. a.m. R59 observed lying in bed. viding care assisting the or the day. NA-D informed the ent had been about to fall and the bed. R59 began resisting ated, "I need to find another is acting strange today and the room and returned with d NA-D to wash and dress the nsfer her to the wheelchair and				
	room and assisted	3 a.m. NA-F, came to resident R59 to brush her teeth in the assisted the resident in her				

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED			
		00973	B. WING		01/	05/2017			
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE					
ASTLE	RIDGE CARE CENTI	FR	IRIE CENTER RAIRIE, MN 55						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE			
2 830	weak and drowsy. R59's care plan da	ted 10/24/16, indicated the	2 830 f						
	an antidepressant, weakness, depress mobility and cognit getting out of bed a Although the reside impaired, intervent my call light is with use it for assistanc wearing appropriat effectiveness of my basis. Follow my to at night, place me bed related to seize bed to help me with	resident was at risk for falling related to the use of an antidepressant, as well as a seizure disorder, weakness, depression, psychosis, impaired mobility and cognitive loss. "I have a history of getting out of bed and crawling on the floor." Although the resident was severely cognitively mpaired, interventions directed staff to "Be sure my call light is within reach and encourage me to use it for assistance as needed. Ensure that I am wearing appropriate footwear. Evaluate effectiveness of my interventions on an ongoing pasis. Follow my toileting schedule. grippy socks at night, place me in middle of bed. I use a low ped related to seizures. I use grab bars on my ped to help me with repositioning. If acute change n an increase of behaviors, complete clinical assessment"							
	revealed "Will care RT [related to] phys medication. Has im of sit to stand lift for requires staff supp daily living], use of Has cognitive loss also noted the resid psychosis, depress recent Minimum Da indicated the reside cognition and requi	sment (CAAs) dated 4/27/16, plan for falls. Is at risk for falls sical, cognitive status & use of paired mobility, requires use or transfer, unable to walk, ort for daily ADLs [activities of W/C [wheelchair] for mobility. RT anoxic brain injury." It was dent utilized medication to treation, and seizures. R59's most ata Set (MDS) dated 10/19/16, ent had severely impaired ired extensive assistance with ility, transferring, toileting and	t						
	R59's 1/17, physici	an orders revealed diagnoses al disorder, major depressive							

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00973	B. WING		01/	05/2017		
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE	01/03/2011			
		625 PBA	RIE CENTER					
CASTLE	RIDGE CARE CENTE	ER EDEN PF	AIRIE, MN 55	5344				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
2 830	Continued From pa	ige 16	2 830					
	disease, absence e medication orders i amoxicillin-clavular (for seizures), Abilit fluoxetine (for majo R59's fall informatio 1) 10/24/16, at 6:29 "Resident noted on When writer intervio not fall. I crawled on denied pain, abrasi [range of motion] po Resident able to mo	hate (antibiotic), levtiracetam fy (antipsychotic), and fy (antipsychotic), and or depressive disorder). on revealed the following: 0 a.m. progress note: floor around 0340 [3:40 a.m.] ewed, resident stated, 'I did ut of my bedis dirty.' Resident ons noted to right knee. ROM erformed to all extremities. ove extremities w/o [without] tting head." R59 was toileted						
	revealed, R59 had toilet at 9:36 p.m. h lacked information toileted between 9:	ence Reports dated 10/24/16 last been assisted to use the owever, the medical record showing the resident had been 36 p.m. and 3:40 a.m. (the as found on the floor).						
	"R59 was assisted updated to check a [bedtime] cares, to	Intervention on 10/25/16, read to the bathroom. Care Plan nd assist to toilet AM and HS and from meals, naps and 00 p.m. and 4-5 a.m. daily."						
	"At 9:35 a.m. res [refrom her w/c in the station. Res stated toilet." It was noted and then fell. Follow and voided and had	1 a.m. progress note: esident] had a witnessed fall common area near nursing that she wanted to use the she stood up, walked forward, ving the fall R59 was toileted d a bowel movement. It was plan was already in place						

