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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: WCGU
Facility ID: 00208

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **24E150**

2. STATE VENDOR OR MEDICAID NO. (L2) **950842200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRAND AVENUE REST HOME**
(L4) **3956 GRAND AVENUE S0UTH**
(L5) **MINNEAPOLIS, MN** (L6) **55409**

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 **9/6/2016** (L34)

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

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

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

* Code: A,8 (L12)

12.Total Facility Beds **20** (L18)

13.Total Certified Beds **20** (L17)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		20		
(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):
Facility's request for continuing waivers involving tag 0458 (Bedrooms measure at least 70 sq ft) has been approved.

17. SURVEYOR SIGNATURE Date :
Carrie Euerle, HFE NE II 9/20/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 9/20/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/31/1974** (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. (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **06/24/2016** (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 24E150

September 20, 2016

Mr. Allen Soderbeck, Administrator
Grand Avenue Rest Home
3956 Grand Avenue South
Minneapolis, MN 55409

Dear Mr. Soderbeck:

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 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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective September 6, 2016 the above facility is certified for:

20 Nursing Facility I Beds

Your request for waiver of F0458 (room size waiver) has been approved based on the submitted documentation.

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 Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions about this electronic notice.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 20, 2016

Mr. Allen Soderbeck, Administrator
Grand Avenue Rest Home
3956 Grand Avenue South
Minneapolis, MN 55409

RE: Project Number Project Number SE150025 and Complaint Number HE150007

Dear Mr. Soderbeck:

On May 4, 2016 we informed you that the following Category 1 remedy is being imposed:

- State Monitoring effective May 28, 2016. (42 CFR 488.422)

In addition, on July 8, 2016 we informed you that the following enforcement remedy would be imposed:

- Mandatory denial of payment for new Medicaid admissions effective July 18, 2016, 2016. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on April 18, 2016, and failure to achieve substantial compliance by July 1, 2016 when the Department of Health, Office of Health Facility Complaints completed an abbreviated standard survey. The most serious deficiencies at the time of the Abbreviated Standard Survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 6, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on June 30, 2016 and the abbreviated standard survey completed on July 1, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 6, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on June 30, 2016, and the abbreviated standard survey, completed on July 1, 2016 as of September 6, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 6, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of June 21, 2016. The CMS Region V Office concurs and has

authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicaid admissions, effective July 18, 2016, be discontinued, effective September 6, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective July 14, 2016, is to be discontinued.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

As we notified you in our letter of May 4, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 18, 2016.

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.

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
85 East Seventh Place, Suite 220
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
24E150		9/6/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409

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 F0465 Reg. # 483.70(h) LSC	Correction Completed 09/06/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GD/kfd	DATE 9/20/2016	SIGNATURE OF SURVEYOR 33560	DATE 9/6/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/1/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING _______ B. WING _______	C 07/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	**3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409**

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #HE150007. As a result, the following deficiencies are issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a clean and sanitary environment in the dining room, day room, smoke room, and hallways. In addition, the facility failed to ensure the room of one of one residents (R1) reviewed was kept clean and free of odors. Findings include: On 6/7/16, at 10:10 a.m. the following observations were made: -In the dining room a dirty and dusty air condition was located above a dining table. The fireplace was covered in dust and was next to another table. A thick layer of dust and dirt laid on and under the heat register, on top of the outlets and electrical cords. A dead bug laid on a window sill	F 465	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any fasts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the facility has prepared this Plan of Correction prior to the resolution of the dispute resolution process. The Plan of Correction must be filed because	8/31/16

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

Electronically Signed — 07/20/2016

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

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F 465	Continued From page 1 and a live spider and spider web were on the floor underneath the window sill. -On the stairway leading to the second level there was a large, thick, cobweb hanging down from the ceiling along with smaller cobwebs. -The day room had surface dust on the woodwork and covering the upright scale, and layers of dirt and dust were present along the baseboards. The fluorescent light in the room was full of dead bugs and black spots and the two cloth chairs and carpet had stains. -The smoke room had a thick layer of dust and dirt on and suspended from the three electrical cords hanging across a wall. Layers of dust and dirt were on and under the heat register, on top of the window, the window sill, blinds, and along the baseboards and smoke vent. All four walls were dirty and stained. -R1's room had an odor and there were layers of dust and dirt on the floor, along the baseboards and on the headboard. Cobwebs hung from the ceiling above the bed. A broken dresser with no drawers sat next to the bed. Mobility in the room was restricted by stacked boxes and belongings. -The fluorescent ceiling light in the front door entry was full of dead bugs and black flecks. The survey book kept in the front entry was covered in a layer of dust. Surface dust and dirty carpets were observed throughout both the first and second floors of the facility. On 6/7/16, at 2:40 p.m. the social service designee (SSD) stated the housekeeper was responsible for maintaining the environment.	F 465	of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the delivery of the CMS-2567 allegations of deficiencies as a condition to participate in the program even if a the facility disputes any of the information. The facility has requested the informal dispute resolution process regarding this cited deficiency. This Plan of Correction is submitted as the facility’s credible allegation of compliance. To assure compliance with this the following plan has been put into place. We have discussed the findings with the housekeeper and have discussed the expectations of what “clean” is and have reviewed and retrained on the cleaning policies. Housekeeping will clean the entire facility with a new view on cleaning and will be cleaned to the Administrators standard according to the updated checklist. This will be completed by the date listed. Resident R1 lives in a single room and has a long history of depression. Part of this is the amount of belongings she has in the room. She has for a long time asked to clean her own room so she would not have to move or find another storage location for the cluttered belongings. This was documented in the individual resident care plan. Acknowledging that she is not able to clean the room adequately, we have implemented some interventions that we are working with her to clean her room. Half of the room has been uncluttered and cleaned. After lengthy discussions with	

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F 465	Continued From page 2 During the environmental tour conducted on 6/7/16, at 2:45 p.m. the housekeeper (H) confirmed the large cobweb in the stairway, and stated she notified the SSD about it last week because she couldn't reach it to remove it. Housekeeper (H) confirmed the dirty carpet in the dayroom stating she only has time to clean it once a year. In R1's bedroom, R1 stated she was working on getting rid of the broken dresser along with some of the boxes she had stacked in the room. Housekeeper (H) stated the dresser fell apart six months ago and then abruptly ended the tour. The environmental tour continued with the SSD on 6/7/16, from 3:00-3:20 p.m. The SSD confirmed the cobweb in the stairway and stated she informed the administrator about it week or so ago. While with R1 in her room SSD sharply stated, R1 finally emptied the dresser drawers and they planned to get rid of the broken dresser this afternoon. R1 became upset and started crying. The administrator entered the resident's room, the SSD looked at R1 and sternly stated, you were told two weeks ago to clean this place up. As the tour continued the administrator denied knowing about the cobweb in the stairway, and stated if he had noticed the fluorescent light full of dead bugs in the day room he would have cleaned it. While inspecting the smoke room the administrator verified the dirty, dusty vent and stated he cleans the vent weekly. An undated form titled Grand Avenue Residence Daily Housekeeping Routines indicated: *8 Clean dayroom (upstairs smoking area). a. wash ashtrays b. wipe down tables, chairs, furniture,	F 465	the resident and after involving the family for assistance and storage, housekeeping has taken over cleaning her room on the side that is uncluttered. Resident R1 has allowed her family to assist and we are making faster progress on the other half of the room but will keep to the care plan of at least one box per week. Going too fast puts the resident at risk. Much has been done and we will continue to work with the resident and family to unclutter the other side of the room also so housekeeping can take over cleaning that side too. At the end of the entire process, housekeeping will have taken over cleaning the entire room and resident will be involved in cleaning. To address housekeeping through the entire facility which affects all residents, we have reviewed and modified the cleaning task schedules. To be able to do this, we have increase housekeeping hours by 15%. Each room will be thoroughly cleaned weekly. To do this, we are enforcing the resident policies that limit the amount of belongings and where the belongings can be stored so cleaning is possible. With this change, the beds can be more easily moved to clean under and behind them. We are working with each resident on this. In addition, we have removed carpet cleaning from the housekeeping responsibilities. The facility has carpeting throughout the entire facility except for the office, bathrooms and the dining room. Housekeeping will be responsible for spills and spot stain clean up, but we are now contracting with a commercial carpet	

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F 465	Continued From page 3 pictures, baseboards, etc. c. vacuum *11 Dust dining room and living room. Clean mirrors, buffet, windows, glass, baseboards, tables, chairs, furniture, etc. *12 Vacuum throughout house, upstairs, downstairs, hallway stairs and offices. A form titled Grand Avenue Residence Weekly Housekeeping Routines last updated 2/12/09, indicated: Monday 1. Thoroughly clean bedrooms 102, 103. 2. Stock linens in upstairs closet. 3. Clean dining room baseboards after mopping. Tuesday 1. Thoroughly clean bedroom 201. 2. Clean privacy room. 3. Clean office. 4. Sweep porch (on warmer days). Wednesday 1. Thoroughly clean bedroom 202. 2. Vacuum stairs going from 1st to 2nd floor, wipe down handrails, baseboards, walls, etc. 3. Mop basement (Laundry room and hallway back to storage rooms). 4. Clean stairway from kitchen to basement. Thursday 1. Thoroughly clean bedrooms 203, 204. 2. First floor linen exchange (flat, fitted, pillowcase). 3. Clean front door and side door entryways/hallways including baseboards, handrails, pictures, windows, etc.	F 465	cleaning service to clean all of the carpeting. The Administrator will monitor this with a walk through of the entire facility with the housekeeper every other week. We created a detailed walkthrough checklist so that items are not missed during the walk through. Areas of concern will be noted and followed before the next walk through. The walkthrough checklists will be filed in housekeeping.	

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F 465	Continued From page 4 Friday 1. Thoroughly clean bedroom 101. 2. Second floor linen exchange (flat, fitted, pillowcase). 3. Dust with feather duster where wall meets ceiling throughout house, also lights, fixtures & mini-blinds, above window ledges, sprinkler heads, moldings. Thoroughly cleaning rooms includes: Vacuuming, dusting walls, baseboards, fixtures, pipes, pull out furniture and vacuum, clean mirrors, pictures, overhead bed lights, etc.). Wipe windows, clean glass. A form titled Grand Avenue Residence Monthly Housekeeping Routines 2016, last updated 3/21/01, indicated: Duties: *Clean chairs and tables used for meals; legs, arms, sides & underneath. Date last cleaned 5/16. *Change vacuum cleaner bags (or sooner if needed). Date last completed 5/17. *Clean soiled linen hampers. Date last cleaned 5/18. *Clean lint from top & bottom of dryer. Date last cleaned 5/19 *Wash all bedspreads & blankets on residents' beds. Date last washed 5/20. *Pull all strings on call systems to make sure working properly. Dated last completed 5/19. *Wash dayroom curtains and blinds. Dated last washed 5/20. *Change and wash 2nd floor bathroom. Privacy curtain. Date last completed 5/21. *Wipe pull cords with sanitizing cleaner. Date last cleaned 5/22. A form titled Grand Avenue Residence 6 Month	F 465		

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F 465	Continued From page 5	F 465		

Chart for Housekeeping 2016, last updated 3/21/01, indicated:
Duties: *Dust & scrub windowsills & casings. Date last dusted 1/13.
*Dust bed frames & mattresses. Date last dusted 5/16.
*Wash all doors & frames. Date last washed 2/10.
*Dust along where ceiling & wall meet. Date last dusted unknown.
*Wash all curtains & shades, mend if necessary. Date last washed 2/24.
*Wash all privacy screens & spray for fire retardant. Date last washed 5/17.
*Wash all heat registers (also underneath). Date last washed 2/9.
*Seasonal clothing exchange per resident's request. Date last done unknown.
*Wash all supply cupboards on all three floors. Date last washed 5/16.
*Wash mini blinds. Date last washed unknown.

A form titled Grand Avenue Residence Annual Housekeeping Routines 2016, last updated 3/21/01, indicated:
Duties: *Clean windows inside & out. Date last cleaned 1/19.
*Wash residents' bathroom & office wastebaskets. Date last washed 4/4.
*Clean walls & light fixtures. Date last cleaned 3/23.

On 6/7/16, at 2:45 p.m. Housekeeper (H) stated she has a check off list she dates and initials as she completes the cleaning tasks designated as either daily, weekly, monthly, twice a year or yearly.

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F 465	Continued From page 6	F 465		

On 6/7/16, at 3:00 p.m. SSD stated she doesn't look at the work Housekeeper (H) does, she just looks at the check off list to see if it has been completed.

The undated Grand Avenue Residence Housekeeping Department Policy indicated effective environmental sanitation is required to lesson the hazards of exposure to contaminated air, dust, furnishings, equipment, and other fomites. Frequent cleaning of the building's interior will aid in physically remove some of the microorganisms, which might cause these hazards.

The undated Grand Avenue Residence Housekeeping Department Procedure 8) indicated periodic inspections of the faculty [sic] will be made by the housekeeping supervisor or as a joint exercise with the Infection Control Team.

The Grand Avenue Residence Cleaning Diningroom [sic] Procedure dated 4/21/95 indicated 1. Vacuum room thoroughly. 2. Dust off light fixtures and pictures. 3. Clean all woodwork-baseboards, window sills and frame. 4. Wipe down all radiators and vacuum underneath. 5. Clean mirror and doors on fireplace. 6. Soap to use: Assert-located in basement in control tower.

