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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VUR3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00973

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245312**
2.STATE VENDOR OR MEDICAID NO.
(L2) **255342200**

3. NAME AND ADDRESS OF FACILITY
(L3) **CASTLE RIDGE CARE CENTER**
(L4) **625 PRAIRIE CENTER DRIVE**
(L5) **EDEN PRAIRIE, MN** (L6) **55344**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/23/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **60** (L18)
13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___ 1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, HFE NEII 03/29/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/01/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/27/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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

MDH
Minnesota Department of Health

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, effective February 17, 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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245312 Y1	A. Building 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).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0156	Correction	ID Prefix	F0280	Correction	ID Prefix	F0323	Correction
Reg. #	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18)	Completed	Reg. #	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)	Completed	Reg. #	483.25(d)(1)(2)(n)(1)-(3)	Completed
LSC		01/31/2017	LSC		02/10/2017	LSC		02/10/2017
ID Prefix	F0334	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	483.80(d)(1)(2)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		02/03/2017	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	GL/mm	03/29/2017	15507	02/23/2017
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
[ ]				

FOLLOWUP TO SURVEY COMPLETED ON	
1/5/2017	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245312	A. Building 01 - MAIN BUILDING 01 B. Wing	2/27/2017

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 02/17/2017	ID Prefix Reg. # NFPA 101 LSC K0712	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 Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [X]	REVIEWED BY (INITIALS) TL/mm	DATE 03/29/20017	SIGNATURE OF SURVEYOR 37009	DATE 02/27/2017
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
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?			[ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VUR3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00973

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245312**
2.STATE VENDOR OR MEDICAID NO.
(L2) **255342200**

3. NAME AND ADDRESS OF FACILITY
(L3) **CASTLE RIDGE CARE CENTER**
(L4) **625 PRAIRIE CENTER DRIVE**
(L5) **EDEN PRAIRIE, MN** (L6) **55344**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/05/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **60** (L18)
13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lisa Hakanson, HFE NEII 02/02/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/27/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

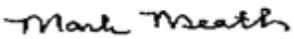
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

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

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245312	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility 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 000		
F 156 SS=D	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF 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 legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;	F 156		1/31/17

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

Electronically Signed | 01/31/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245312	A. BUILDING _____ B. WING _____	01/05/2017

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F 156	Continued From page 1 (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and	F 156		

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F 156	Continued From page 2 as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email),	F 156		

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F 156	Continued From page 3 and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.	F 156		

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F 156	Continued From page 4 (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.	F 156		

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F 156	Continued From page 5 (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the appropriate liability and appeal notices for 1 of 3 residents (R64) whose liability notices were reviewed. Findings include:	F 156	This plan of correction constitutes this facilities written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of/or agreement with the deficiencies or conclusions contained in the department inspection report.	

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F 156	Continued From page 6 Three resident records were reviewed for proper Medicare liability and appeal notices. R64 lacked any record for the provision of the required notifications. The admissions director explained in an interview on 1/5/16, at 11:00 a.m. the R64's stay in the facility was covered by Medicare due to required skilled services. R64 had a power of attorney (POA) who handled her financial affairs. Skilled services for R64 ended on 10/24/16, but R64 did not discharge from the facility until 10/26/16. R64 was then liable for 2 days of coverage. The AD stated she believed the POA had been informed verbally regarding liability for coverage. The AD verified the proper written notifications had been missed and R64 was billed for the remaining 2 days of her stay. The POA for R64 had not contacted the facility to question the billing. The facility provided the Centers for Medicare Services (CMS) form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123, dated 12/31/2011, as policy and procedure for providing NOMNC. The form read, "A Medicare provider or health plan must give an advance, completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving skilled nursing, home health, comprehensive outpatient rehabilitation facility, and hospice services not later than two days before the termination of services."	F 156	R64's skilled services ended on 10/24/16 and she discharged back to her Assisted Living on 10/26/16. The denial was not documented in writing and the billing department was not notified of skilled services ending, so R64's care for 10/25/16 was billed to Medicare. The billing department has now adjusted the claim showing her last cover day of 10/24/16. A write off was completed by the facility for the cost of R64's care for 10/25/16. Systemic changes were made to the process that is followed in regards to Medicare Denials. The Health Information Manager has been trained and educated in the denial process on 1/19/17. The Health Information Manager began taking over this process effective 1/23/17. This duty being performed by Health Information is consistent with corporate policy. In addition, the RAI coordinator for the facility has been re-educated on her role in notifying Health Information during IDT when a denial needs to be issued. The facility will identify other residents having the potential to be affected by conducting a quarterly audit during the QA meetings each quarter. This process will help the QA team monitor performance in regards to denials. The audits will be continued until 100% compliancy is met and QA team can evaluate for frequency of auditing in the future.	
F 280	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO	F 280		2/10/17

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F 280 SS=D	Continued From page 7 PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and	F 280		

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F 280	Continued From page 8 cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 280		

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F 280	Continued From page 9 assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise care plan interventions to minimize the risk for falls for 2 of 5 residents (R84, R59) reviewed for falls. Finding include: R84's care plan revised 12/22/16, revealed the resident had functional incontinence (cognitive and/or physical difficulty using toilet), "I am at risk for falls related to history of falls, impaired cognition impaired mobility, Alzheimer's dementia, anxiety, depression hallucinations, cataracts, bowel and bladder incontinence and medications...Be sure my call light is within reach and encourage me to use it. Offer toileting per schedule." The goal was that R84 would be free of falls through the review date. Interventions included checking and changing the resident's incontinence brief including at 10:00 p.m. and 4:00 a.m. and offer toileting before and after meals, activities and as needed. A risk for falls was also identified on the care plan related to a decline in activities of daily living with limited mobility and balance problems. Staff were to promote safety promote safety and prevent falls and/or injury. The most recent Minimum Data Set dated 12/12/16, identified R84 was severely cognitively impaired. He was unsteady with transferring and required extensive assistance from staff for both transferring and ambulation. The MDS noted R84 had experienced two or more falls without injury and two or more falls with minor injury.	F 280	This plan of correction constitutes this facilities written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of/or agreement with the deficiencies or conclusions contained in the department inspection report. R84 fell last on 12/11/16. He was enrolled in hospice and passed away peacefully on 1/14/17. Falls for R59 were reviewed from the last 6 months and a summary regarding fall interventions was documented in the medical record. The IDT team reviewed interventions and the care plan was updated at that time. The Care Plan Policy and Procedure will be reviewed with all IDT members with emphasis on timeliness of care plan revisions. Director of Nursing completed 1:1 education with all scheduled licensed nursing staff on the Fall Prevention and Management Program Policy. This included verbalized understanding of importance of immediate interventions and root cause analysis. In addition, audits are being completed on fall documentation with each fall. Incident reports, progress notes, care plans and team sheets will be reviewed as part of the audit to ensure all steps in the Fall Prevention Policy are completed well.	