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED			
		00973	B. WING		01/	05/2017			
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	CITY, STATE, ZIP CODE					
CASTLE	RIDGE CARE CENTE	-R	RIE CENTER AIRIE, MN 5						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE			
2 830	<ul> <li>which directed staff AM and HS cares, activities."</li> <li>The IDT follow up f interventions were dose will be review</li> <li>3) 12/30/16, at 6:43 "Resident observed the door sitting. Cra door." When asked do not know.' Was the head against of floor and in her brie to bed." The fall hu last time the reside a.m.</li> <li>A progress note da discussed and dec resident's medication the reason for freque BMs a day)."</li> <li>A progress note da pharmacist called b medication and sait tabs twice daily was</li> </ul>	age 17 f to "check and assist to toilet to and from meals, naps and all on 12/16/16, indicated for "Bowel review and laxative ed and make changes PRN." B a.m. progress note: d on the floor of her room by awled from her bed to the I what was trying to do, said 'I very agitated. Denied hitting oject. Loose stool noted on the fbrief changed and put back ddle review form revealed the nt had been changed was 4:45 ted on 12/30/16, read "IDT ided to ask pharmacy to review ons and give consultation on uent bowel movements (2-3 ted on 12/30/16, indicated the pack after reviewing resident's d that only magnesium oxide 2 s a concern related to loose er planned to update the nurse	2 830	DEFICIENC	ΣΥ)				
	9:00 a.m. LPN-A exhaust been reviewed had not been adminedication. The NI thought the resider magnesium oxide,	on 1/4/16, at approximately control of the second s							

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00973	B. WING		01/	05/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	R	RIE CENTER			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830		al factors for falls and a	2 830			
	determine the resid establish appropria related to fall risk ir personnel in deliver careMembers of responsible for ass	ram policy directed staff to lent's risk for falls and to te intervention the care plan n the plan of care. "Supervising ring safe and personalized the interdisciplinary team are				
	The director of nurs develop and impler related to minimizin designee, could pro staff related to mini- assessment and as perform random au	THOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures ng risk for falls. The DON or ovide training for all nursing mizing risk for falls. The quality ssurance committee could idits to ensure compliance.				
	(21) days.	R CORRECTION: Twenty-one				
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			1/30/17
	maintain a compret infection control pro current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines d States Centers for Disease htion (CDC), Division of hation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and				

Minnesc	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		00973	B. WING		01/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CASTLE	RIDGE CARE CENTE	R	RIE CENTEF AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	unpaid employees, residents, and volu Health shall provide regarding implement (b) Written complia be maintained by th Demaintained by th Demainta	<ul> <li>contractors, students, inteers. The Department of e technical assistance intation of the guidelines.</li> <li>ance with this subdivision must ine nursing home.</li> <li>ent is not met as evidenced and document review, the ure tuberculin skin testing tered as required for one of o reviewed for tuberculosis</li> <li>for Disease Control] enting the Transmission of operculosis in Health Care incted all residents must receive pois (TB) screening within 72 or within three months prior to eening must include an resident's risk factors for TB, symptoms.</li> <li>o the facility on 8/19/16. The administered on 8/26/16, d lacked documentation a</li> </ul>		Corrected		
	(DON) explained R epartment of Health	a.m. the director of nursing 65 did not receive her second				
STATE FOR	VI		6899	/UR311	It continuation	sheet 20 of 24