The undated Grand Avenue Residence Day Room Cleaning Procedure indicated 1) Vacuum, and or sweep room thoroughly. 2) Empty all ashtrays and cans, make sure to wash. 3) Clean all woodwork, baseboards, windowsills, and frames. 4) Dust off pictures, light fixtures, shelves, and piano. 5) Clean off all tables and

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	24E150	A. BUILDING ______ B. WING ______	C 07/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	**3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409**

(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 465	Continued From page 7	F 465		

chairs, dust all pipes and sprinkler heads. 6) Soap to use: Assert, located in the basement at the control tower. 7) Sweep and vacuum floor.

The undated Grand Avenue Residence Cleaning Walls Procedure indicated 1) Remove all pictures, calendars, and wall plaques. Move beds out of the way of the wall. 2) Use ladder or step stool, and start at the top of the wall and work your way down. 3) BE EXTRA CAREFUL OF NAILS, AND PICTURE HOOKS, so that you do not cut your hands. Also avoid electrical sockets (be sure not to get them wet!). 4) Use assert soap (basement at control tower).

The undated Grand Avenue Residence Stairway Cleaning Procedure indicated 1. Vacuum thoroughly. 2. Use vacuum hose/edging tool on edges of stairs, landing. 3. Be aware that residents wil [sic] be using stairway and assist them going up or down. 4. Clean baseboards, handrails. 5. Soap to use: Quat Sanitizer/mild detergent. 6. Spot clean carpet as needed with carpet spot cleaner.

The undated Grand Avenue Residence Cleaning Carpets and Rugs Policy indicated: To keep a clean and attractive carpet that is free if [sic] dirt and bad odors.
The Procedure indicated: Daily Cleaning: ,
1) Vacuum carpet and rugs thoroughly everyday.
a) This is important especially in heavy traffic areas.
b) Be sure to remove any paper clips or other large objects before vacuuming.
2) Spot removal - "3m carpet spot remover".
a) Remove soil and moisture from

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F 465	Continued From page 8 spotted areas with clean white absorbent cloth. b) Shake can well and apply spot remover over entire surface. c) Wipe or blot clean with white absorbent cloth. Steam Cleaning: Maintenance will clean carpets per schedule using our own carpet-cleaning machine.	F 465		

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

September 20, 2016

Mr. Allen Soderbeck, Administrator
Grand Avenue Rest Home
3956 Grand Avenue S0uth
Minneapolis, MN 55409

Re: Reinspection Results - Project Number SE150025 and Complaint Number HE150005

Dear Mr. Soderbeck:

On September 6, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 6, 2016, that included an investigation of complaint number HE150005. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
00208 (Y1)	(Y2)	9/6/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 21695 Reg. # MN Rule 4658.1415 Subp. 4 LSC	Correction Completed 09/06/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GD/kfd	DATE 9/20/2016	SIGNATURE OF SURVEYOR 33560	DATE 9/6/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/1/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: PO0F12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED
	00208		C 07/01/2016

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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: A complaint investigation was conducted to investigate complaint #HE150007. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at	2 000		

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2 000	Continued From page 1 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a clean and sanitary environment in the dining room, day room, smoke room, and hallways. In addition, the facility failed to ensure the room of one of one residents (R1) reviewed was kept clean and free of odors. Findings include: On 6/7/16, at 10:10 a.m. the following observations were made:	21695	Corrected	8/31/16

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21695	Continued From page 2	21695		

-In the dining room a dirty and dusty air condition was located above a dining table. The fireplace was covered in dust and was next to another table. A thick layer of dust and dirt laid on and under the heat register, on top of the outlets and electrical cords. A dead bug laid on a window sill and a live spider and spider web were on the floor underneath the window sill.

-On the stairway leading to the second level there was a large, thick, cobweb hanging down from the ceiling along with smaller cobwebs.

-The day room had surface dust on the woodwork and covering the upright scale, and layers of dirt and dust were present along the baseboards. The fluorescent light in the room was full of dead bugs and black spots and the two cloth chairs and carpet had stains.

-The smoke room had a thick layer of dust and dirt on and suspended from the three electrical cords hanging across a wall. Layers of dust and dirt were on and under the heat register, on top of the window, the window sill, blinds, and along the baseboards and smoke vent. All four walls were dirty and stained.

-R1's room had an odor and there were layers of dust and dirt on the floor, along the baseboards and on the headboard. Cobwebs hung from the ceiling above the bed. A broken dresser with no drawers sat next to the bed. Mobility in the room was restricted by stacked boxes and belongings.

-The fluorescent ceiling light in the front door entry was full of dead bugs and black flecks. The survey book kept in the front entry was covered in a layer of dust. Surface dust and dirty carpets were observed throughout both the first and

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21695	Continued From page 3	21695		

second floors of the facility.

On 6/7/16, at 2:40 p.m. the social service designee (SSD) stated the housekeeper was responsible for maintaining the environment.

During the environmental tour conducted on 6/7/16, at 2:45 p.m. the housekeeper (H) confirmed the large cobweb in the stairway, and stated she notified the SSD about it last week because she couldn't reach it to remove it. Housekeeper (H) confirmed the dirty carpet in the dayroom stating she only has time to clean it once a year. In R1's bedroom, R1 stated she was working on getting rid of the broken dresser along with some of the boxes she had stacked in the room. Housekeeper (H) stated the dresser fell apart six months ago and then abruptly ended the tour.

The environmental tour continued with the SSD on 6/7/16, from 3:00-3:20 p.m. The SSD confirmed the cobweb in the stairway and stated she informed the administrator about it week or so ago. While with R1 in her room SSD sharply stated, R1 finally emptied the dresser drawers and they planned to get rid of the broken dresser this afternoon. R1 became upset and started crying. The administrator entered the resident's room, the SSD looked at R1 and sternly stated, you were told two weeks ago to clean this place up. As the tour continued the administrator denied knowing about the cobweb in the stairway, and stated if he had noticed the fluorescent light full of dead bugs in the day room he would have cleaned it. While inspecting the smoke room the administrator verified the dirty, dusty vent and stated he cleans the vent weekly.

An undated form titled Grand Avenue Residence

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Daily Housekeeping Routines indicated:
*8 Clean dayroom (upstairs smoking area).
a. wash ashtrays
b. wipe down tables, chairs, furniture, pictures, baseboards, etc.
c. vacuum
*11 Dust dining room and living room. Clean mirrors, buffet, windows, glass, baseboards, tables, chairs, furniture, etc.
*12 Vacuum throughout house, upstairs, downstairs, hallway stairs and offices.

A form titled Grand Avenue Residence Weekly Housekeeping Routines last updated 2/12/09, indicated:
Monday 1. Thoroughly clean bedrooms 102, 103.
2. Stock linens in upstairs closet.
3. Clean dining room baseboards after mopping.

Tuesday 1. Thoroughly clean bedroom 201.
2. Clean privacy room.
3. Clean office.
4. Sweep porch (on warmer days).

Wednesday 1. Thoroughly clean bedroom 202.
2. Vacuum stairs going from 1st to 2nd floor, wipe down handrails, baseboards, walls, etc.
3. Mop basement (Laundry room and hallway back to storage rooms).
4. Clean stairway from kitchen to basement.

Thursday 1. Thoroughly clean bedrooms 203, 204.
2. First floor linen exchange (flat, fitted, pillowcase).
3. Clean front door and side door

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entryways/hallways including baseboards, handrails, pictures, windows, etc.

Friday 1. Thoroughly clean bedroom 101.
2. Second floor linen exchange (flat, fitted, pillowcase).
3. Dust with feather duster where wall meets ceiling throughout house, also lights, fixtures & mini-blinds, above window ledges, sprinkler heads, moldings.

Thoroughly cleaning rooms includes: Vacuuming, dusting walls, baseboards, fixtures, pipes, pull out furniture and vacuum, clean mirrors, pictures, overhead bed lights, etc.). Wipe windows, clean glass.

A form titled Grand Avenue Residence Monthly Housekeeping Routines 2016, last updated 3/21/01, indicated:
Duties: *Clean chairs and tables used for meals; legs, arms, sides & underneath. Date last cleaned 5/16.
*Change vacuum cleaner bags (or sooner if needed). Date last completed 5/17.
*Clean soiled linen hampers. Date last cleaned 5/18.
*Clean lint from top & bottom of dryer. Date last cleaned 5/19
*Wash all bedspreads & blankets on residents' beds. Date last washed 5/20.
*Pull all strings on call systems to make sure working properly. Dated last completed 5/19.
*Wash dayroom curtains and blinds. Dated last washed 5/20.
*Change and wash 2nd floor bathroom. Privacy curtain. Date last completed 5/21.
*Wipe pull cords with sanitizing cleaner. Date last cleaned 5/22.

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A form titled Grand Avenue Residence 6 Month Chart for Housekeeping 2016, last updated 3/21/01, indicated:
Duties: *Dust & scrub windowsills & casings. Date last dusted 1/13.
*Dust bed frames & mattresses. Date last dusted 5/16.
*Wash all doors & frames. Date last washed 2/10.
*Dust along where ceiling & wall meet. Date last dusted unknown.
*Wash all curtains & shades, mend if necessary. Date last washed 2/24.
*Wash all privacy screens & spray for fire retardant. Date last washed 5/17.
*Wash all heat registers (also underneath). Date last washed 2/9.
*Seasonal clothing exchange per resident's request. Date last done unknown.
*Wash all supply cupboards on all three floors. Date last washed 5/16.
*Wash mini blinds. Date last washed unknown.

A form titled Grand Avenue Residence Annual Housekeeping Routines 2016, last updated 3/21/01, indicated:
Duties: *Clean windows inside & out. Date last cleaned 1/19.
*Wash residents' bathroom & office wastebaskets. Date last washed 4/4.
*Clean walls & light fixtures. Date last cleaned 3/23.

On 6/7/16, at 2:45 p.m. Housekeeper (H) stated she has a check off list she dates and initials as she completes the cleaning tasks designated as either daily, weekly, monthly, twice a year or yearly.

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21695	Continued From page 7	21695		

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On 6/7/16, at 3:00 p.m. SSD stated she doesn't look at the work Housekeeper (H) does, she just looks at the check off list to see if it has been completed.

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The undated Grand Avenue Residence Housekeeping Department Procedure 8) indicated periodic inspections of the faculty [sic] will be made by the housekeeping supervisor or as a joint exercise with the Infection Control Team.

The Grand Avenue Residence Cleaning Diningroom [sic] Procedure dated 4/21/95 indicated 1. Vacuum room thoroughly. 2. Dust off light fixtures and pictures. 3. Clean all woodwork-baseboards, window sills and frame. 4. Wipe down all radiators and vacuum underneath. 5. Clean mirror and doors on fireplace. 6. Soap to use: Assert-located in basement in control tower.

The undated Grand Avenue Residence Day Room Cleaning Procedure indicated 1) Vacuum, and or sweep room thoroughly. 2) Empty all ashtrays and cans, make sure to wash. 3) Clean all woodwork, baseboards, windowsills, and frames. 4) Dust off pictures, light fixtures, shelves, and piano. 5) Clean off all tables and

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21695	Continued From page 8	21695		

chairs, dust all pipes and sprinkler heads. 6) Soap to use: Assert, located in the basement at the control tower. 7) Sweep and vacuum floor.

The undated Grand Avenue Residence Cleaning Walls Procedure indicated 1) Remove all pictures, calendars, and wall plaques. Move beds out of the way of the wall. 2) Use ladder or step stool, and start at the top of the wall and work your way down. 3) BE EXTRA CAREFUL OF NAILS, AND PICTURE HOOKS, so that you do not cut your hands. Also avoid electrical sockets (be sure not to get them wet!). 4) Use assert soap (basement at control tower).

The undated Grand Avenue Residence Stairway Cleaning Procedure indicated 1. Vacuum thoroughly. 2. Use vacuum hose/edging tool on edges of stairs, landing. 3. Be aware that residents wil [sic] be using stairway and assist them going up or down. 4. Clean baseboards, handrails. 5. Soap to use: Quat Sanitizer/mild detergent. 6. Spot clean carpet as needed with carpet spot cleaner.

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The Procedure indicated: Daily Cleaning: ,
1) Vacuum carpet and rugs thoroughly everyday.
a) This is important especially in heavy traffic areas.
b) Be sure to remove any paper clips or other large objects before vacuuming.
2) Spot removal - "3m carpet spot remover".
a) Remove soil and moisture from spotted areas with clean white absorbent cloth.

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21695	Continued From page 9 b) Shake can well and apply spot remover over entire surface. c) Wipe or blot clean with white absorbent cloth. Steam Cleaning: Maintenance will clean carpets per schedule using our own carpet-cleaning machine. SUGGESTED METHOD OF CORRECTION: The administrator and or designee, could evaluate the environment for cleanliness. Develop a plan to address how to maintain a clean environment, implement the plan and monitor to ensure all areas of the residents' environment remains clean and odor free. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 26, 2016

Mr. Allen Soderbeck, Administrator
Grand Avenue Rest Home
3956 Grand Avenue South
Minneapolis, MN 55409

Subject: Grand Avenue Rest Home - IDR
Provider # 24E150
Project # SE150025

Dear Mr. Soderbeck:

This is in response to your letter of May 14, 2016, in regard to your request of an informal dispute resolution (IDR) for the federal deficiencies at tag F164, F169, F225, F226, F315, F323, F514, F520, issued pursuant to the survey event WCGU11, completed on April 18, 2016.