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F 280	Continued From page 10 Resident Occurrence Reports for R84 were as follows: 1) 10/18/16, at 2:40 p.m. The report indicated the resident was found on the floor stating he needed to use the toilet, and his incontinence brief was wet. The report also indicated R84 was "usually in bed after lunch, was sitting in recliner." Although the interdisciplinary team (IDT) intervention indicated staff was to assist R84 to the toilet before and after meals. The questions "When was the last time you observed the resident?" and "When was the last time the resident was assisted to the restroom or incontinent pad changed?" were both left blank. The analysis did not include whether the toileting plan was followed or whether additional toileting was necessary in the afternoon. 2) 12/1/16, at 2:50 a.m. The report on 12/1/16 revealed R84 was found on floor at the bathroom entrance, and stated he was trying to use the toilet. When asked how he fell he stated, "I fainted." His wheelchair was at his bedside, the toilet riser and wastebasket were tipped over. R84's brief was wet and his, finger was cold and oxygen saturation registered between 78-91%. When the resident was asked what he was trying to do at the time of the fall he replied that he was tying to use the toilet. The post fall assessment indicated the resident had last been toileted or brief changed at midnight. "What suggestions do you have to prevent this from occurring again? Clip call light to Res [resident]--further investigation re: [regarding] oxygenation." The interdisciplinary team (IDT) intervention indicated the nurse practitioner (NP) ordered staff check R84's vital signs including his oxygen (O2) levels every shift and update the NP	F 280	Fall incidents will continue to be reviewed daily at IDT team meetings. Systemic changes include access to three computers during this meeting. One computer is used to update the care plan with the new fall interventions, one computer is used to update the NAR team sheets, and the third computer is used to write the IDT follow up progress note. All follow up work for the fall incident is completed by the time the IDT meeting adjourns each day. The facility plans to monitor performance by completing fall tracking reviews every month. This information along with the audits will be brought to the QA committee quarterly until 100% compliance has been determined by the QA team.	

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F 280	Continued From page 11	F 280		

with the results. Interventions did not include a root cause analysis or revisions to the resident's toileting plan.

3) 12/7/16, at 10:15 p.m.
The report indicated the resident was observed on the floor on his back during routine rounds. The wheelchair was between the bed and bathroom. R84 stated, "'I don't know'" what he was doing prior to the fall. R84's O2 saturation was between 76-83% at room air, and his brief was wet. The IDT falls follow up form indicated the NP ordered O2 at 2 liters per minute, however, the interventions did not address the resident's need for additional toileting when he was found with a wet brief.

A quarterly Fall Risk assessment dated 12/8/16, indicated R84 experienced three or more falls in the past 180 days, had poor recall, inadequate vision, and frequent incontinence, poor gait and balance, and use of non-steroidal pain and psychotropic medications. "Interventions updated on care plan included ambulating the resident 100 feet twice daily to improve strength and monitoring medications for side effects. The effectiveness of interventions read, "Will continue monitoring resident and update POC [plan of care]. Resident had last fall 12/7/16."

4) 12/11/16, at 2:30 a.m.
The report indicated R84 fell in his room and when asked what he was doing prior to the fall he replied he did not know. The report indicated R84 had been toileted at 1:45 a.m. prior this fall. He sustained skin injury "measuring 4.0 cm x 0.7 cm [centimeters]. Covered with non-adherent dressing and Tegaderm film [protective dressing]." The IDT team falls follow up

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intervention read, "Residents falls have historically been related to toileting. Resident's night toileting schedule has been updated. Resident will be offered toileting at 10 pm and 4 am." The intervention, however, did not address how the toileting times had been determined, to minimize the risk for further falls.

R84's current NA care guide directed staff to assist resident to ambulate 100 feet a day. The toileting plan did not specify times staff was to toilet R84 to minimize his risk for falls, but was generic and directed staff to toilet the resident in the morning and evening, before and after meals, activities, and as needed, and check for incontinence on night rounds.

Nursing assistant (NA)-A was interviewed regarding R84's falls on 1/4/17, at 7:25 a.m. and stated, "I remember one of the falls he was trying to go to the bathroom and fell before he reached the bathroom. He does not use the call light--that is the problem."

Licensed nurse practical (LPN)-A was interviewed on 1/5/17, at 11:45 a.m. about R84's fall occurred on 10/18/16. LPN-A stated, "We put the plan in place so that staff assist R84 to the bathroom before and after meals. He was falling because he was trying to use the bathroom." LPN-A stated the NP also added O2 (since was discontinued) since his saturations were low at the time of some of the falls. The staff was also to administer mediations as ordered and check on R84 frequently. LPN-A stated, "It is not in his care plan, but that is what we have done."

R59's care plan dated 10/24/16, indicated the resident was at risk for falling related to the use of

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE RIDGE CARE CENTER	625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

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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 impaired, 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 basis. Follow my toileting schedule. grippy socks at night, place me in middle of bed. I use a low bed related to seizures. I use grab bars on my bed to help me with repositioning. If acute change in an increase of behaviors, complete clinical assessment...."

R59's Minimum Data Set (MDS) dated 10/19/16, indicated the resident had severely impaired cognition and required extensive assistance with staff with bed mobility, transferring, toileting and dressing.

R59's 1/17, physician orders revealed diagnoses including delusional disorder, major depressive disorder, anoxic brain damage, chronic kidney disease, absence epileptic syndrome. R59's medication orders included the amoxicillin-clavulanate (antibiotic), levtiracetam (for seizures), Abilify (antipsychotic), and fluoxetine (for major depressive disorder).

R59's fall information revealed the following:

1) 10/24/16, at 6:29 a.m. progress note: "Resident noted on floor around 0340 [3:40 a.m.] When writer interviewed, resident stated, 'I did not fall. I crawled out of my bed--is dirty.' Resident denied pain, abrasions noted to right knee. ROM

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[range of motion] performed to all extremities. Resident able to move extremities w/o [without] difficulty. Denied hitting head." R59 was toileted after removed from floor.

A Resident Occurrence Reports dated 10/24/16 revealed, R59 had last been assisted to use the toilet at 9:36 p.m. however, the medical record lacked information showing the resident had been toileted between 9:36 p.m. and 3:40 a.m. (the time the resident was found on the floor).

The Fall Follow Up Intervention on 10/25/16, read "R59 was assisted to the bathroom. Care Plan updated to check and assist to toilet AM and HS [bedtime] cares, to and from meals, naps and activities, at 10-11:00 p.m. and 4-5 a.m. daily."

2) 12/15/16, at 11:11 a.m. progress note: "At 9:35 a.m. res [resident] had a witnessed fall from her w/c in the common area near nursing station. Res stated that she wanted to use the toilet." It was noted she stood up, walked forward, and then fell. Following the fall R59 was toileted and voided and had a bowel movement. It was also noted the care plan was already in place which directed staff to "check and assist to toilet AM and HS cares, to and from meals, naps and activities."

The IDT follow up fall on 12/16/16, indicated for interventions were "Bowel review and laxative dose will be reviewed and make changes PRN."

3) 12/30/16, at 6:43 a.m. progress note: "Resident observed on the floor of her room by the door sitting. Crawled from her bed to the door." When asked what was trying to do, said 'I do not know.' Was very agitated. Denied hitting

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the head against object. Loose stool noted on the floor and in her brief...brief changed and put back to bed." The fall huddle review form revealed the last time the resident had been changed was 4:45 a.m.