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED	
		00973	B. WING		01/	05/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CASTLE	RIDGE CARE CENTI	FR	IRIE CENTER RAIRIE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21426	Continued From pa	age 20	21426			
		ause, "We missed it. We will R65's] TB testing today."				
	directed "Each resi skilled nursing faci screening including resident risk factor symptoms. A stand test (TST) will be a residents within 72 there is a written de TST within the last contraindicated in	Tuberculosis Control Plan ident being admitted to a lity will receive a baseline g an assessment of the s for TB and any current TB dard intradermal tuberculin skir idministered to all skilled facility hours of admission, unless ocumentation of a negative three months or if writing by a physician/nurse step TST procedure will be				
	director of nursing nurse could review related to the comp and TB monitoring educated on the TB TST process. The	THOD OF CORRECTION: The (DON) and/or infection control policies and procedures conents of the infection control program. Facility staff could be B regulations and the two-step director of nursing and/or velop a monitoring system to mpliance.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
21800	MN St. Statute144 Residents of HC F	.651 Subd. 4 Patients & ac.Bill of Rights	21800			1/31/17
	residents shall, at a are legal rights for stay at the facility o treatment and main	ation about rights. Patients and admission, be told that there their protection during their or throughout their course of ntenance in the community and cribed in an accompanying				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		ATE SURVEY OMPLETED	
		00973	B. WING		01/	05/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE			
CASTLE	RIDGE CARE CENT	FR	IRIE CENTER RAIRIE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21800	Continued From pa	age 21 If the applicable rights and	21800				
	case of patients ad as defined in section statement shall als person 16 years old provided in section shall list the names individuals and org advocacy and lega residential program accommodations s communication imp speak a language of facility policies, insp local health authori the written statement to patients, resident chosen representat to the administration person, consistent	forth in this section. In the Imitted to residential programs on 253C.01, the written o describe the right of a d or older to request release as 253B.04, subdivision 2, and s and telephone numbers of anizations that provide I services for patients in ns. Reasonable shall be made for those with pairments and those who other than English. Current pection findings of state and ties, and further explanation of ent of rights shall be available its, their guardians or their tives upon reasonable request r or other designated staff with chapter 13, the Data section 626.557, relating to					
	by: Based on interview failed to provide the	ent is not met as evidenced and record review, the facility e appropriate liability and 1 of 3 residents (R64) whose e reviewed.		Corrected			
	Findings include:						
	Medicare liability and any record for the protocol notifications. The a	ords were reviewed for proper nd appeal notices. R64 lacked provision of the required dmissions director explained 1/5/16, at 11:00 a.m. the R64's					

STATE FORM

STATEMEN	DT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Multiple A. Building: _		(X3) DATE SURVEY COMPLETED 	
		00973	B. WING			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
	RIDGE CARE CENTE	625 PRA	<b>RIE CENTER</b>	DRIVE		
CASILE		EDEN PR	AIRIE, MN 55	5344		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21800	Continued From pa	age 22	21800			
	to required skilled s	vas covered by Medicare due services. R64 had a power of b handled her financial affairs.				
	R64 did not discha	R64 ended on 10/24/16, but rge from the facility until then liable for 2 days of				
	informed verbally re The AD verified the had been missed a remaining 2 days o	believed the POA had been egarding liability for coverage. proper written notifications and R64 was billed for the f her stay. The POA for R64 the facility to question the				
	Services (CMS) for Medicare Non-Cov dated 12/31/2011, a providing NOMNC. provider or health p completed copy of Non-Coverage (NC beneficiaries/enroll home health, comp rehabilitation facility	d the Centers for Medicare m Instructions for the Notice of erage (NOMNC) CMS-10123, as policy and procedure for The form read, "A Medicare blan must give an advance, the Notice of Medicare DMNC) to ees receiving skilled nursing, orehensive outpatient y, and hospice services not before the termination of				
	The administrator of review, and/or revise ensure staff are ed liability notices to p Medicare services, are communicated The administrator of	THOD OF CORRECTION: or designee could develop, se policies and procedures to ucated on the appropriate rovide residents at the end of and to ensure resident rights appropriately and acted upon. or designee could educate all n the policies and procedures.				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00973	B. WING		01/	05/2017
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
CASTLE	RIDGE CARE CENT	FB	NRIE CENTER RAIRIE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21800	Continued From pa	age 23	21800			
		The administrator or designee could develop monitoring systems to ensure ongoing compliance.				
	TIME PERIOD FOR CORRECTION: Fourteen (14) days.					