Information you presented during the telephone review conference call meeting 6/30/16, information presented with your letter, the CMS 2567 dated April 18, 2016 and corresponding Plan of Correction, as well as survey documents, discussion with representatives of L&C and OHFC staff have been carefully considered and the following determinations have been made:

Tag F164, S/S – (D) 42 CFR § 483.10(e), 483.75(1)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS. The resident has the right to personal privacy.

Summary of the facility's reason for IDR of this tag:
The facility disputed the findings and indicated R2 has resided at the facility since 2005, R7 since 2012 and R17 since 2014. The facility staff indicated all 3 residents are assessed as cognitively intact and independent with activities of daily living. They further asserted shared bedrooms and bathrooms have been in place since 1974, and that resident privacy assessments were instituted a long time ago and are reviewed at admission, quarterly, or sooner, if an issue. Windows have mini blinds that are hidden behind a 12" valance during the day. The administrator stated privacy screens are provided upon request.

Summary of findings:
The 3 residents identified in the deficiency are cognitively intact, independent with activities of daily living and able to make needs known. During survey all three residents reported concerns regarding lack of privacy. The deficiency also indicates the residents who had privacy screens available, the screens were broken and could not be moved without falling apart. The fact the screens could not be moved, made the screens ineffective for provision of privacy.

The deficiency remains valid at S/S D.

Tag F169, S/S – (D) 42 CFR § 483.10(h) RIGHT TO PERFORM FACILITY SERVICES OR REFUSE. The resident has the right to refuse to perform services for the facility; or perform services for the facility, if he or she chooses, when the facility has documented the need or desire for work in the plan of care; the plan specifies the nature of the services performed and whether the services are voluntary or paid; compensation for paid services is at or above prevailing rates; and the resident agrees to the work arrangement described in the plan of care.

Summary of the facility's reason for IDR of this tag:
The facility disputed the findings indicating the jobs R17 and R13 performed had changed from 40 minutes to 10 minutes a day which reduced their earnings. The administrator asserted a time study was completed which was documented for training and performance of the residents related to their jobs and that the time study was available for review. The administrator further stated R17 and R23 desired to work and volunteered for the assigned kitchen duties.

Summary of findings
The deficiency indicates R13 & R17 were providing assistance with passing trays during meals. The deficiency documentation further establishes no care plan had been developed to include this information for either resident. The survey staff had interviewed the social worker designee (SWD) and administrator on 4/15/16, at 4:15 p.m. at which time the SWD acknowledged the residents had come to her to ask for jobs and that both were either paid cash, or with gift cards, for the services rendered in the kitchen. The SWD verified R17's and R13's desire to work, work arrangement, and the assigned kitchen duties were not documented on their plans of care." The interpretive guidelines include: "The resident has the right to refuse to perform services for the facility; or perform services for the facility, if he or she chooses, when the facility has documented the need or desire for work in the plan of care; the plan specifies the nature of the services performed and whether the services are voluntary or paid; compensation for paid services is at or above prevailing rates; and the resident agrees to the work arrangement described in the plan of care."

This is a valid example of a deficient practice under this regulation and will remain in the Statement of Deficiencies at S/S (D).

Tag F225, S/S – (E) 42 CFR § 483.13(c)(1)(ii)-(iii), (c)(2)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS
...The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress...

Summary of the facility's reason for IDR of this tag:
The facility identified residents R20, R7, R16, R14, R6, as cognitively intact.

The administrator stated R6 actually knew she had fallen, but just did not know how. The administrator acknowledged the fall was not witnessed.

The administrator stated R16 was on a provisional discharge if she behaved herself. She was approved to come and go as she had a BIMS (Brief Interview for Mental Status) of 15, therefore he did not consider the resident's absence from the facility an elopement.

R20 was described by the administrator as having been admitted 3/5/15 with chemical dependency issues. The administrator asserted R20's drug overdose had occurred outside the building, and that when R20 came back to the facility she had been sent to the hospital.

The administrator also stated R7 had history of alcohol abuse and found an open bottle of alcohol in another resident's room and consumed it. He said the incident had been identified during routine hourly rounds and R7 had been sent to the hospital. The administrator did not feel the incident was reportable.

Finally, the administrator alleged R14's complaint had first been reported during survey and stated he had not been aware of the complaint.

<u>Summary of findings:</u>
R20 had been admitted to the facility 3/5/15 with known chemical dependency issues. Documentation from the resident's medical record confirmed R20 experienced the heroin overdose while at the facility on 2/3/16. As documented in the statement of deficiencies, a nurse's note from 7:30 a.m. on 2/3/16, indicated: "[R20} states 'I'm not feeling well' Res (resident) had just woken up & appeared somewhat lethargic/although able to respond to questions if asked twice. Given 5 oz of apple juice which she drank-'I'm just so thirsty'. 1/2 hour later res. was coaxed downstairs by nurse to eat breakfast 'I can't eat, I feel sick to my stomach'. Given her a.m. (morning) meds (medications) & another 8 oz of apple juice-Ativan (an antianxiety medication) 1mg (milligram) held d/t (due to) sleepiness. Res. was checked again after being called by roomate [sic] 'I'm worried about (R20)'. Found laying across bed with head and neck hyperextended. Res. warm and breathing, pulse approx 80/PM (per minute) & strong-Res. just not responsive-pupils dilated. 911 was called-attendants gave Narcan -& resident responded. Taken to ER (emergency room) @ HCMC (local hospital) via EMTS (emergency medical training services) Dr. has been notified as well as (R20's) mother (attempted)." Further the record and deficiency indicated the resident had admitted to the EMTS that she had snorted heroin. R20's Hospital Discharge Summary dated 2/8/16 indicated R20 had been admitted to the hospital for altered mental status and accidental heroin overdose.

Although R20 was cognitively intact and capable of making independent choices the facility was responsible for providing adequate supervision to minimize the risk of overdose in a resident with known drug abuse. The facility should have reported the incident to the state's Office of Health Facility Complaints (OHFC) and initiated an investigation.

R7's record indicated she had a history of alcohol abuse. The statement of deficiencies indicated the resident's progress notes had been reviewed from 10/21/15 through 4/11/16, and revealed on 12/27/15, at 9:11 p.m. R7 had been found to be intoxicated requiring transfer to the hospital. "R7 reportedly got the alcohol from her roommates R20 and R17. An emergency department hospital admission sheet dated 12/17/15, indicated that R7 was hospitalized for alcohol intoxication." During the survey, the SWD and administrator had been interviewed at 4:03 p.m. on 4/14/16, and had verified being familiar with R7's chemical dependency issues. The SWD and administrator had confirmed at that time the alcohol use and resulting hospitalization were not reported to the State agency. However, a subsequent interview with the interim director of nursing (IDON) on 4/15/16, at 2:28 pm. revealed she thought the facility had reported the incident.

Because the resident accessed and consumed the alcohol while at the facility, and subsequently required hospitalization for alcohol intoxication, the facility should have reported the incident as potential neglect of supervision to OHFC, then initiated an investigation.

R16's medical record indicated the resident was cognitively intact and independent with activities of daily living.

The record validated R16 had been approved to leave and return to the facility independently following facility protocol. On 12/8/15, R16 had left the facility in a taxi to attend a medical appointment, and had indicated following the appointment she was going to spend time with her boyfriend. Documentation in her record indicated facility staff had sent with R16 enough medication to get her through her anticipated return at bedtime. However, the resident did not return to the facility until 12/15/15 (7 days later).

Although the resident had rights to leave on provisional discharge, the resident had told the provider she would return that same evening when she'd left the facility 12/8/15. A Mental Health Summary dated 12/9/15, verified R16's vulnerabilities, indicating R16 was noncompliant with medications, had a long history of alcohol use and multiple chemical dependencies, treatment programs and long history of unstable housing. The summary further indicated R16 was currently getting alcohol from her boyfriend in exchange for favors.

R14 had reported to a surveyor during survey that she'd been routinely called derogatory names by another resident in the facility. R14's record indicated the resident had been assessed as cognitively intact. Furthermore, the progress notes from 3/20/16 and 4/12/16 revealed R14 had reported the incident to staff, and had told the staff it was upsetting and offensive. The progress note dated 4/12/16, indicated R14 had complained of being called derogatory names by another resident "qday" (every day).

This resident's allegations should have been reported to the administrator to make a determination as to whether it required further investigation and/or reporting.

R6's record indicated the resident had experienced an unexplained fracture of the left 5th finger on 12/23/15, and had sustained injuries around her right eye including lacerations and swelling, from an incident of unknown origin on 4/21/15.

The facility should have reported injuries of unknown injury to the state's OHFC and then investigated.

This is a valid deficiency at this tag at the S/S (E).

Tag F226, S/S – (E) 42 CFR § 483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES. The facility must develop and implement written policies that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

<u>Summary of the facility's reason for IDR of this tag:</u>
The facility did not feel this tag should have been issued, because they did not agree with the findings at F225.

<u>Summary of facts:</u>
The facility's policy, Vulnerable Adult Maltreatment Prevention Plan dated 3/6/15, indicated that the facility "does not tolerate any form of maltreatment" which included "any form of physical, verbal, mental or sexual abuse: any form of neglect, involuntary seclusion, corporal punishment or mishandling of resident property". The policy also included the following:
-"An assessment will be made of a prospective resident prior to admission for a known history of potentially dangerous behavior patterns".

-"Individual susceptibility will be assessed and included in the overall resident careplan along with goals and approaches for prevention and safety".
-"If maltreatment is suspected or observed the administrator must be notified immediately".
-The administrator or representative will use the flowchart to determine the reporting requirements".
-"Nursing completes the internal reporting forms whish [sic] is a collection of information that needs to be

submitted to MDH online. The Administrator submits the online report to the Minnesota Department of Health immediately as available".
-"You must make your report directly to the facility Administrator immediately after ensuring resident safety. the facility is responsible to report all reportable incidents and suspected crimes to MDH".

Each of the examples described in the deficient practice statement should have been reported to the administrator and/or to the state's OHFC. The provider is responsible to ensure their policies and procedures are implemented.

This is a valid deficiency at this tag at the S/S (E).

Tag F315, S/S – (D) 42 CFR § 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

Summary of the facility's reason for IDR of this tag:
The facility indicated this tag should not have been written, because they asserted that R6 was continent, and felt the survey team had identified an inaccurate resident. The administrator stated R6 had been admitted to the facility in 1977 and had been assessed and coded as continent. He stated R6 required no assistance with toileting. The administrator stated the resident had been reassessed and remained continent.

Summary of facts:
Review of documents faxed to MDH by the facility 4/19/16, discussion with MDH staff and review of facility documents obtained during survey 4/18/16, it was verified that R6 is the correct resident. The assessments and care plan indicate R6 suffered from occasional nocturnal incontinence. R6 was observed during survey to be incontinent during the day and the housekeeper (who does laundry) acknowledged that happened with regularity and that "(R6's) underclothes were often soiled." Deficiency documentation indicates: "On 4/15/16, at 2:08 p.m. the interim director of nursing (IDON) stated the last several years R6 had been incontinent over the years but stated the last several years she had been incontinent mostly at night. The DON stated R6's incontinence "has been fairly under control." Therefore, her care plan had not been revised to include regular assistance with helping R6 manage the incontinence." R6 was interviewed during survey, 4/13/16, and stated her incontinence had improved but that she still experienced incontinence. Review of a toileting plan dated 3/3/16 identified R6 was "assisted to the BR at 2 AM. Bladder incontinence 'yes' occasional. On toileting program-effective in reducing episodes incontinence."

Summary of findings:

The deficiency is valid at S/S (D).

Tag F323, S/S – (E) 42 CFR § 483.25(h) FREE OF ACCIDENTS. The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

Summary of the facility's reason for IDR of this tag:
The facility's administrator asserted residents R20, R7, R16, R6, are all cognitively intact and could make decisions for themselves. He stated R6 knew she had fallen, but just couldn't state how. The administrator did verify the fall had not been witnessed. The administrator said that R16 had been assessed to be on a provisional discharge if she behaved appropriately. He said this meant R16 was approved to come and go. He asserted that since R16 had a BIMS of 15, and had been assessed as having provisional discharge privileges, her leaving the building should not be reviewed as an elopement. The administrator also stated R20, who had been admitted 3/5/15 with chemical dependency issues, had sustained the drug overdose outside the building. The

administrator said when R20 came back to the facility she'd been sent to the hospital. Regarding R7, the administrator said R7 had a history of alcohol abuse, found a bottle of open alcohol in another resident's room and consumed it. He said R7 had been found to be intoxicated on routine hourly rounds and had been sent to the hospital. The administrator did not feel the example related to R7 was reportable because nursing had appropriately sent R7 to the hospital for care.