A progress note dated on 12/30/16, read "IDT discussed and decided to ask pharmacy to review resident's medications and give consultation on the reason for frequent bowel movements (2-3 BMs a day)."

A progress note dated on 12/30/16, indicated the pharmacist called back after reviewing resident's medication and said that only magnesium oxide 2 tabs twice daily was a concern related to loose stools and the writer planned to update the nurse practitioner.

During an interview on 1/4/16, at approximately 9:00 a.m. LPN-A explained R59's medication use had been reviewed and it was concluded they had not been administering the laxative medication. The NP was updated and she thought the resident's loose stools were not from magnesium oxide, however, LPN-A verified the facility had not completed a further assessment as to potential causal factors for falls and a revised plan developed.

The facility's 9/15, Fall Prevention and Management Program policy directed staff to determine the resident's risk for falls and to establish appropriate intervention the care plan related to fall risk in the plan of care. "Supervising personnel in delivering safe and personalized care...Members of the interdisciplinary team are responsible for assisting, treating and implementing strategies for the prevention of

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F 280	Continued From page 16 resident falls."	F 280		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care and services to minimize the risk for falls for 2 of 5 residents (R84, R59) reviewed for falls. Finding include:	F 323	This plan of correction constitutes this facilities written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of/or agreement with the deficiencies or conclusions contained in the department inspection report.	2/10/17

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F 323	Continued From page 17 R84 was observed on 1/4/17, at 7:18 a.m. while seated in his wheelchair. When asked about falls the resident did not recall experiencing any falls. At 9:41 a.m. licensed practical nurse (LPN)-A assisted R84 to bed and was provided his call light. He was not asked if he needed to use the toilet. The bathroom door was slightly ajar and the light was on. On 1/5/17, at 8:11 a.m. R84 was in bed with his eyes closed. His call light was within reach, and the bathroom door was slightly ajar and the light was on. A 9/9/16, Fall Profile Checklist at the time of R84's admission revealed R84 required hands on assistance to move from place to place. He also had problems including difficulty walking and falls with diagnoses including Alzheimer's disease, psychotic disorder with hallucinations and altered mental status. A fall Care Area Assessment (CAA) dated 9/20/16, indicated R84 had difficulty maintaining sitting balance and had impaired balance during transitions. The most recent Minimum Data Set dated 12/12/16, identified R84 was severely cognitively impaired. He was unsteady with transferring and required extensive assistance from staff for both transferring and ambulation. The MDS noted R84 had experienced two or more falls without injury and two or more falls with minor injury. R84's care plan revised 12/22/16, revealed the resident had functional incontinence (cognitive and/or physical difficulty using toilet), "I am at risk for falls related to history of falls, impaired cognition impaired mobility, Alzheimer's dementia, anxiety, depression hallucinations, cataracts, bowel and bladder incontinence and medications...Be sure my call light is within reach	F 323	R84 fell last on 12/11/16. He was enrolled in hospice and passed away peacefully on 1/14/17. Falls for R59 were reviewed from the last 6 months and a summary regarding fall interventions was documented in the medical record. The IDT team reviewed interventions and the care plan was updated at that time. Occupational therapy orders were obtained and R59 was fitted for a broda chair for comfort, positioning, and safety. Revisions were made to R64's toileting schedule and a sleep log for overnight was initiated to monitor R64's night schedule. Pharmacy conducted a medication review to assess side effects to medications related to loose stools. NP was notified of this and no changes were made. Bowel patterns were monitored and loose stools have since resolved. Director of Nursing completed 1:1 education with all scheduled licensed nursing staff on the Fall Prevention and Management Program Policy. This included verbalized understanding of importance of immediate interventions and root cause analysis. In addition, audits are being completed on fall documentation with each fall. Incident reports, progress notes, care plans and team sheets will be reviewed as part of the audit to ensure all steps in the Fall Prevention Policy are completed well. NAR team sheets were reviewed and revisions were made to ensure resident	

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F 323	Continued From page 18 and encourage me to use it. Offer toileting per schedule." The goal was that R84 would be free of falls through the review date. Interventions included checking and changing the resident's incontinence brief including at 10:00 p.m. and 4:00 a.m. and offer toileting before and after meals, activities and as needed. A risk for falls was also identified on the care plan related to a decline in activities of daily living with limited mobility and balance problems. Staff were to promote safety promote safety and prevent falls and/or injury. Resident Occurrence Reports for R84 were as follows: 1) 10/18/16, at 2:40 p.m. The report indicated the resident was found on the floor stating he needed to use the toilet, and his incontinence brief was wet. The report also indicated R84 was "usually in bed after lunch, was sitting in recliner." Although the interdisciplinary team (IDT) intervention indicated staff was to assist R84 to the toilet before and after meals. The questions "When was the last time you observed the resident?" and "When was the last time the resident was assisted to the restroom or incontinent pad changed?" were both left blank. The analysis did not include whether the toileting plan was followed or whether additional toileting was necessary in the afternoon. 2) 12/1/16, at 2:50 a.m. The report on 12/1/16 revealed R84 was found on floor at the bathroom entrance, and stated he was trying to use the toilet. When asked how he fell he stated, "I fainted." His wheelchair was at his bedside, the toilet riser and wastebasket were tipped over. R84's brief was wet and his, finger	F 323	preferences and safety interventions are properly communicated to the line staff. A new format/tool to communicate night toileting schedules has been initiated. Fall incidents will continue to be reviewed daily at IDT team meetings. Systemic changes include access to three computers during this meeting. One computer is used to update the care plan with the new fall interventions, one computer is used to update the NAR team sheets, and the third computer is used to write the IDT follow up progress note. All follow up work for the fall incident is completed by the time the IDT meeting adjourns each day. The facility plans to monitor performance by completing fall tracking reviews every month. This information along with the audits will be brought the QA committee quarterly until 100% compliance has been determined by the QA team.	

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was cold and oxygen saturation registered between 78-91%. When the resident was asked what he was trying to do at the time of the fall he replied that he was tying to use the toilet. The post fall assessment indicated the resident had last been toileted or brief changed at midnight. "What suggestions do you have to prevent this from occurring again? Clip call light to Res [resident]--further investigation re: [regarding] oxygenation." The interdisciplinary team (IDT) intervention indicated the nurse practitioner (NP) ordered staff check R84's vital signs including his oxygen (O2) levels every shift and update the NP with the results. Interventions did not include a root cause analysis or revisions to the resident's toileting plan.

3) 12/7/16, at 10:15 p.m.
The report indicated the resident was observed on the floor on his back during routine rounds. The wheelchair was between the bed and bathroom. R84 stated, "'I don't know'" what he was doing prior to the fall. R84's O2 saturation was between 76-83% at room air, and his brief was wet. The IDT falls follow up form indicated the NP ordered O2 at 2 liters per minute, however, the interventions did not address the resident's need for additional toileting when he was found with a wet brief.