<u>Summary of facts.</u>
R20: had been admitted to the facility 3/5/15 with known chemical dependency issues. Documentation from the resident's medical record confirmed R20 experienced the heroin overdose while at the facility on 2/3/16. As documented in the statement of deficiencies, a nurse's note from 7:30 a.m. on 2/3/16, indicated "[R20} states 'I'm not feeling well' Res (resident) had just woken up & appeared somewhat lethargic/although able to respond to questions if asked twice. Given 5 oz of apple juice which she drank-'I'm just so thirsty'. 1/2 hour later res. was coaxed downstairs by nurse to eat breakfast 'I can't eat, I feel sick to my stomach'. Given her a.m. (morning) meds (medications) & another 8 oz of apple juice-Ativan (an antianxiety medication) 1mg (milligram) held d/t (due to) sleepiness. Res. was checked again after being called by roomate [sic] 'I'm worried about (R20)'. Found laying across bed with head and neck hyperextended. Res. warm and breathing, pulse approx 80/PM (per minute) & strong-Res. just not responsive-pupils dilated. 911 was called-attendants gave Narcan -& resident responded. Taken to ER (emergency room) @ HCMC (local hospital) via EMTS (emergency medical training services). Dr. has been notified as well as (R20's) mother (attempted)." Further the record and deficiency indicated the resident had admitted to the EMTS that she had snorted heroin. R20's Hospital Discharge Summary dated 2/8/16 indicated R20 had been admitted to the hospital for altered mental status and accidental heroin overdose.

Although R20 was cognitively intact and capable of making independent choices the facility was responsible for providing adequate supervision to minimize the risk of overdose in a resident with known drug abuse.

R7's medical record indicated she had a history of alcohol abuse. The statement of deficiencies indicated the resident's progress notes had been reviewed form 10/21/15 through 4/11/16, and revealed on 12/27/15, at 9:11 p.m. R7 had been found to be intoxicated requiring transfer to the hospital." R7 reportedly got the alcohol from her roommates R20 and R17. An emergency department hospital admission sheet dated 12/17/15, indicated that R7 was hospitalized for alcohol intoxications" during the survey, thee SED and administrator had been interviewed at 4:03 p.m. on 4/14/16, and had verified being familiar with R7's chemical dependency issues.

The facility should have taken responsibility to ensure the facility environment remained free of alcohol in residents' rooms. The facility was responsible to provide adequate supervision for R7 while in their care. F7 accessed and consumed the alcohol while at the facility, and subsequently required hospitalization for alcohol intoxication.

R16's medical record indicated the resident was cognitively intact and independent with activities of daily living. The record validated R16 was approved to leave and return to the facility independently following the facility protocol. On 12/8/15, R16 had left the facility in a taxi to attend a medical appointment, and had indicated following the appointment she was going to spend time with her boyfriend. Documentation in her record indicated facility staff had sent with R16 enough medication to get her through her anticipated return at bedtime. However, the resident did not return to the facility until 12/15/15 (7 days later).

Although the resident had rights to leave on provisional discharge, the resident had told the provider she would return that same evening when she'd left the facility 12/8/15. A Mental Health Summary dated 12/9/15, verified R16's vulnerabilities, indicating R16 was noncompliant with medications, had a long history of alcohol use and

multiple chemical dependencies, treatment programs and long history of unstable housing. The summary further indicated R16 was currently getting alcohol form her boyfriend in exchange for favors.

The facility should have followed up to ensure R16 was safe when she did not return to the facility according to the original plan. The facility should have reported this vulnerable resident's unanticipated extended absence.

R6's record indicated the resident had experienced an unexplained fracture of the left 5th finger on 12/23/15, and had sustained injuries around her right eye including lacerations and swelling, from an incident of unknown origin on 4/21/15.

The provider should have conducted an assessment of R6's risk factors in an effort to determine how R6 had sustained the injuries, so they could identify appropriate interventions to implement in order to minimize the risk of further injury.

The deficiency remains valid, at S/S (E).

Tag F514, S/S – (D) 42 CFR § 483.75(l)(l) Clinical Records. (1) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are-(i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized.

<u>Summary of the facility's reason for IDR of this tag:</u>
The facility administrator stated that every resident record in the facility was reviewed during survey and this was the only one cited. The administrator identified that the deficiency documentation had an inaccurate admission date for R20 and explained that laboratory test results are considered to be part of the medical record. Additional information was submitted for review.

<u>Summary of facts.</u>
The statement of deficiency did not adequately identify a deficient practice related to accuracy of clinical records. While there were components of the record identified that could have been more clearly documented, overall the record contained enough information to provide an accurate and functional representation of the actual experiences for R20 while at the facility. In addition, the documentation contained enough information to show that the facility was aware of the status of R20, had adequate plans of care, and provided sufficient evidence of the effects of the care provided.

<u>Summary of findings:</u>
The findings do not support a deficient practice at F514. The deficiency will be removed from the Statement of Deficiencies.

Tag F520, S/S – (F) 42 CFR § 483.75(o) Quality Assessment and Assurance (2) the quality assessment and assurance committee - (i) Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies. (3) State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. (4) Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

<u>Summary of the facility's reason for IDR of this tag:</u>
The administrator asserted the facility's Quality Assurance (QA) committee had addressed the issues identified during their meetings. The administrator stated the QA committee had discussed R6 many times over the

course of her stay at the facility. The administrator also stated the QA minutes reflected regular discussion about R7 who knew the consequences of her drinking would cause intoxication. The administrator asserted R20 did not intend to overdose on illegal drugs and stated previous QA meeting notes had indicated discussion related to issues R20 experienced. The administrator again reiterated R16 had been assessed and approved to come and go from the facility. He asserted R16's BIMS of 15 and right to come and go, did not indicate any risk and was not an elopement. The administrator stated each of the residents identified in the statement of deficiencies had made a choice to violate facility policy and put their health at risk.

Summary of facts.

The facility had held QA meetings quarterly and notes indicated the Medical Director had been involved in the meetings. The notes also indicated discussion about R7, R16, R20 and in addition, the QA committee had discussed R6 many times over the course of her stay. Although the residents identified in the deficiency at F323 had been mentioned during QA, there was no specific outcome determined, or plan implemented to ensure the residents were provided adequate supervision. The deficiency stated: "the facility failed to ensure the Quality Assessment committee recognized and developed action plans to address potential for injury", for 4 residents who were known to consume alcohol and use illegal drugs in the facility.

The deficiency remains valid at S/S F.

In addition to revisions to the Federal findings, State licensing tags that correspond to the Federal deficiencies will be revised and/or removed from the State form.

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Susanne Reuss, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 651-201-3793

cc: Office of Ombudsman for Long-Term Care
Maria King, Assistant Program Manager
Licensing and Certification File
Gloria Derfus, Metro C Supervisor

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
24E150		6/30/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409

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 F0164 Reg. # 483.10(e), 483.75(l)(4) LSC	Correction Completed 05/11/2016	ID Prefix F0169 Reg. # 483.10(h) LSC	Correction Completed 05/23/2016	ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	Correction Completed 06/09/2016
ID Prefix F0226 Reg. # 483.13(c) LSC	Correction Completed 06/09/2016	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 06/10/2016	ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 06/09/2016
ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 06/09/2016	ID Prefix F0354 Reg. # 483.30(b) LSC	Correction Completed 05/16/2016	ID Prefix F0356 Reg. # 483.30(e) LSC	Correction Completed 04/18/2016
ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 06/09/2016	ID Prefix F0520 Reg. # 483.75(o)(1) LSC	Correction Completed 06/03/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GD/KJ	DATE 08/26/2016	SIGNATURE OF SURVEYOR 18623	DATE 06/30/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/18/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING ______ B. WING ______	C 04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	**3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409**

(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 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		6/9/16

REVISED

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/14/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING ______ B. WING ______	C 04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409

(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 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to report allegations of verbal abuse, injuries of unknown origin, neglect of supervision for elopement and substance abuse within the facility for 5 of 17 residents (R20, R7, R16, R14, R6). Findings include: R20 was admitted to the facility on 3/23/15. A Minimum Data Set (MDS) annual assessment dated 2/6/16, identified R20 as independent with activities of daily living and intact cognition. R20's Community Safety Assessment dated 8/3/15, indicated R20 had an extensive history of substance abuse, poor decision making, and was currently attending treatment three times per week. The assessment further indicated "since admission has used illegal drugs." The assessment further identified R20 had multiple vulnerable adult (VA) issues since admission related to poor choices. Staff recommendations on the assessment indicated R20 could leave the facility independently. A note dated 12/28/15, in R20's medical record signed by the administrator revealed that R20 admitted to having alcohol in her room which contributed to another resident (R7) going to the emergency room. The note indicated that this was not the first time this has occurred. R20's progress notes were reviewed from 1/16 through 4/11/16, and revealed on 2/3/16, at 7:30 a.m. R20 was found to be lethargic and unresponsive. Emergency Medical Services	F 225	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any fasts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the facility has prepared this Plan of Correction prior to resolution of any dispute resolution which must be filed because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the delivery of the CMS-2567 allegations of deficiencies as a condition to participate in the programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. To assure compliance with this the following plan has been put into place. The Administrator met with OHFC management to clarify the reporting criteria for Vulnerable adult reports between federal and state requirements. Incident and investigation reports have been submitted to OFHC for R7, R16, and R20. We have updated our reporting policy and	

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F 225	Continued From page 2 (EMS) were activated, the resident was provided Narcan (medication which reverses some overdoses such as Heroin) and transported to the emergency room. R20 was admitted. R20's Hospital Discharge Summary dated 2/8/16 indicated that R20 was admitted to the hospital for altered mental status and accidental heroin overdose. R20's Mental Health Summary dated 3/5/16 through 4/5/16, indicated R20 had a "lengthy history of heroin abuse and methamphetamine abuse" and staff had an order for Narcan if overdose was suspected. The mental health summary further indicated that R20 had a verbal altercation with another resident and resident's family member and "needs to be closely monitored by staff". R20's careplan dated 3/3/16, identified a history of heroin addiction-recent heroin overdose and indicated that the facility now had and order for Narcan. Interview with the social worker designee (SWD) on 4/14/16 at 2:42 p.m. revealed that she was aware of R20's heroin overdose on 2/3/16. The SWD was unaware if R20 had any other hospitalizations due to overdose. The SWD was asked if R20's heroin overdose with hospitalization was reported to the state agency. The SWD replied the incidents were "not required to be reported , even if hospitalized. We follow a flow chart." Interview with the interim director of nursing (IDON) on 4/15/16 at 2:28 p.m. revealed that she was the nurse working on 2/3/16, and stated she was aware of R20's previous drug use but was unaware why R20 was unresponsive that morning. The IDON stated she was not familiar	F 225	workflow charts for reporting. We have begun retraining the staff on the requirement to report these going forward. We have modified our vulnerable adult staff in-service material to add this clarity and address these issues. Internal reporting was done correctly in these cases, but DON and Administrator will continue to monitor staff for compliance in reporting internally. We have also recommended changes to OHFC in their reporting process and documentation to include this information to clarify the confusion between state and federal requirements.	

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F 225	Continued From page 3	F 225		

with R20 having any similar incidents related to drug use prior to 2/3/16, was not aware of any drugs in the facility. When asked if this incident should be reported to the state agency the IDON replied "I don't know."

R7 was admitted to the facility on 9/30/14, with diagnoses included but not limited to mood disorder, schizophrenia, and alcohol dependency. R7's MDS quarterly review assessment dated 1/5/16, indicated R7's cognition was intact and was independent with activities of daily living.

R7's careplan dated 10/19/15, included VA issues of history of chemical use making poor decisions. The care plan identified 12/28/16 (sic- facility dated the care plan as the year 2016) R7 consumed alcohol that resulted in hospitalization.

R7's progress notes were reviewed from 10/21/15 through 4/11/16, and revealed on 12/27/15, at 9:11 p.m. R7 was found with a "blank stare unable to sit up in bed" and slurred speech. 911 was called and R7 was transported to the hospital. She returned 12/28/15. R7 reportedly got the alcohol from her roommates R20 and R17. An emergency department hospital admission sheet dated 12/17/15, which indicated that R7 was hospitalized for alcohol intoxication.

R7's medical record included a psych appointment referral dated 1/11/16, which included the note that R7 was hospitalized for alcohol intoxication. Roommate gave her alcohol that was hidden in the room.

An interview with the SWD and administrator on 4/14/16, at 4:03 p.m. indicated the SWD was familiar with R7's chemical dependency issues.

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F 225	Continued From page 4 The SWD stated the alcohol use was "not a problem, just because something happens once, if it was an ongoing issue I would have put it as a problem on the careplan." The SWD and administrator confirmed the alcohol use and resulting hospitalization were not reported to the state agency. The administrator stated the incident was "not required to be reported, even if hospitalized" and that the facility followed a flow chart for reporting of incidents to the state agency. An interview with the IDON on 4/15/16, at 2:28 p.m. revealed she thought the facility reported the incident to "where it should be reported to." R16 was accepted and admitted to the facility 11/9/15, under commitment for chemical dependency. The MDS dated 12/7/15, indicated R16 was cognitively intact, mildly depressed, had verbal behavioral symptoms directed towards others, and rejected care daily. The Care Area Assessment (CAA) dated 12/7/15, indicated R16 was receiving anti-psychotic medications for anxiety and verbal aggression. The undated care plan identified R16 had one missing person report for failure to return to facility at specified time. R16 was able to have leaves of absence (LOA's) and self administer medications. Nursing progress notes on 11/17/15, at 6:00 p.m. R16 was found to be lethargic and confused. The resident was taken to the emergency room via ambulance. The hospital reported an alcohol level of 0.37. On 11/18/15, it was documented that R16 had been admitted to the hospital. On 11/24/15, R16 returned to the facility. On 12/8/15, at 10:00 R16 left via taxi to the doctor and spend the day with her boyfriend. She had	F 225		

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F 225	Continued From page 5 medications through bedtime. She stated she will be back at 10:00 p.m. Although contacted through her boyfriend, R16 did not return to the facility until 12/15/15 at 5:30 p.m. When asked why she didn't return for a week, R16 replied "I had some things I had to take care of." Mental Health Summary dated 12/9/15, indicated: R16 was noncompliant with medications, had a long history of alcohol use and multiple chemical dependencies, treatment programs and long history of unstable housing. R16 was currently getting alcohol from her boyfriend in exchange for favors. On 12/25/15, R16 went on LOA with her boyfriend and medications. R16 stated she would be back that evening. On 12/26/15, at 6:45 p.m. R16 called the facility to inform them she was at the emergency room and was being admitted for pneumonia. The facility verified this with the ER staff. The IDON's hand written, undated Discharge/Summary Information identified "Consumption of alcohol, left premises for extended time without notice. Broke court order for no overnights outside of facility." On 4/14/16, at 2:42 p.m. the SWD and administrator were asked for policies for resident LOA's. The SWD stated the residents "Sign LOA form and ask for meds." The SWD stated they complete one community assessment and one self administration of medication assessment. If a resident did not return from the outing, she would utilize the missing person protocol. When asked if the overdoses were reported to the state agency, the SWD stated they were "Not required to be reported, even if hospitalized. We follow a flow chart." The IDON was not available in the facility, a scheduled phone conversation occurred with	F 225		

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F 225	Continued From page 6	F 225		

IDON at 2:00 on 4/15/16. The IDON had not considered R16 an elopement, but she was a VA, "I thought it was reported."
The facility failed to report R16's alcohol intoxication to the State agency (SA). The facility also failed to report the elopement from 12/8 through 12/15/15, to the SA even though the facility reported it to the police on 12/10/15, as a missing person.
R14 quarterly MDS indicated she was cognitively intact and was independent with all activities of daily living. R14's care plan dated 2/23/16, identified her as a vulnerable adult and indicated no vulnerable adult issues.

A review of facility progress notes indicated in 3/20/16, R14 had been called a derogatory name by another resident in the facility three times that day. The noted indicated "this incident was very upsetting" to R14. A progress note dated 4/12/16, indicated R14 had complained of being called derogatory names by another resident "qday" (every day). R14 stated it had happened as recently as the previous day.

During an interview on 4/12/16, at 4:26 p.m., R14 further stated a resident in the house is "nasty" to other residents and stated another resident beat that resident up. R14 stated the staff is aware of the situation, but no one did anything about it.

During a subsequent interview on 4/14/16, at 10:22 a.m., R14 stated another resident in the house yells all the time and is "bossy" and "hard to deal with."

During an interview on 4/15/16, at 2:15 p.m. the SWD stated she was responsible for handling and reporting potential abuse and abuse

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allegations. She stated when a resident had concerns she would talk to the other person. She stated "you have to separate whether it's happening, or if it is their perception of what's happening." The SWD further stated, "reporting to the state agency isn't always the answer." She stated verbal aggression between resident's is not reportable to the state agency and takes place "frequently" but are not an actual threat to a resident.
R6's quarterly MDS dated 2/5/16, indicated R6 was cognitively intact with delusions (fixed false beliefs) and was independent with all activities of daily living except dressing and personal hygiene. The MDS also indicated R6 was unsteady when going from sitting to standing or turning around, did not use any mobility devices and that R6 became short of breath with walking. R6's MDS indicated R6 had diagnoses of anemia, diabetes, hypertension, and schizophrenia. Diagnosis of mild mental retardation noted on office visit note dated 4/14/15.

R6's care plan dated 8/26/15, identified R6 as a vulnerable adult and comments dated 11/16/15, and 2/16/16, indicated no vulnerable adult issues. 12/23/15, temporary care plan problem "Fx [fracture]. of proximal phalanx of L [left] 5th finger (etiology unknown-res does not know how it happened)"

Observation on 4/13/16, at 11:40 a.m. identified R6 walking without a cane, limping and stumbling into the smoking room. R6 fell into a chair in the smoking room. At 12:41 p.m. R6 was again observed to stumble and fall into chair in the smoking room.

Review of Incident/Accident Report dated

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F 225	Continued From page 8 4/21/15, at 11:29 a.m. indicated "Pt woke up-few hours p[after] being up we noticed her R [right] eye all puffy and 2 sm [small] lacerations around R [right] eye. She does not remember how it happened." Type of injury listed as "hematoma, abrasion, and swelling." Incident form indicated staff did not know when injury happened and resident did not remember falling. Incident /Accident report did not indicate the administrator or state agency were informed of the injury. Nurses Record and Progress Notes dated 4/21/15, at 12:00 p.m. indicated: "Appears pt [patient] fell against something during the noc [night], has a swollen right eye under each eye and two small lacerations are 3 mm [millimeters] long around eye." "Does not remember what she fell against." Note dated 4/21/15, at 3:00 p.m. ..."is now c/o [complaining of] (unreadable) w c/o headache. States hit head on door going to BR-has flashlight to help guide her." Review of progress notes 4/21/15 through 4/27/15, did not indicate the administrator or SA were notified of the injury of unknown origin. Nurses Record and Progress Notes dated 12/23/15, at 1:30 p.m. indicated R6 came into office and showed nurse her left hand. Nurse noted bruising on the front and back of hand with minor swelling. R6 was sent to urgent care. Physician' Progress Notes dated 12/23/15, indicated R6 was in clinic for assessment of bruising and swelling of left hand and that R6 did not remember hitting hand or banging it. Progress note indicated X-ray showed fracture of proximal phalanx of left fifth finger splint placed and	F 225		

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F 225	Continued From page 9 orthopedic follow up with in next week recommended. The Serious Injury Report dated 12/23/15, sent to the Office of the Ombudsman for Mental Health and Mental Retardation, indicated R6 had sustained an fracture of the fifth finger of the left hand. Description of how the injury happened indicated "resident does not know what happened. Nurse observed swelling and bruising of left hand" The section triggering others to be notified including medical, OHFC [Office of Health Facility Complaints - State agency] and adult protection were blank. At time of the injury R6 was unable to state what happened. While the Office of the Ombudsman was notified there was no evidence that the state agency was notified of the significant injury of unknown origin. During interview on 4/14/16, at 10:25 a.m. the social worker designee (SWD) stated the injury for R6 was reported to the ombudsman's office but not to the state agency because they were not vulnerable adult issues. During interview on 4/15/16, at 9:25 a.m. licensed practical nurse (LPN)-A said "We do not document notifying the administrator. If there is a fracture we do not notify administrator on the weekend or nights because we have dealt with it. If the resident were admitted to the hospital we would let them know." During interview on 4/15/16, at 9:27 a.m. the SWD said "I don't think they would bother calling the administrator because it was not a vulnerable adult issue, it was a serious injury. [Administrator]	F 225		

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would need to know about fractures if it were a vulnerable adult issue like the fracture was due to being beaten. Do not need to know if it is due to a fall."

During interview on 4/15/16, at 2:15 p.m. the administrator said, "I ask them to chart notifying me. I expect them to notify me about fractures."

During interview on 4/15/16, at 2:19 p.m. the IDON stated, the facility reported injuries of unknown origin. Reporting fractures depended on whether or not we know where the resident had been. The IDON said, "If there have not been any incidents then it is not reportable. We report to where ever we are supposed to." When asked about reporting injuries of unknown origin to the state agency versus the office of the ombudsman the IDON said, "I have always reported to the same place."

The facility's policy entitled "Vulnerable Adult Maltreatment Prevention Plan" dated 3/6/15, indicated that the facility "does not tolerate any form of maltreatment" which included "any form of physical, verbal, mental or sexual abuse; any form of neglect, involuntary seclusion, corporal punishment or mishandling of resident property". The policy also included the following:
-" An assessment will be made of a prospective resident prior to admission for a known history of potentially dangerous behavior patterns"
-"Individual susceptibility will be assessed and included in the overall resident careplan along with goals and approaches for prevention and safety".
-"If maltreatment is suspected or observed the administrator must be notified immediately".
-"The administrator or representative will use the

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F 225	Continued From page 11 flowchart to determine the reporting requirements. -"Nursing completes the internal reporting forms whish [sic] is a collection of information that needs to be submitted to MDH online. The Administrator submits the online report to the Minnesota Department of Health immediately as available" -"You must make your report directly to the facility Administrator immediately after ensuring resident safety. The facility is responsible to report all reportable incidents and suspected crimes to MDH."	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to operationalize their policy for reporting of allegations of verbal abuse, injuries of unknown origin, neglect of supervision of elopement, substance abuse within the facility for 5 of 17 residents (R20, R7, R16, R14, R6). Findings include: The facility's policy entitled "Vulnerable Adult Maltreatment Prevention Plan" dated 3/6/15, indicated that the facility "does not tolerate any form of maltreatment" which included "any form	F 226	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any fasts alleged	6/9/16

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F 226	Continued From page 12 of physical, verbal, mental or sexual abuse; any form of neglect, involuntary seclusion, corporal punishment or mishandling of resident property". The policy also included the following: -" An assessment will be made of a prospective resident prior to admission for a known history of potentially dangerous behavior patterns" -"Individual susceptibility will be assessed and included in the overall resident careplan along with goals and approaches for prevention and safety". -"If maltreatment is suspected or observed the administrator must be notified immediately". -"The administrator or representative will use the flowchart to determine the reporting requirements. -"Nursing completes the internal reporting forms whish [sic] is a collection of information that needs to be submitted to MDH online. The Administrator submits the online report to the Minnesota Department of Health immediately as available" -"You must make your report directly to the facility Administrator immediately after ensuring resident safety. The facility is responsible to report all reportable incidents and suspected crimes to MDH". R20 was admitted to the facility on 3/23/15. A minimum data set (MDS) annual assessment dated 2/6/16 identified R20 as independent with activities of daily living and intact cognition. R20's Community Safety Assessment dated 8/3/15 indicated that R20 had an extensive history of substance abuse, poor decision making, and was currently attending treatment three times per week. The assessment further indicated "since admission has used illegal	F 226	or the correctness of any conclusions set forth in the allegations. Accordingly, the facility has prepared this Plan of Correction prior to resolution of any dispute resolution which must be filed because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the delivery of the CMS-2567 allegations of deficiencies as a condition to participate in the programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. To assure compliance with this the following plan has been put into place. The Administrator met with OHFC management to clarify the reporting criteria for Vulnerable adult reports between federal and state requirements. Incident and investigation reports have been submitted to OFHC for R7, R16, and R20. We have updated our reporting policy and workflow charts for reporting. We have begun retraining the staff on the requirement to report these going forward. We have modified our vulnerable adult staff in-service material to add this clarity and address these issues. Internal reporting was done correctly in these cases, but DON and Administrator will continue to monitor staff for compliance in reporting internally. We have also recommended changes to OHFC in their reporting process and documentation to include this information to clarify the confusion between state and	

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F 226	Continued From page 13 drugs". The assessment further identified R20 had multiple vulnerable adult (VA) issues since admission related to poor choices. Staff recommendations on the assessment indicated R20 could leave the facility independently. A note dated 12/28/15 in R20's medical record signed by the administrator revealed that R20 admitted to having alcohol in her room which contributed to another resident (R7) going to the emergency room. The note indicated that this was not the first time this has occurred. R20's progress notes were reviewed from 1/16-4/11/16 and revealed on 2/3/16 at 7:30 a.m. R20 was found to be lethargic and unresponsive. Emergency Medical Services (EMS) were activated, the resident was provided Narcan (medication which reverses some overdoses such as Heroin) and transported to the emergency room. R20 was admitted. R20's Hospital Discharge Summary dated 2/8/16 indicated that R20 was admitted to the hospital for altered mental status and accidental heroin overdose. R20's Mental Health Summary dated 3/5/16-4/5/16 indicated that R20 had a "lengthy history of heroin abuse and methamphetamine abuse" and staff had an order for Narcan if overdose was suspected. The mental health summary further indicated that R20 had a verbal altercation with another resident and resident's family member and "needs to be closely monitored by staff". R20's careplan dated 3/3/16 identified a history of heroin addiction-recent heroin overdose and indicated that the facility now had and order for Narcan.	F 226	federal requirements.	

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Interview with the Social Worker Designee (SWD) on 4/14/16 at 2:42 p.m. revealed that she was aware of R20's heroin overdose on 2/3/16. The SWD was unaware if R20 had any other hospitalizations due to overdose. The SWD was asked if R20's heroin overdose with hospitalization was reported to the state agency. The SWD replied the incidents were "not required to be reported , even if hospitalized. We follow a flow chart".

Interview with the Interim Director of Nursing (IDON) on 4/15/16 at 2:28 p.m. revealed that she was the nurse working on 2/3/16 and stated she was aware of R20's previous drug use but was unaware why R20 was unresponsive that morning. The IDON stated she was not familiar with R20 having any similar incidents related to drug use prior to 2/3/16 was not aware of any drugs in the facility. When asked if this incident should be reported to the state agency the DON replied "I don't know".