A quarterly Fall Risk assessment dated 12/8/16, indicated R84 experienced three or more falls in the past 180 days, had poor recall, inadequate vision, and frequent incontinence, poor gait and balance, and use of non-steroidal pain and psychotropic medications. "Interventions updated on care plan included ambulating the resident 100 feet twice daily to improve strength and monitoring medications for side effects. The

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effectiveness of interventions read, "Will continue monitoring resident and update POC [plan of care]. Resident had last fall 12/7/16."

4) 12/11/16, at 2:30 a.m.
The report indicated R84 fell in his room and when asked what he was doing prior to the fall he replied he did not know. The report indicated R84 had been toileted at 1:45 a.m. prior this fall. He sustained skin injury "measuring 4.0 cm x 0.7 cm [centimeters]. Covered with non-adherent dressing and Tegaderm film [protective dressing]." The IDT team falls follow up intervention read, "Residents falls have historically been related to toileting. Resident's night toileting schedule has been updated. Resident will be offered toileting at 10 pm and 4 am." The intervention, however, did not address how the toileting times had been determined, to minimize the risk for further falls.

R84's current NA care guide directed staff to assist resident to ambulate 100 feet a day. The toileting plan did not specify times staff was to toilet R84 to minimize his risk for falls, but was generic and directed staff to toilet the resident in the morning and evening, before and after meals, activities, and as needed, and check for incontinence on night rounds.

Nursing assistant (NA)-A was interviewed regarding R84's falls on 1/4/17, at 7:25 a.m. and stated, "I remember one of the falls he was trying to go to the bathroom and fell before he reached the bathroom. He does not use the call light--that is the problem."

Licensed nurse practical (LPN)-A was interviewed on 1/5/17, at 11:45 a.m. about R84's fall occurred

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on 10/18/16. LPN-A stated, "We put the plan in place so that staff assist R84 to the bathroom before and after meals. He was falling because he was trying to use the bathroom." LPN-A stated the NP also added O2 (since was discontinued) since his saturations were low at the time of some of the falls. The staff was also to administer mediations as ordered and check on R84 frequently. LPN-A stated, "It is not in his care plan, but that is what we have done."

R59 was observed on 1/3/17, at 7:21 p.m. seated in a wheelchair and participating in music activity. On 1/4/17 at 7:30 a.m. R59 observed lying in bed. NA-D was with providing care assisting the resident to dress for the day. NA-D informed the surveyor the resident had been about to fall and was at the edge of the bed. R59 began resisting cares and NA-D stated, "I need to find another aide to help. [R59] is acting strange today and fighting." NA-D left the room and returned with NA-E. R59 assisted NA-D to wash and dress the resident, and to transfer her to the wheelchair and to the toilet. At 8:08 a.m. NA-F, came to resident room and assisted R59 to brush her teeth in the bathroom and then assisted the resident in her wheelchair to the dining room. R59 appeared weak and drowsy.

R59's care plan dated 10/24/16, indicated the 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 impaired, 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

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wearing appropriate footwear. Evaluate effectiveness of my interventions on an ongoing basis. Follow my toileting schedule. grippy socks at night, place me in middle of bed. I use a low bed related to seizures. I use grab bars on my bed to help me with repositioning. If acute change in an increase of behaviors, complete clinical assessment...."

A Care Area Assessment (CAAs) dated 4/27/16, revealed "Will care plan for falls. Is at risk for falls RT [related to] physical, cognitive status & use of medication. Has impaired mobility, requires use of sit to stand lift for transfer, unable to walk, requires staff support for daily ADLs [activities of daily living], use of W/C [wheelchair] for mobility. Has cognitive loss RT anoxic brain injury." It was also noted the resident utilized medication to treat psychosis, depression, and seizures. R59's most recent Minimum Data Set (MDS) dated 10/19/16, indicated the resident had severely impaired cognition and required extensive assistance with staff with bed mobility, transferring, toileting and dressing.

R59's 1/17, physician orders revealed diagnoses including delusional disorder, major depressive disorder, anoxic brain damage, chronic kidney disease, absence epileptic syndrome. R59's medication orders included the amoxicillin-clavulanate (antibiotic), levtiracetam (for seizures), Abilify (antipsychotic), and fluoxetine (for major depressive disorder).

R59's fall information revealed the following:

1) 10/24/16, at 6:29 a.m. progress note: "Resident noted on floor around 0340 [3:40 a.m.] When writer interviewed, resident stated, 'I did

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not fall. I crawled out of my bed--is dirty.' Resident denied pain, abrasions noted to right knee. ROM [range of motion] performed to all extremities. Resident able to move extremities w/o [without] difficulty. Denied hitting head." R59 was toileted after removed from floor.

A Resident Occurrence Reports dated 10/24/16 revealed, R59 had last been assisted to use the toilet at 9:36 p.m. however, the medical record lacked information showing the resident had been toileted between 9:36 p.m. and 3:40 a.m. (the time the resident was found on the floor).

The Fall Follow Up Intervention on 10/25/16, read "R59 was assisted to the bathroom. Care Plan updated to check and assist to toilet AM and HS [bedtime] cares, to and from meals, naps and activities, at 10-11:00 p.m. and 4-5 a.m. daily."

2) 12/15/16, at 11:11 a.m. progress note:
"At 9:35 a.m. res [resident] had a witnessed fall from her w/c in the common area near nursing station. Res stated that she wanted to use the toilet." It was noted she stood up, walked forward, and then fell. Following the fall R59 was toileted and voided and had a bowel movement. It was also noted the care plan was already in place which directed staff to "check and assist to toilet AM and HS cares, to and from meals, naps and activities."

The IDT follow up fall on 12/16/16, indicated for interventions were "Bowel review and laxative dose will be reviewed and make changes PRN."

3) 12/30/16, at 6:43 a.m. progress note:
"Resident observed on the floor of her room by the door sitting. Crawled from her bed to the

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door." When asked what was trying to do, said 'I do not know.' Was very agitated. Denied hitting the head against object. Loose stool noted on the floor and in her brief...brief changed and put back to bed." The fall huddle review form revealed the last time the resident had been changed was 4:45 a.m.

A progress note dated on 12/30/16, read "IDT discussed and decided to ask pharmacy to review resident's medications and give consultation on the reason for frequent bowel movements (2-3 BMs a day)."

A progress note dated on 12/30/16, indicated the pharmacist called back after reviewing resident's medication and said that only magnesium oxide 2 tabs twice daily was a concern related to loose stools and the writer planned to update the nurse practitioner.

During an interview on 1/4/16, at approximately 9:00 a.m. LPN-A explained R59's medication use had been reviewed and it was concluded they had not been administering the laxative medication. The NP was updated and she thought the resident's loose stools were not from magnesium oxide, however, LPN-A verified the facility had not completed a further assessment as to potential causal factors for falls and a revised plan developed.