R7 was admitted to the facility on 9/30/14 with diagnoses that included but not limited to mood disorder, schizophrenia, and alcohol dependency. R7's Minimum Data Set (MDS) quarterly review assessment dated 1/5/16 indicated R7's cognition was intact and was independent with activities of daily living.

R7's careplan dated 10/19/15 included vulnerable adult (VA) issues of history of promiscous behavior and chemical use making poor decisions. The care plan identified 12-28-16 (sic-facility dated the care plan as the year 2016) R7 consumed alcohol that resulted in hospitalization.

R7's progress notes were reviewed from 10/21/15

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through 4/11/16, and revealed on 12/27/15, at 9:11 p.m. R7 was found with a "blank stare unable to sit up in bed" and slurred speech. 911 was called and R7 was transported to the hospital. She returned 12/28/15. R7 reportedly got the alcohol from her roommates R20 and R17. An emergency department hospital admission sheet dated 12/17/15, which indicated that R7 was hospitalized for alcohol intoxication.

R7's social service progress notes were also reviewed and indicated on 1/4/16, the social worker designee (SWD) spoke with R7 regarding the drinking incident and resulting hospitalization. R7 got angry and screamed "that was not me."

R7's medical record included a psych appointment referral dated 1/11/16, which included the note that R7 was hospitalized for alcohol intoxication. Roommate gave her alcohol that was hidden in the room.

An interview with the SWD and administrator on 4/14/16, at 4:03 p.m. indicated the SWD was familiar with R7's chemical dependency issues. The SWD stated the alcohol use was "not a problem, just because something happens once, if it was an ongoing issue I would have put it as a problem on the careplan". The SWD and administrator confirmed the alcohol use and resulting hospitalization were not reported to the state agency. The administrator stated the incident was "not required to be reported, even if hospitalized" and that the facility followed a flow chart for reporting of incidents to the state agency.

An interview with the Interim Director of Nursing (IDON) on 4/15/16 at 2:28 p.m. revealed she

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F 226	Continued From page 16 thought the facility reported the incident to "where it should be reported to". R16 was accepted and admitted to the facility 11/9/15, under commitment for chemical dependency. The Minimum Data Set (MDS) dated 12/7/15, indicated R16 was cognitively intact, mildly depressed, had verbal behavioral symptoms directed towards others, and rejected care daily. The Care Area Assessment (CAA) dated 12/7/15, indicated R16 was receiving anti-psychotic medications for anxiety and verbal aggression. The undated care plan identified R16 had one missing person report for failure to return to facility at specified time. R16 was able to have leaves of absence (LOA's) and self administer medications. Nursing progress notes on 11/17/15, at 6:00 p.m. R16 was found to be lethargic and confused. The resident was taken to the emergency room via ambulance. The hospital reported an alcohol level of 0.37. On 11/18/15, it was documented that R16 had been admitted to the hospital. On 11/24/15, R16 returned to the facility. On 12/8/15, at 10:00 R16 left via taxi to the doctor and spend the day with her boyfriend. She had medications through bedtime. She stated she will be back at 10:00 p.m. Although contacted through her boyfriend, R16 did not return to the facility until 12/15/15 at 5:30 p.m. When asked why she didn't return for a week, R16 replied "I had some things I had to take care of." Mental Health Summary dated 12/9/15, indicated: R16 was noncompliant with medications, had a long history of alcohol use and multiple chemical dependencies, treatment programs and long history of unstable housing. R16 was currently getting alcohol from her boyfriend in exchange for	F 226		

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favors.
On 12/25/15, R16 went on LOA with her boyfriend and medications. R16 stated she would be back that evening. On 12/26/15, at 6:45 p.m. R16 called the facility to inform them she was at the emergency room and was being admitted for pneumonia. The facility verified this with the ER staff.
The interim director of nursing (IDON) ' s hand written, undated Discharge/Summary Information identified "Consumption of alcohol, left premises for extended time without notice. Broke court order for no overnights outside of facility."
On 4/14/16, at 2:42 p.m. the social work designee (SWD) and administrator were asked for policies for resident LOA's. The SWD stated the residents "Sign LOA form and ask for meds."
The SWD stated they complete one community assessment and one self administration of medication assessment. If a resident did not return from the outing, she would utilize the missing person protocol.
When asked if the overdoses were reported to the state agency, the SWD stated they were "Not required to be reported, even if hospitalized. We follow a flow chart."
The IDON was not available in the facility, a scheduled phone conversation occurred with IDON at 2:00 on 4/15/16. The IDON had not considered R16 an elopement, but she was a vulnerable adult (VA), "I thought it was reported."
The facility failed to report R16's alcohol intoxication to the SA. The facility also failed to report the elopement from 12/8-12/15/15 to the SA even though the facility reported it to the police on 12/10/15 as a missing person.
R14 quarterly Minimum Data Set (MDS) indicated she was cognitively intact and was independent with all activities of daily living. R14's care plan

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dated 2/23/16 identified her as a vulnerable adult and indicated no vulnerable adult issues.

A review of facility progress notes indicated in 3/20/16, R14 had been called a derogatory name by another resident in the facility three times that day. The noted indicated "this incident was very upsetting" to R14. A progress note dated 4/12/16 indicated R14 had complained of being called derogatory names by another resident "qday" (every day). R14 stated it had happened as recently as the previous day.

During an interview on 4/12/16, at 4:26 p.m., R14 further stated a resident in the house is "nasty" to other residents and stated another resident beat that resident up. R14 stated the staff is aware of the situation, but no one did anything about it.

During a subsequent interview on 4/14/16, at 10:22 a.m., R14 stated another resident in the house yells all the time and is "bossy" and "hard to deal with."

During an interview on 4/15/16, at 2:15 p.m. the social work designee (SWD) stated she was responsible for handling and reporting potential abuse and abuse allegations. She stated when a resident had concerns she would talk to the other person. She stated "you have to separate whether it's happening, or if it is their perception of what's happening." The SWD further stated, "reporting to the state agency isn't always the answer." She stated verbal aggression between resident's is not reportable to the state agency and takes place "frequently" but are not an actual threat to a resident.
R6's quarterly Minimum Data Set (MDS) dated 2/5/16, indicated R6 was cognitively intact with

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delusions (fixed false beliefs) and was independent with all activities of daily living except dressing and personal hygiene. The MDS also indicated R6 was unsteady when going from sitting to standing or turning around, did not use any mobility devices and that R6 became short of breath with walking. R6's MDS indicated R6 had diagnoses of anemia, diabetes, hypertension, and schizophrenia. Diagnosis of mild mental retardation noted on office visit note dated 4/14/15.

R6's care plan dated 8/26/15, identified R6 as a vulnerable adult and comments dated 11/16/15, and 2/16/16, indicated no vulnerable adult issues. 12/23/15, temporary care plan problem "Fx [fracture]. of proximal phalanx of L [left] 5th finger (etiology unknown-res does not know how it happened)"

Observation on 4/13/16, at 11:40 a.m. identified R6 walking without a cane, limping and stumbling into the smoking room. R6 fell into a chair in the smoking room. At 12:41 p.m. R6 was again observed to stumble and fall into chair in the smoking room.

Review of Incident/Accident Report dated 4/21/15, at 11:29 a.m. indicated "Pt woke up-few hours p[after] being up we noticed her R [right] eye all puffy and 2 sm [small] lacerations around R [right] eye. She does not remember how it happened." Type of injury listed as "hematoma, abrasion, and swelling." Incident form indicated staff did not know when injury happened and resident did not remember falling. Incident /Accident report did not indicate the administrator or state agency were informed of the injury.

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F 226	Continued From page 20 Nurses Record and Progress Notes dated 4/21/15, at 12:00 p.m. indicated: "Appears pt [patient] fell against something during the noc [night], has a swollen right eye under each eye and two small lacerations are 3 mm [millimeters] long around eye." "Does not remember what she fell against." Note dated 4/21/15, at 3:00 p.m. ..."is now c/o [complaining of] (unreadable) w c/o headache. States hit head on door going to BR-has flashlight to help guide her." Review of progress notes 4/21/15 through 4/27/15, did not indicate the administrator or SA were notified of the injury of unknown origin. Nurses Record and Progress Notes dated 12/23/15 at 1:30 p.m. indicated R6 came into office and showed nurse her left hand. Nurse noted bruising on the front and back of hand with minor swelling. R6 was sent to urgent care. Physician's Progress Notes dated 12/23/15, indicated R6 is in clinic for assessment of bruising and swelling of left hand and that R6 did not remember hitting hand or banging it. Progress note indicated X-ray showed fracture of proximal phalanx of left fifth finger splint placed and orthopedic follow up with in next week recommended. The Serious Injury Report dated 12/23/15, sent to the Office of the Ombudsman for Mental Health and Mental Retardation, indicated R6 had sustained an fracture of the fifth finger of the left hand. Description of how the injury happened indicated "resident does not know what happened. Nurse observed swelling and bruising of left hand" The section triggering others to be	F 226		

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F 226	Continued From page 21 notified including medical, OHFC [Office of Health Facility Complaints - state agency] and adult protection were blank. During interview on 4/15/16, at 9:25 a.m. Licensed practical nurse (LPN)-A said "We do not document notifying the administrator. If there is a fracture we do not notify administrator on the weekend or nights because we have dealt with it. If the resident were admitted to the hospital we would let them know." During interview on 4/15/16, at 9:27 a.m. the SWD said "I don't think they would bother calling the administrator because it was not a vulnerable adult issue, it was a serious injury. [Administrator] would need to know about fractures if it were a vulnerable adult issue like the fracture was due to being beaten. Do not need to know if it is due to a fall." During interview on 4/15/16, at 2:15 p.m. the administrator said, "I ask them to chart notifying me. I expect them to notify me about fractures." During interview on 4/15/16, at 2:19 p.m. the interim director of nurses (IDON) stated, the facility reported injuries of unknown origin. Reporting fractures depended on whether or not we know where the resident had been. The IDON said, "If there have not been any incidents then it is not reportable. We report to where ever we are supposed to." When asked about reporting injuries of unknown origin to the state agency versus the office of the ombudsman the IDON said, "I have always reported to the same place."	F 226		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		6/9/16

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F 315	Continued From page 22 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess, identify appropriate interventions and provide assistance with toileting, for 1 of 1 residents (R6) reviewed for incontinence. Findings include: R6's quarterly Minimum Data Set (MDS) dated 2/5/16, indicated R6 was cognitively intact, and experienced incontinence of bowel and bladder requiring assistance with personal hygiene. However, the MDS further indicated R6 had become continent with staff assistance at night. R6's diagnoses included developmental delays and incontinence. A bladder assessment dated 2/11/16, indicated R6 had urinary frequency and nocturia. R6's care plan dated 2/11/16, indicated R6 experienced urinary incontinence with frequency to toilet, and indicated R6 had no incontinence with scheduled toileting at night. During an observation on 4/12/16, at 5:28 p.m. R6 was observed to independently remove urine	F 315	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any fasts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the facility has prepared this Plan of Corrections prior to resolution of any dispute resolution which must be filed because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the delivery of the CMS-2567 allegations of deficiencies as a condition to participate in the programs. This Plan	

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F 315	Continued From page 23 soiled slacks and underclothing and placed them in a laundry basket in her room. No staff assistance was provided to R6 at that time. During an interview on 4/13/16, at 3:25 p.m. R6 stated her incontinence had improved but that she still experienced incontinence if she was out of the facility for a period of time. During an interview on 4/15/16, at 8:21 a.m., housekeeper (HK)-A stated she did the residents' laundry and stated R6's underclothes were often soiled. HK-A stated, "I don't think [R6] cleans herself appropriately." During an interview on 4/15/16, at 8:29 a.m. licensed practical nurse (LPN)-A stated R6's incontinence was "up and down" and verified R6 still had incontinence at times. LPN-A verified R6's care plan approach stating, "We wake her up at night for toileting, but not during the day." R6's plan of care had not been revised to include approaches for helping R6 improve her continence during the day, nor to encourage/assist R6 with personal hygiene following incontinence. During an interview on 4/15/16, at 2:08 p.m. the interim director of nursing (IDON) stated R6 had been incontinent over the years but stated the last several years she had been incontinent mostly at night. The DON stated R6's incontinence "has been fairly under control." Therefore, her care plan had not been revised to include regular assistance with helping R6 manage the incontinence. There was no current assessment which accurately reflected R6's pattern for continence,	F 315	of Correction is submitted as the facility s credible allegation of compliance. Survey Team information written is incorrect and we are requesting a IDR. To assure compliance with this the following plan has been put into place. We have interviewed R6 and she reports being completely continent. R6 saw a urologist and had a medical procedure completed to 5/17/16 to help R6 to help decrease urgency. Our new DON completed a new bladder assessment on R6. The results were that the resident is continent with the existing overnight toileting plan. Actions taken to identify other potential residents having similar occurrences. Each resident has a bladder assessment as part of their medical record. We have reviewed the bladder assessments for all other residents and have determined that no changes are needed. The quality assurance committee, including the Medical Director, reviewed the bladder assessment form and determined that no changes are needed. Nursing will continue to monitor incontinence and notify the DON when there is a change in status as well as chart in the resident medical record. The DON will continue to complete bladder assessments upon admission, quarterly, or more often as needed. The DON will continue to take actions as necessary when changes in a bladder assessment is warranted. We have added incontinence monitoring to the weekly DON checklist. The Administrator will monitor to maintain	

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F 315	Continued From page 24 and needs for toileting and grooming assistance located in her record.	F 315	compliance by monitoring the weekly DON checklist.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to supervise and provide interventions to prevent injury and hospitalizations for 4 of 4 residents (R20, R7, R16, R6) reviewed for accidents. Findings include: R20 was admitted to the facility on 3/23/15. An annual minimum data set (MDS) assessment dated 2/6/16, identified R20 as independent with activities of daily living and intact cognition. R20's Community Safety Assessment dated 8/3/15, indicated R20 had a history of making poor decisions, chemical dependency issues and was currently attending treatment three times per week. The assessment further indicated that R20 had a history of substance abuse and was a "former heroin addict" and that "since admission has used illegal drugs". The assessment also indicated R20 had made multiple poor choices.	F 323	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any fasts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the facility has prepared this Plan of Corrections prior to resolution of any dispute resolution which must be filed because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the delivery of the CMS-2567	6/9/16

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F 323	Continued From page 25 However, staff recommendations identified on the assessment indicated R20 could leave the facility independently. The facility had not developed a plan to minimize safety risks when R20 was out of the facility. In addition, the facility had not developed a plan with appropriate interventions to minimize the risk of R20 obtaining and using alcohol and/or illegal drugs in the facility. A note dated 12/28/15, in R20's medical record signed by the administrator revealed that R20 admitted to having alcohol in her room which contributed to another resident (R7) going to the emergency room. The note indicated this was not the first time this had occurred and that this was a violation of the facility policy. The note further stated that additional interventions were required to ensure the safety of R20 and the other residents and suggested that R20 was now subject to random room checks and a room change. R20's medical record did not identify previous dates or incidents related to alcohol use. R20's progress notes were reviewed from 1/1/16-4/11/16, and revealed the following: 2/3/16, at 7:30 a.m. resident appeared lethargic although able to respond to questions if asked. Given 5 ounces of apple juice and stated "I'm just so thirsty". One half hour later R20 states she couldn't eat breakfast and "felt sick to her stomach". R20 was checked again after the nurse was called by roommates stating they "were worried" about R20. Nurse found resident "laying across bed with head and neck hyperextended. Res. warm and breathing, pulse approx [sic] 80/bpm and strong. Res. just not responsive-pupils dilated. 911 was called- attendants gave Narcan (a medication to reverse	F 323	allegations of deficiencies as a condition to participate in the programs. This Plan of Correction is submitted as the facility s credible allegation of compliance. To assure compliance with this the following plan has been put into place. R6 saw a physician on 5/2/16 and orthopedic surgeon 5/5/16. The result of that visit was to receive cortisone shots in her left knee to improve her gait due to osteoarthritis and will follow up every four months for review. R6, R7, and R20 were specifically reviewed at the QA meeting on 5/19/16. R6 was recommended for physical therapy to improve her gait. She had previous refused, but after explaining the seriousness of this need for PT, she has now agreed to attend. R7 has been stable before the incident and since. R16 has been discharged. R20's care plan and community assessment have been updated. Actions taken to identify other potential residents having similar occurrences. We have reviewed other resident diagnoses for history of addictive behavior and will updated the community assessments and care plan interventions for each as necessary. We will continue to screen residents and increase our research on issues of alcohol and chemical addictions. The DON and SWD will continue to qualify residents that are within the scope of a Board and Care home. We do screen and have not	

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drugs like heroin) and resident responded and taken to ER". Physician and family notified.

2/3/16, a "Postnote" was written below the above entry that indicated that "EMTS [sic] state they found a suicide note and took it with them. Res. not reported any suicidal thoughts to this nurse on duty from 7 am-3 pm [sic] . EMTS [sic] state resident admitted for snorting heroin".

2/3/15, at 5:00 p.m. R20 admitted to hospital

There was no follow up documentation to the information regarding R20's suicide note in R20's medical record.

R20's Hospital Discharge Summary dated 2/8/16, indicated that R20 was admitted to the hospital for altered mental status and accidental heroin overdose.

Review of R20's MDS assessments indicated a discharge summary was also completed on 1/9/16. In addition an entry tracking record MDS was completed on 1/13/16.

When asked for the 1/9/16 hospital discharge summary and documentation, the SWD stated the hospital did not provide them with any written summary. Licensed practical nurse (LPN-A) stated "We only need the medication list, we shred the rest."

R20's Mental Health Summary dated 3/5/16-4/5/16, indicated that R20 had a "lengthy history of heroin abuse and methamphetamine abuse" and staff had an order for Narcan (reverses an overdose for some medications) if overdose was suspected. The mental health

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accepted four potential residents in the past six months. We have retrained the nursing staff on the importance of the orthostatic pressures and have updated our Fall Scene Investigation report to include more details on reporting of drops in orthostatic blood pressures and the followup required before the completion of the form. We have a new DON in place and she will be reviewing each new fall form for completion, correctness and followup.

The DON will implement these changes and the Administrator will monitor that we maintaining compliance by reviewing the Fall Scene Investigation reports during the QA meetings.

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summary further indicated that R20 had a verbal altercation with another resident and resident's family member and "needs to be closely monitored by staff".

R20's careplan dated 3/3/16, identified a history of heroin addiction-recent heroin overdose and indicated that the facility now has Narcan orders for possible heroin overdose. The careplan further indicated staff was to monitor for signs and symptoms of drug overdose. R20's hospitalization on 2/3/16, for heroin overdose and initiation of off-site treatment on 2/29/16, was identified on the careplan. R20's careplan further identified the resident had no vulnerable adult issues this past quarter. The careplan did not identify concerns with alcohol possession or use. R20's labs were reviewed which indicated that R20 tested positive for THC (marijuana) on 3/26/16. R20's medical record did not indicate any further follow up with the positive lab result.

R20 was interviewed on 4/14/16, at 3:15 p.m. and stated that she did not write a suicide note, that it was a love letter to her boyfriend who had committed suicide. R20 also confirmed that she had been given alcohol as a gift. R20, R16 and R7 had a few drinks and when she and R16 left for a cigarette, R7 had "gotten into it" and "glugged down the whole bottle". R20 stated that she and R16 contacted the nurse when they came back and found R7 was intoxicated and had "wet herself". R20 also stated she had knowingly used Heroin laced with Fentanyl, just like her boyfriend who overdosed.

Interview with the Social Service Designee (SWD) on 4/14/16 at 2:42 p.m. revealed she was aware of R20's heroin overdose on 2/3/16. The

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SWD did not know if R20 had any other hospitalizations due to overdose. The SWD stated she had followed up with the hospital on the note that the EMT's found, which she indicated the hospital nurse stated was a love letter and not a suicide note. The SWD confirmed there was no documentation of follow up in R20's medical record about the note. However the SWD further stated she discussed the incident with R20 who stated she "wanted to live". The SWD was aware of R20's past drug use and stated that R20 had tested positive for marijuana once before and confirmed this was not indicated on R20's careplan. The SWD stated there were no drugs or alcohol in the facility. She further stated R20 was in treatment for past drug addiction, which she attended as ordered. The SWD stated R20 had alcohol in her room and when R20 had left the room, R7 consumed the whole bottle. The SWD confirmed R7 was hospitalized due to alcohol intoxication and she had discussed the incident with R20. The SWD went on to say that R20 did not have a room change as R7 stated upon her hospital return that she "loved her roommates". The SWD stated that alcohol is not allowed in the facility. She was not aware of R20's alcohol use in the facility and when asked if alcohol use or interventions to prevent alcohol use were addressed on R20's care plan the SWD stated "I don't know what you want me to do. I can say if you don't follow the rules you have to leave. She is not committed to any program, I don't have any leverage on these people."

Interview with the Interim Director of Nursing (IDON) on 4/15/16 at 2:28 p.m. revealed she was the nurse working on 2/3/16, and she was aware of R20's previous drug use. The IDON was unaware why R20 was unresponsive that

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morning. The IDON stated that she was not familiar with R20 having any similar incidents related to drug use prior to 2/3/16. Further, she was not aware of any drugs in the facility. The IDON stated she did not observe a suicide note the morning of 2/3/16, and was only aware of the information from the EMT's. The
IDON stated someone at the facility followed up with the hospital and found out the note was actually a "love letter" and not a suicide note. The IDON stated this information should have been followed up in R20's medical record.

R7 was admitted to the facility on 9/30/14, with diagnoses that included mood disorder, schizophrenia, and alcohol dependency.

R7's careplan dated 10/19/15, included the vulnerable adult issues of "hx of promiscuous behavior. Chemical use making poor decisions". The care plan identified "12/28/16 (sic- facility dated the care plan as the year 2016) consumed alcohol that resulted in hospitalization Prognosis favorable. Not a typical behavior". For the dates 1/11/16 and 4/11/16 "No VA issues" were identified. R7's care plan did not identify appropriate interventions to minimize alcohol use or monitoring R7 for incidents of use.

R7's progress notes were reviewed from 10/21/15-4/11/16 and revealed the following:

12/27/15 at 9:11 p.m. revealed the nurse received a call from [R7]'s sister who stated she was on the phone with [R7] and her speech was slurred. The nurse went to R7's room and found R7 with a "blank stare unable to sit up in bed" with slurred speech. The nurse asked R7 if she had been drinking and she did not answer. 911 was called.

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12/27/15 at 9:20 p.m. 911 arrived and R7 was "unable to stand and walk on her own, speech was slurred and she was carried down to the first floor by paramedics". R7 was transported to the hospital at 9:30 p.m. R7's family notified and administrator updated.

12/27/15 at 9:35 p.m. R7's roommates (R20, R17) came to nurse and informed that R7 had drank 24 ounces of Vodka that they left in the room when they went out to smoke. When they returned the 24 ounce bottle of Vodka was empty. Administrator notified.

12/27/15 at 9:40 p.m. nurse updated emergency room (E.R.) on R7's consumption of alcohol.

12/28/15 at 3:20 p.m. R7 returned from the hospital via transport.

No further incidents of alcohol use were identified in R7's progress notes or medical record. however, an emergency department hospital admission sheet dated 12/17/15, identified R7 was hospitalized for alcohol intoxication.

R7's social service progress notes identified the following:

1/4/16, writer spoke with resident regarding drinking incident and hospitalization. Resident got upset and starting screaming loudly saying "that was not me". Resident continued to be agitated and writer did not continue conversation.

1/11/16, care conference held today. Resident had 1 hospitalization due to alcohol poisoning-liquor was given to her by her

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roommate. Resident counseled and educated on incident along with roommate. No VA issues this past quarter.

R7's medical record included a mental health appointment referral dated 1/11/16, which included the note that R7 was hospitalized for alcohol intoxication. The not identified R7's blood alcohol level was >0.3.

An interview with the SWD and administrator on 4/14/16 at 4:03 p.m. indicated the SWD was familiar with R7's alcohol and dependency issues. The SWD stated she was unaware R7's roommate had alcohol. Alcohol was not allowed in the house. The SWD stated alcohol searches were completed with room checks once a week. The SWD confirmed there was no documentation of room checks and was not aware of any residents that were currently using alcohol. SWD completed R7's care plan and stated alcohol use was addressed in R7's careplan. Alcohol use was "not a problem, just because something happens once, if it was an ongoing issue I would have put it as a problem on the careplan". The SWD stated she discussed the alcohol use with R7 and she declined treatment. R7 said she "would not do it again" and she "believes her". SWD stated she informed R7's roommates (R20, R17) they could not have alcohol in the house nor provide alcohol to other residents.

An interview with the Interim Director of Nursing (IDON) on 4/15/16 at 2:28 p.m. revealed she was aware of R7's alcohol intoxication and hospitalization. However she was not working the day the incident occurred.

The undated facility document entitled "Resident

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Rules and Responsibilities" included no alcoholic beverages were allowed in the home unless prior approval from the physician and no illegal drugs were allowed in the home.

R16 was admitted to the facility on a court commitment for chemical dependency. The facility failed to ensure R16 had appropriate supervision and interventions in place to minimize the risk for elopement and ongoing chemical use. had been committed for chemical dependency initially on 8/5/14, and commitment was continued on 12/30/14. R16 was granted a provisional discharge on 3/31/15, however she violated the material conditions of her provisional discharge. R16 missed many appointments at the primary clinic and continued to consume alcohol which contributed to multiple falls and hip injuries. R16 required a full hip replacement on 9/16/15. The hospital record identified alcohol intoxication upon admission at that time. On 10/13/15 a hospital discharge planning note indicated social worker (SW)-B called and left a message with social work designee (SWD), "Director at Grand Ave Residence."