The facility's 9/15, Fall Prevention and Management Program policy directed staff to determine the resident's risk for falls and to establish appropriate intervention the care plan related to fall risk in the plan of care. "Supervising personnel in delivering safe and personalized care...Members of the interdisciplinary team are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245312	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 25 responsible for assisting, treating and implementing strategies for the prevention of resident falls."	F 323		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 334		2/3/17

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F 334	Continued From page 26 (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure each resident received a pneumococcal immunization, or had documented evidence of the vaccination being contraindicated for 1 of 5 residents (R65) in the sample reviewed for immunizations.	F 334	This plan of correction constitutes this facilities written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of/or agreement with the deficiencies or conclusions contained in	

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F 334	Continued From page 27 Findings include: R65 was an 86 year old resident admitted to the facility on 8/19/16. Immunization records revealed R65 had not received pneumococcal immunization. On 1/5/17, at 8:52 a.m. the director of nursing (DON) stated R65 had not received pneumococcal vaccination "due to an oversight." The DON explained that although they had received a Pneumococcal Vaccinations Consent by R65 on 12/8/16, they failed to administer the vaccine. The DON further stated both the consent and administration of the vaccination should have been completed at the time of R65's admission in 8/16. She did not know why consent from the resident had not been obtained until 12/8/16, but said she would address the situation immediately. The facility's 5/16, Pneumococcal Vaccination Policy indicated, "Each resident's pneumococcal immunization status will be determined upon admission or soon afterwards; vaccination date (if resident received vaccination) will be documented in the resident's medical record."	F 334	the department inspection report. R64's immunization record from MICC was reviewed and the information was documented in the facility's Point Click Care system. R65 received the pneumococcal immunization per policy on 1/24/17. All current residents historical immunization records were reviewed using the MICC system and Point Click Care was updated to reflect this. Consent forms for receiving immunizations is included in the admission paperwork for all residents. The systematic process was reviewed by the Director of Nursing on 1/23/17. Through this review, the Health Information Manager was re-educated on the policy to ensure that timely immunizations are completed. The facility plans to monitor its performance by running immunization reports weekly until 100% compliant. This information will be included in the infection control section of the QA meetings each quarter.	

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	245312	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/04/2017**

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on January 04, 2017. At the time of this survey, Castle Ridge Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/01/2017

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.

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Castle Ridge Care Center is a 1-story building with no basement. The building was constructed at three different times. The original building was constructed in 1983 and was determined to be of Type V (111) construction. In 1987, an addition was constructed and was determined to be of Type V (111) construction. In 1997, an addition was constructed and was determined to be Type V (111) construction. Because the original building and the two additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully protected by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 60 beds and had a census of 54 at time of the survey.	K 000		

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	245312	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/04/2017**

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and document review, the facility did not maintain and test their automatic fire sprinkler system in accordance with NFPA 25 and the 2012 LSC NFPA 101. 9.7.5, 9.7.7, 9.7.8. This deficient practice could effect all 54 residents. Findings include: On a facility tour between the hours of 1130 and 1630 on January 04, 2017, observation revealed that the five year, automatic fire sprinkler system internal obstruction investigation was due but was	K 353	The sprinkler system internal obstruction piping inspection will be completed by 2/17/2017. In accordance with NFPA 25 (2011) and NFPA 101 (2012) all required fire systems inspections will be entered into the electronic work order system by the ESD at the proper intervals in order to generate a work order when the inspection is due. The Environmental Services Director (ESD) will ensure these inspections are completed in a timely manner. The records of the inspections will be kept available for review by the	2/17/17

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K 353	Continued From page 3 not performed. The last internal obstruction investigation was conducted on September 19, 2011 This deficient practice was verified by the director of environmental services at the time of inspection.	K 353	CMS safety inspector or the state fire marshal's representative in the ESD office.	
K 712 SS=C	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility could not provide documentation that fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2012 NFPA 101, Section 19.7.1.4. through 19.7.1.7. This deficient practice could affect all 54 residents. Findings include: On a facility tour between the hours of 1130 and	K 712	Fire drills will be conducted as required by NFPA 101 (2012. A fire drill schedule will be entered into the electronic work order system by the ESD at the required intervals to generate a work order when the fire drill is due. The ESD or his proxy will conduct the fire drill in a timely manner. Fire drill reports will be reviewed by the QA committee quarterly and safety committee annually to ensure compliance. The Campus Administrator will be responsible to ensure compliance in the	2/1/17

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K 712	Continued From page 4 1630 on January 04, 2017, observation revealed that the facility could not provide documentation for conducting fire drill for the first shift during the third quarter of 2016, the second shift during the second quarter of 2016 and the third shift during the second quarter of 2016. This deficient practice was verified by the director of environmental services at the time of inspection.	K 712	event of the ESD's absence.	

Minnesota Department of Health

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00973	A. BUILDING: _____ 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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 1/3/17, 1/4/17 and 1/5/17 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to revise care plan interventions to minimize the risk for falls for 2 of 5 residents (R84, R59) reviewed for falls. Finding include: R84's care plan revised 12/22/16, revealed the resident had functional incontinence (cognitive and/or physical difficulty using toilet), "I am at risk for falls related to history of falls, impaired cognition impaired mobility, Alzheimer's dementia, anxiety, depression hallucinations, cataracts, bowel and bladder incontinence and medications...Be sure my call light is within reach	2 570	Corrected	2/10/17

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CASTLE RIDGE CARE CENTER	625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

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2 570	Continued From page 3 and encourage me to use it. Offer toileting per schedule." The goal was that R84 would be free of falls through the review date. Interventions included checking and changing the resident's incontinence brief including at 10:00 p.m. and 4:00 a.m. and offer toileting before and after meals, activities and as needed. A risk for falls was also identified on the care plan related to a decline in activities of daily living with limited mobility and balance problems. Staff were to promote safety promote safety and prevent falls and/or injury. The most recent Minimum Data Set dated 12/12/16, identified R84 was severely cognitively impaired. He was unsteady with transferring and required extensive assistance from staff for both transferring and ambulation. The MDS noted R84 had experienced two or more falls without injury and two or more falls with minor injury. Resident Occurrence Reports for R84 were as follows: 1) 10/18/16, at 2:40 p.m. The report indicated the resident was found on the floor stating he needed to use the toilet, and his incontinence brief was wet. The report also indicated R84 was "usually in bed after lunch, was sitting in recliner." Although the interdisciplinary team (IDT) intervention indicated staff was to assist R84 to the toilet before and after meals. The questions "When was the last time you observed the resident?" and "When was the last time the resident was assisted to the restroom or incontinent pad changed?" were both left blank. The analysis did not include whether the toileting plan was followed or whether additional toileting was necessary in the afternoon.	2 570		

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	00973	A. BUILDING: _____ B. WING _____	01/05/2017

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2 570	Continued From page 4 2) 12/1/16, at 2:50 a.m. The report on 12/1/16 revealed R84 was found on floor at the bathroom entrance, and stated he was trying to use the toilet. When asked how he fell he stated, "I fainted." His wheelchair was at his bedside, the toilet riser and wastebasket were tipped over. R84's brief was wet and his, finger was cold and oxygen saturation registered between 78-91%. When the resident was asked what he was trying to do at the time of the fall he replied that he was tying to use the toilet. The post fall assessment indicated the resident had last been toileted or brief changed at midnight. "What suggestions do you have to prevent this from occurring again? Clip call light to Res [resident]--further investigation re: [regarding] oxygenation." The interdisciplinary team (IDT) intervention indicated the nurse practitioner (NP) ordered staff check R84's vital signs including his oxygen (O2) levels every shift and update the NP with the results. Interventions did not include a root cause analysis or revisions to the resident's toileting plan. 3) 12/7/16, at 10:15 p.m. The report indicated the resident was observed on the floor on his back during routine rounds. The wheelchair was between the bed and bathroom. R84 stated, "'I don't know'" what he was doing prior to the fall. R84's O2 saturation was between 76-83% at room air, and his brief was wet. The IDT falls follow up form indicated the NP ordered O2 at 2 liters per minute, however, the interventions did not address the resident's need for additional toileting when he was found with a wet brief. A quarterly Fall Risk assessment dated 12/8/16, indicated R84 experienced three or more falls in the past 180 days, had poor recall, inadequate	2 570		

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2 570	Continued From page 5 vision, and frequent incontinence, poor gait and balance, and use of non-steroidal pain and psychotropic medications. "Interventions updated on care plan included ambulating the resident 100 feet twice daily to improve strength and monitoring medications for side effects. The effectiveness of interventions read, "Will continue monitoring resident and update POC [plan of care]. Resident had last fall 12/7/16." 4) 12/11/16, at 2:30 a.m. The report indicated R84 fell in his room and when asked what he was doing prior to the fall he replied he did not know. The report indicated R84 had been toileted at 1:45 a.m. prior this fall. He sustained skin injury "measuring 4.0 cm x 0.7 cm [centimeters]. Covered with non-adherent dressing and Tegaderm film [protective dressing]." The IDT team falls follow up intervention read, "Residents falls have historically been related to toileting. Resident's night toileting schedule has been updated. Resident will be offered toileting at 10 pm and 4 am." The intervention, however, did not address how the toileting times had been determined, to minimize the risk for further falls. R84's current NA care guide directed staff to assist resident to ambulate 100 feet a day. The toileting plan did not specify times staff was to toilet R84 to minimize his risk for falls, but was generic and directed staff to toilet the resident in the morning and evening, before and after meals, activities, and as needed, and check for incontinence on night rounds. Nursing assistant (NA)-A was interviewed regarding R84's falls on 1/4/17, at 7:25 a.m. and stated, "I remember one of the falls he was trying to go to the bathroom and fell before he reached	2 570		

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2 570	Continued From page 6 the bathroom. He does not use the call light--that is the problem." Licensed nurse practical (LPN)-A was interviewed on 1/5/17, at 11:45 a.m. about R84's fall occurred on 10/18/16. LPN-A stated, "We put the plan in place so that staff assist R84 to the bathroom before and after meals. He was falling because he was trying to use the bathroom." LPN-A stated the NP also added O2 (since was discontinued) since his saturations were low at the time of some of the falls. The staff was also to administer mediations as ordered and check on R84 frequently. LPN-A stated, "It is not in his care plan, but that is what we have done." R59's care plan dated 10/24/16, indicated the 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 impaired, 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 basis. Follow my toileting schedule. grippy socks at night, place me in middle of bed. I use a low bed related to seizures. I use grab bars on my bed to help me with repositioning. If acute change in an increase of behaviors, complete clinical assessment...." R59's Minimum Data Set (MDS) dated 10/19/16, indicated the resident had severely impaired cognition and required extensive assistance with staff with bed mobility, transferring, toileting and dressing.	2 570		

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2 570	Continued From page 7 R59's 1/17, physician orders revealed diagnoses including delusional disorder, major depressive disorder, anoxic brain damage, chronic kidney disease, absence epileptic syndrome. R59's medication orders included the amoxicillin-clavulanate (antibiotic), levtiracetam (for seizures), Abilify (antipsychotic), and fluoxetine (for major depressive disorder). R59's fall information revealed the following: 1) 10/24/16, at 6:29 a.m. progress note: "Resident noted on floor around 0340 [3:40 a.m.] When writer interviewed, resident stated, 'I did not fall. I crawled out of my bed--is dirty.' Resident denied pain, abrasions noted to right knee. ROM [range of motion] performed to all extremities. Resident able to move extremities w/o [without] difficulty. Denied hitting head." R59 was toileted after removed from floor. A Resident Occurrence Reports dated 10/24/16 revealed, R59 had last been assisted to use the toilet at 9:36 p.m. however, the medical record lacked information showing the resident had been toileted between 9:36 p.m. and 3:40 a.m. (the time the resident was found on the floor). The Fall Follow Up Intervention on 10/25/16, read "R59 was assisted to the bathroom. Care Plan updated to check and assist to toilet AM and HS [bedtime] cares, to and from meals, naps and activities, at 10-11:00 p.m. and 4-5 a.m. daily." 2) 12/15/16, at 11:11 a.m. progress note: "At 9:35 a.m. res [resident] had a witnessed fall from her w/c in the common area near nursing station. Res stated that she wanted to use the toilet." It was noted she stood up, walked forward,	2 570		

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2 570	Continued From page 8 and then fell. Following the fall R59 was toileted and voided and had a bowel movement. It was also noted the care plan was already in place which directed staff to "check and assist to toilet AM and HS cares, to and from meals, naps and activities." The IDT follow up fall on 12/16/16, indicated for interventions were "Bowel review and laxative dose will be reviewed and make changes PRN." 3) 12/30/16, at 6:43 a.m. progress note: "Resident observed on the floor of her room by the door sitting. Crawled from her bed to the door." When asked what was trying to do, said 'I do not know.' Was very agitated. Denied hitting the head against object. Loose stool noted on the floor and in her brief...brief changed and put back to bed." The fall huddle review form revealed the last time the resident had been changed was 4:45 a.m. A progress note dated on 12/30/16, read "IDT discussed and decided to ask pharmacy to review resident's medications and give consultation on the reason for frequent bowel movements (2-3 BMs a day)." A progress note dated on 12/30/16, indicated the pharmacist called back after reviewing resident's medication and said that only magnesium oxide 2 tabs twice daily was a concern related to loose stools and the writer planned to update the nurse practitioner. During an interview on 1/4/16, at approximately 9:00 a.m. LPN-A explained R59's medication use had been reviewed and it was concluded they had not been administering the laxative medication. The NP was updated and she	2 570		

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2 570	Continued From page 9 thought the resident's loose stools were not from magnesium oxide, however, LPN-A verified the facility had not completed a further assessment as to potential causal factors for falls and a revised plan developed. The facility's 9/15, Fall Prevention and Management Program policy directed staff to determine the resident's risk for falls and to establish appropriate intervention the care plan related to fall risk in the plan of care. "Supervising personnel in delivering safe and personalized care...Members of the interdisciplinary team are responsible for assisting, treating and implementing strategies for the prevention of resident falls." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and	2 830		2/10/17

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2 830	Continued From page 10 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care and services to minimize the risk for falls for 2 of 5 residents (R84, R59) reviewed for falls. Finding include: R84 was observed on 1/4/17, at 7:18 a.m. while seated in his wheelchair. When asked about falls the resident did not recall experiencing any falls. At 9:41 a.m. licensed practical nurse (LPN)-A assisted R84 to bed and was provided his call light. He was not asked if he needed to use the toilet. The bathroom door was slightly ajar and the light was on. On 1/5/17, at 8:11 a.m. R84 was in bed with his eyes closed. His call light was within reach, and the bathroom door was slightly ajar and the light was on. A 9/9/16, Fall Profile Checklist at the time of R84's admission revealed R84 required hands on assistance to move from place to place. He also had problems including difficulty walking and falls with diagnoses including Alzheimer's disease, psychotic disorder with hallucinations and altered mental status. A fall Care Area Assessment (CAA) dated 9/20/16, indicated R84 had difficulty maintaining sitting balance and had impaired balance during transitions.	2 830	Corrected	

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2 830	Continued From page 11 The most recent Minimum Data Set dated 12/12/16, identified R84 was severely cognitively impaired. He was unsteady with transferring and required extensive assistance from staff for both transferring and ambulation. The MDS noted R84 had experienced two or more falls without injury and two or more falls with minor injury. R84's care plan revised 12/22/16, revealed the resident had functional incontinence (cognitive and/or physical difficulty using toilet), "I am at risk for falls related to history of falls, impaired cognition impaired mobility, Alzheimer's dementia, anxiety, depression hallucinations, cataracts, bowel and bladder incontinence and medications...Be sure my call light is within reach and encourage me to use it. Offer toileting per schedule." The goal was that R84 would be free of falls through the review date. Interventions included checking and changing the resident's incontinence brief including at 10:00 p.m. and 4:00 a.m. and offer toileting before and after meals, activities and as needed. A risk for falls was also identified on the care plan related to a decline in activities of daily living with limited mobility and balance problems. Staff were to promote safety promote safety and prevent falls and/or injury. Resident Occurrence Reports for R84 were as follows: 1) 10/18/16, at 2:40 p.m. The report indicated the resident was found on the floor stating he needed to use the toilet, and his incontinence brief was wet. The report also indicated R84 was "usually in bed after lunch, was sitting in recliner." Although the interdisciplinary team (IDT) intervention indicated staff was to assist R84 to the toilet before and	2 830		

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2 830	Continued From page 12 after meals. The questions "When was the last time you observed the resident?" and "When was the last time the resident was assisted to the restroom or incontinent pad changed?" were both left blank. The analysis did not include whether the toileting plan was followed or whether additional toileting was necessary in the afternoon. 2) 12/1/16, at 2:50 a.m. The report on 12/1/16 revealed R84 was found on floor at the bathroom entrance, and stated he was trying to use the toilet. When asked how he fell he stated, "I fainted." His wheelchair was at his bedside, the toilet riser and wastebasket were tipped over. R84's brief was wet and his, finger was cold and oxygen saturation registered between 78-91%. When the resident was asked what he was trying to do at the time of the fall he replied that he was tying to use the toilet. The post fall assessment indicated the resident had last been toileted or brief changed at midnight. "What suggestions do you have to prevent this from occurring again? Clip call light to Res [resident]--further investigation re: [regarding] oxygenation." The interdisciplinary team (IDT) intervention indicated the nurse practitioner (NP) ordered staff check R84's vital signs including his oxygen (O2) levels every shift and update the NP with the results. Interventions did not include a root cause analysis or revisions to the resident's toileting plan. 3) 12/7/16, at 10:15 p.m. The report indicated the resident was observed on the floor on his back during routine rounds. The wheelchair was between the bed and bathroom. R84 stated, "'I don't know'" what he was doing prior to the fall. R84's O2 saturation was between 76-83% at room air, and his brief	2 830		

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2 830	Continued From page 13 was wet. The IDT falls follow up form indicated the NP ordered O2 at 2 liters per minute, however, the interventions did not address the resident's need for additional toileting when he was found with a wet brief. A quarterly Fall Risk assessment dated 12/8/16, indicated R84 experienced three or more falls in the past 180 days, had poor recall, inadequate vision, and frequent incontinence, poor gait and balance, and use of non-steroidal pain and psychotropic medications. "Interventions updated on care plan included ambulating the resident 100 feet twice daily to improve strength and monitoring medications for side effects. The effectiveness of interventions read, "Will continue monitoring resident and update POC [plan of care]. Resident had last fall 12/7/16." 4) 12/11/16, at 2:30 a.m. The report indicated R84 fell in his room and when asked what he was doing prior to the fall he replied he did not know. The report indicated R84 had been toileted at 1:45 a.m. prior this fall. He sustained skin injury "measuring 4.0 cm x 0.7 cm [centimeters]. Covered with non-adherent dressing and Tegaderm film [protective dressing]." The IDT team falls follow up intervention read, "Residents falls have historically been related to toileting. Resident's night toileting schedule has been updated. Resident will be offered toileting at 10 pm and 4 am." The intervention, however, did not address how the toileting times had been determined, to minimize the risk for further falls. R84's current NA care guide directed staff to assist resident to ambulate 100 feet a day. The toileting plan did not specify times staff was to toilet R84 to minimize his risk for falls, but was	2 830		

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2 830	Continued From page 14 generic and directed staff to toilet the resident in the morning and evening, before and after meals, activities, and as needed, and check for incontinence on night rounds. Nursing assistant (NA)-A was interviewed regarding R84's falls on 1/4/17, at 7:25 a.m. and stated, "I remember one of the falls he was trying to go to the bathroom and fell before he reached the bathroom. He does not use the call light--that is the problem." Licensed nurse practical (LPN)-A was interviewed on 1/5/17, at 11:45 a.m. about R84's fall occurred on 10/18/16. LPN-A stated, "We put the plan in place so that staff assist R84 to the bathroom before and after meals. He was falling because he was trying to use the bathroom." LPN-A stated the NP also added O2 (since was discontinued) since his saturations were low at the time of some of the falls. The staff was also to administer mediations as ordered and check on R84 frequently. LPN-A stated, "It is not in his care plan, but that is what we have done." R59 was observed on 1/3/17, at 7:21 p.m. seated in a wheelchair and participating in music activity. On 1/4/17 at 7:30 a.m. R59 observed lying in bed. NA-D was with providing care assisting the resident to dress for the day. NA-D informed the surveyor the resident had been about to fall and was at the edge of the bed. R59 began resisting cares and NA-D stated, "I need to find another aide to help. [R59] is acting strange today and fighting." NA-D left the room and returned with NA-E. R59 assisted NA-D to wash and dress the resident, and to transfer her to the wheelchair and to the toilet. At 8:08 a.m. NA-F, came to resident room and assisted R59 to brush her teeth in the bathroom and then assisted the resident in her	2 830		

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2 830	Continued From page 15 wheelchair to the dining room. R59 appeared weak and drowsy. R59's care plan dated 10/24/16, indicated the 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 impaired, 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 basis. Follow my toileting schedule. grippy socks at night, place me in middle of bed. I use a low bed related to seizures. I use grab bars on my bed to help me with repositioning. If acute change in an increase of behaviors, complete clinical assessment...." A Care Area Assessment (CAAs) dated 4/27/16, revealed "Will care plan for falls. Is at risk for falls RT [related to] physical, cognitive status & use of medication. Has impaired mobility, requires use of sit to stand lift for transfer, unable to walk, requires staff support for daily ADLs [activities of daily living], use of W/C [wheelchair] for mobility. Has cognitive loss RT anoxic brain injury." It was also noted the resident utilized medication to treat psychosis, depression, and seizures. R59's most recent Minimum Data Set (MDS) dated 10/19/16, indicated the resident had severely impaired cognition and required extensive assistance with staff with bed mobility, transferring, toileting and dressing. R59's 1/17, physician orders revealed diagnoses including delusional disorder, major depressive	2 830		

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	00973	A. BUILDING: _____ B. WING _____	01/05/2017

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2 830	Continued From page 16 disorder, anoxic brain damage, chronic kidney disease, absence epileptic syndrome. R59's medication orders included the amoxicillin-clavulanate (antibiotic), levtiracetam (for seizures), Abilify (antipsychotic), and fluoxetine (for major depressive disorder). R59's fall information revealed the following: 1) 10/24/16, at 6:29 a.m. progress note: "Resident noted on floor around 0340 [3:40 a.m.] When writer interviewed, resident stated, 'I did not fall. I crawled out of my bed--is dirty.' Resident denied pain, abrasions noted to right knee. ROM [range of motion] performed to all extremities. Resident able to move extremities w/o [without] difficulty. Denied hitting head." R59 was toileted after removed from floor. A Resident Occurrence Reports dated 10/24/16 revealed, R59 had last been assisted to use the toilet at 9:36 p.m. however, the medical record lacked information showing the resident had been toileted between 9:36 p.m. and 3:40 a.m. (the time the resident was found on the floor). The Fall Follow Up Intervention on 10/25/16, read "R59 was assisted to the bathroom. Care Plan updated to check and assist to toilet AM and HS [bedtime] cares, to and from meals, naps and activities, at 10-11:00 p.m. and 4-5 a.m. daily." 2) 12/15/16, at 11:11 a.m. progress note: "At 9:35 a.m. res [resident] had a witnessed fall from her w/c in the common area near nursing station. Res stated that she wanted to use the toilet." It was noted she stood up, walked forward, and then fell. Following the fall R59 was toileted and voided and had a bowel movement. It was also noted the care plan was already in place	2 830		

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2 830	Continued From page 17 which directed staff to "check and assist to toilet AM and HS cares, to and from meals, naps and activities." The IDT follow up fall on 12/16/16, indicated for interventions were "Bowel review and laxative dose will be reviewed and make changes PRN." 3) 12/30/16, at 6:43 a.m. progress note: "Resident observed on the floor of her room by the door sitting. Crawled from her bed to the door." When asked what was trying to do, said 'I do not know.' Was very agitated. Denied hitting the head against object. Loose stool noted on the floor and in her brief...brief changed and put back to bed." The fall huddle review form revealed the last time the resident had been changed was 4:45 a.m. A progress note dated on 12/30/16, read "IDT discussed and decided to ask pharmacy to review resident's medications and give consultation on the reason for frequent bowel movements (2-3 BMs a day)." A progress note dated on 12/30/16, indicated the pharmacist called back after reviewing resident's medication and said that only magnesium oxide 2 tabs twice daily was a concern related to loose stools and the writer planned to update the nurse practitioner. During an interview on 1/4/16, at approximately 9:00 a.m. LPN-A explained R59's medication use had been reviewed and it was concluded they had not been administering the laxative medication. The NP was updated and she thought the resident's loose stools were not from magnesium oxide, however, LPN-A verified the facility had not completed a further assessment	2 830		

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2 830	Continued From page 18 as to potential causal factors for falls and a revised plan developed. The facility's 9/15, Fall Prevention and Management Program policy directed staff to determine the resident's risk for falls and to establish appropriate intervention the care plan related to fall risk in the plan of care. "Supervising personnel in delivering safe and personalized care...Members of the interdisciplinary team are responsible for assisting, treating and implementing strategies for the prevention of resident falls." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to minimizing risk for falls. The DON or designee, could provide training for all nursing staff related to minmizing risk for falls. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and	21426		1/30/17

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21426	Continued From page 19 unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculin skin testing (TST) was administered as required for one of five residents (R65) reviewed for tuberculosis prevention. Findings include: The CDC [Centers for Disease Control] Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Settings, 2005, directed all residents must receive a baseline tuberculosis (TB) screening within 72 hours of admission or within three months prior to admission. The screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms. R65 was admitted to the facility on 8/19/16. The first step TST was administered on 8/26/16, however, the record lacked documentation a second step test was administered. On 1/5/17, at 8:52 a.m. the director of nursing (DON) explained R65 did not receive her second	21426	Corrected	

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21426	Continued From page 20 step Mantoux because, "We missed it. We will start over and do [R65's] TB testing today." The facility's 4/16, Tuberculosis Control Plan directed "Each resident being admitted to a skilled nursing facility will receive a baseline screening including an assessment of the resident risk factors for TB and any current TB symptoms. A standard intradermal tuberculin skin test (TST) will be administered to all skilled facility residents within 72 hours of admission, unless there is a written documentation of a negative TST within the last three months or if contraindicated in writing by a physician/nurse practitioner. A two step TST procedure will be followed." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or infection control nurse could review policies and procedures related to the components of the infection control and TB monitoring program. Facility staff could be educated on the TB regulations and the two-step TST process. The director of nursing and/or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying	21800		1/31/17

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21800	Continued From page 21 written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide the appropriate liability and appeal notices for 1 of 3 residents (R64) whose liability notices were reviewed. Findings include: Three resident records were reviewed for proper Medicare liability and appeal notices. R64 lacked any record for the provision of the required notifications. The admissions director explained in an interview on 1/5/16, at 11:00 a.m. the R64's	21800	Corrected	

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21800	Continued From page 22 stay in the facility was covered by Medicare due to required skilled services. R64 had a power of attorney (POA) who handled her financial affairs. Skilled services for R64 ended on 10/24/16, but R64 did not discharge from the facility until 10/26/16. R64 was then liable for 2 days of coverage. The AD stated she believed the POA had been informed verbally regarding liability for coverage. The AD verified the proper written notifications had been missed and R64 was billed for the remaining 2 days of her stay. The POA for R64 had not contacted the facility to question the billing. The facility provided the Centers for Medicare Services (CMS) form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123, dated 12/31/2011, as policy and procedure for providing NOMNC. The form read, "A Medicare provider or health plan must give an advance, completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving skilled nursing, home health, comprehensive outpatient rehabilitation facility, and hospice services not later than two days before the termination of services." SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure staff are educated on the appropriate liability notices to provide residents at the end of Medicare services, and to ensure resident rights are communicated appropriately and acted upon. The administrator or designee could educate all appropriate staff on the policies and procedures.	21800		

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21800	Continued From page 23 The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21800		