A Hennepin County Human Services and Public Health Department, Behavioral Services Case Management, Case information letter dated 11/10/15, identified a long history of R16 being asked to leave treatment centers related to unstable blood sugars. It also identified a long history of unstable housing, with R16 currently at another facility under chemical dependency commitment until 1/16. An Individual Community Support Plan (ICSP) dated 11/10/15-5/8/16, from Hennepin County stated the contact person was [SWD] a "nurse at Grand Ave Residence ". The

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F 323	Continued From page 33 ICSP indicated the longest period of sobriety was 364 days and R16 expressed interest in sobriety. The identified goal was to be sober and feel better. The documented strategies included: complete a Rule 25, return to Huss recovery, re-connect with women for sobriety, maybe AA, look into dealing with mental health issues, socialize with peers at Grand Avenue, manage blood sugars and count carbohydrates. R16 was also identified with anxiety and depression, but did not have a diagnosis of severe mental illness. The ICSP indicated R16 had 2 children, both with fetal alcohol syndrome, due to her drinking while pregnant. R16 had sustained head injuries and other physical health injuries related to high levels of alcohol consumption. R16 was placed at Grand Ave Residence in order to help encourage sobriety and to closely monitor blood sugar levels. R16 was accepted and admitted to the facility on 11/9/15, under commitment for chemical dependency until 1/1/16. The Minimum Data Set (MDS) dated 12/7/15, indicated R16 was cognitively intact, mildly depressed, had verbal behavioral symptoms directed towards others, and rejected care daily. R16 was independent with activities of daily living, and had a diabetic diet. The undated care plan included: Alcoholism-alcohol intoxication, alcoholic gastritis, and homelessness. The goal was will attend treatment three times weekly, therapy once a week, and will not drink. The approaches were to schedule appointments and rides as needed. Check resident bags upon return if out of facility. Check boyfriend's bags when coming to facility. Screening at facilities discretion. Keep case manager involved. Hold meds if intoxicated, notify MD and get instructions. Received naltrexone for	F 323		

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F 323	Continued From page 34 alcohol urges. Comments included: Resident was attending treatment three times weekly, and therapy. Had been intoxicated since admission resulting in one hospitalization. Mental Health issues included anxiety, resident was taking mental health medications and attending appointments. Resident has had no vulnerable adult issues since admission, but did have one missing person report for failure to return to facility at specified time. The Social Service Assessment dated 11/13/15, indicated anxiety and "when intoxicated resident can made poor decisions and behaviors change." The identified expectations were "Attend outpatient treatment and therapy, stay sober." Nursing progress notes (PN) included: PN11/17/15, at 6:00 p.m. writer went to resident's room to get blood sugar. Did not come to office for glucose monitoring. Had stated was not going to eat supper. Found resident in (R17's) bed. Was very difficult to arouse. Resident appeared confused and did not understand writer when trying to redirect to room-unable to sit up in bed with assist of one. Blood sugar level 222. Call placed to paramedics, questioned resident if she had any alcohol today, and denied alcohol usage. PN 6:15 p.m. Paramedics here to assess resident. PN 6:30 p.m. Paramedics transporting resident to Fairview University Hospital. PN 11/17/15 ETOH intoxication [alcohol concentration] level 0.37 per nurse [more than 3 times the legal limit]. PN 11/18/15 Writer placed call to FVR [hospital]: verified ER, R16 was to be admitted. PN 11/18/15, continued. Paramedics were told by resident here at Grand that R16 had been drinking vodka all day-writer informed nurse we are alcohol free residents are (circle with I)	F 323		

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F 323	Continued From page 35 [intoxicated]. PN 11/24/15 Resident returned from hospital via cab. Resident stated "thanks for taking me back". PN 11/25/15 2:00 a.m. resting sound, did awaken to name, denies pain. At 4:00 a.m. Awake, sitting upstairs sitting area with roommate, stated can't sleep, drinking crystal clear. No alcohol smelled on R16 or Beverage. Instructed smoke room open soon. Remain calm. Cooperative. Physicians Progress Notes dated 11/25/15, indicated recent hospitalization due to alcohol intoxication-returned yesterday 11/24/15. Rule 25 assessment. PN 11/27/15 at 9:30 a.m. Resident going on LOA [leave of absence] with oral meds, accucheck machine and Novolog insulin pen. Has demonstrated to writer proper use of pen and verbalizes understanding of sliding scale. Is knowledgeable about her medications and has approval by clinic. 11:50 a.m. Left with boyfriend for LOA, took bus. The undated Resident Rules and Responsibilities signed by R16 on 12/1/15, included: 21. There will be no alcoholic beverages allowed in the home unless prior approval from the physician. 22. There will be no illegal drugs allowed in the home. 38. We need to know where residents are at all times. Residents are required to sign out/in when leaving the home. Information needed includes destination, contact information, and expected time of return. The sign out book is located in the dining room on the fireplace mantel. 41. When planning to be gone from the facility for the day, staff must be given 2 hour notice. When planning to be absent from the facility overnight, staff requires a 24 hour notice. When planning to be away for more than a full day, a 3 day notice is	F 323		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING ______ B. WING ______	C 04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	**3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409**

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F 323	Continued From page 36 required. Physicians Progress Notes dated 12/2/15, identified Ok to do toxicology screen at facility discretion. Please discontinue Novolog order [I unit/10 gram of carbs], "Do not do Carb Counting at facility. " [Consultant pharmacist recommendation "the current order is 1 unit/10 grams of carbs. Making this assessment accurately is not possible in the home"]. PN 12/8/15, 10:00 patient left via taxi to doctor then spend day with boyfriend. She has meds till HS [bedtime]. She states she will be back at 10:00 p.m. PN 12/8/15, at 11:00 has not returned as planned. Reported to 11-7 shift. PN 12/9/15, at 1:00 a.m. R16 had not returned from outing. PN 12/9/15, at 5:00 a.m. R16 had not returned from outing with her boyfriend. PN 12/9/15, at 4:30 p.m. Residents boyfriend called and said resident will not be coming back to facility until tomorrow at 1:00 p.m. "Stated having car trouble " Mental Health Summary dated 12/9/15, indicated: R16 was noncompliant with medications, had a long history of alcohol use and multiple chemical dependencies, treatment programs and long history of unstable housing, currently has therapy at Nystroms Associates for alcohol dependency. Continues to drink and recent hospitalizations 11/17-11/24 due to alcohol intoxication. Has a boyfriend that is currently supplying [R16] with alcohol for favors. PN 12/10/15, (untimed) writer left message on [boyfriend] voice mail as R16 had not returned this a.m. No return call writer also called [aunt] who is resident's aunt. [Aunt] said she would also call boyfriend and leave message that resident must contact us within 2 hours (from 12:15-2:15).	F 323		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 37 No call back at 2:30 p.m. writer reported resident as missing person. PN 12/10/15, 5 p.m. patrol officer came to make report. PN 12/11/15 7:40 p.m. writer, nurse called [boyfriend's] number, he answered and handed the telephone to R16 she states she will be back to (Grand around 8:p.m. this evening, they do have a working car). PN 12/11/15, called boyfriend's phone to contact. PN 10:30 a.m. resident [R16] left voice mail. PN 12/11/15, 9 p.m. resident did not return at 8:00 p.m. (late entry). PN 12/14/15, at 5 p.m. Writer/nurse placed a call to [boyfriend's] cell phone and left a voicemail for him to have R16 call us back to let us know when she is returning. PN 12/14/15, at 5:15 p.m. writer/nurse received a call from [R16], she states she will be back this evening at around 9 p.m. PN 12/14/15, at 8:00 p.m. Resident called writer/nurse to report she will not be back until tomorrow am because something came up. Resident reports she is not drinking. PN 12/15/15, at 5:30 p.m. resident returned from LOA-stated had "insulin needles" at boyfriends house was able to give self-insulin. Writer asked why she did not return for a week, replied "I had some things I had to take care of". An undated handwritten note stated: "Tis the season to be jolly ...and I was wondering ...if when I go to [boyfriend's] on Christmas Day, if it would be alright if I spent the night? I promise I'll be back on the 26th before 10 p.m.!! Also no Drinking!!! I understand if you say " NO", as I realize what I did wrong before!![sic] Can you "Please" just take it into consideration? As it would mean a lot to my man and I!![sic]" PN 12/25/15, Pt went on LOA with meds. Stated	F 323		

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F 323	Continued From page 38 she will be back Friday evening. PN 12/25/15, at 10:30 p.m. writer/nurse call [R16's] boyfriends cell phone, [boyfriend] stated [R16] was sleeping and will be back in the am. PN 12/26/15, 11:00 a.m. Called left message to return call at boyfriends phone number. PN 12/26/15, at 5:00 p.m. phone call from boyfriend's number writer answered but no one on the line. PN 12/26/15, at 6:45 p.m. writer/nurse received a call from [R16], she states she is at Fairview riverside ER to get pain meds for her hip pain until she can have her surgery done. She states she will she will be back later this evening. PN 12/26/15, 10:09 writer /nurse received a call from [R16] she states she is being admitted for pneumonia, they are starting her on IV ' s and plan to do a further work up on her hip pain. PN 12/26/15, at 10:30 p.m. writer/nurse call FV riverside ER and spoke with [R16's] emergency room nurse. He states she is being admitted for pneumonia. Physicians Progress Notes dated 12/31/15, [R16] continues to consume alcohol-conceals in bottle of crystal light. Attended treatment for a first session. PN 1/7/16, Resident discharged today, family member [aunt} came for belongings at 5:00 p.m. The interim director of nursing (IDON) ' s hand written, undated Discharge/Summary Information, " Currently in hospital, history alcohol abuse, peripheral neuropathy, a vascular necrosis, of hip bone, bladder incontinent, esophageal reflux, diabetes type II (DM II). Secondary Hip Dislocation. Psychiatric Conditions: depression, ETOH abuse, chronic pain. Behavior problems: Consumption of alcohol, left premises for extended time without notice. Broke court order for no overnights outside of facility. Needs	F 323		

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F 323	Continued From page 39 continued therapy for chemical dependency, needs clinic involvement for management of DM II. "[R16] was admitted on 11/9/15, from FVR hospital. During course of stay, resident remained non-compliant with facility rules, concerning alcohol on premises and leaving facility without notification. Although compliant with medical appointment & treatment programs on course of improvement. " On 4/14/16, at 2:42 p.m. the social work designee (SWD) and administrator were asked for assessments and policies for resident LOA's. The SWD stated the residents, "sign LOA form and ask for meds". The SWD stated they completed one community assessment and one medicine assessment. "If someone does not return from the outing, I have the missing person's protocol." At 3:00 p.m. the SWD stated the assessment for LOA ability was usually a doctors order for the LOA. The SWD stated sometimes she would talk to the case manager if they had one (LICSW), and the resident had to pass medication self-administration. The facility did not have a LOA assessment. The SWD stated when they knew R16 was drinking, she had called the case manager [LICSW], searched R16's room, and searched the boyfriend. After the elopement the facility lacked reassessments on R16's ability to continue with LOA's. SWD stated " We can't restrict them from going out legally. Then you have to look at discharge or commitment proceedings if that's what you're going to do." The administrator stated "Many times if they want to go [out] even in a snow storm you let them go." The SWD stated she "did not think they [R16] had to be there at night." The case manager wanted her here for 1 week without any outings, then just day outings	F 323		

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F 323	Continued From page 40 and then to step mothers or boyfriends. The IDON was not available in the facility, so a scheduled phone conversation occurred with her on 4/15/16 at 2:00 p.m.. The IDON stated she did not have notes with her and did not want to contradict herself, but R16 had alcohol intoxication and was admitted to the hospital because of that "I guess, she is VA (vulnerable adult) no matter what." The IDON further stated that the leave of absence was not an assessment but was based on other assessments such as community safety that the SWD did. The IDON stated she only worked one day per week, she would give bullet points to SWD who filled out paperwork and then the IDON signed her name. R6 was observed on 4/12/16, at 6:35 p.m. walking from dining room table to bathroom, just off the living room. R6 had a halting gait, was stumbling and reaching for furniture. R6 was not using any device to assist with ambulation. During random observation 4/13/16, at 11:40 a.m. R6 was observed walking without a cane, limping and stumbling into the smoking room. R6 fell into chair in the smoking room. At 12:41 p.m. R6 was again observed to stumble and fall into a chair in smoking room. R6's Grand Avenue Residence Accident Prevention Plan (APP) completed 8/18/15, indicated potential problems included balance problems, dizziness, poor choices regarding clothing and foot wear, and not wearing glasses. R6 had multiple falls in previous year and R6 reported, "Sometimes I get dizzy I don't know why I fall. " The interventions listed on the APP included suspenders when wearing pants, proper fitting	F 323		

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F 323	Continued From page 41 footwear, walker when leaving the facility, night light in bathroom, and a call light next to bed. The APP indicated R6 did not always comply with wearing suspenders, proper fitting shoes and glasses. APP was reviewed by staff on 11/18/15, with no falls identified and on 2/11/16, two falls were identified for 11/25/15, and 1/4/16. Interventions added to the APP and dated 11/25/15, added included, "do not use upstairs B.R. [bathroom] during noc [night]. If B.R. being used pull lite [call light] for nurse to assist accompany to room to use B.R." R6's care plan dated 8/26/15, indicated R6 was at risk for fall due to gait, medications, and vision. R6 was to utilize a walker when out of the facility. Approaches listed on care plan included Fall risk assessment, vitals three times weekly, labs as ordered, suspenders if wearing pants, wear glasses and proper footwear, and night light on at night in bedroom. The 11/25/15, fall with new intervention was listed on care plan. The 1/4/16, fall was listed on care plan with no new interventions. The 2/22/16, fall was not on care plan. Review of Nurses' Record and Progress Notes (PN) from 7/2/15 through 4/13/16, indicated R6 fell on 7/23/15, 11/25/15, 1/4/16, and 2/22/16. - PN on 7/23/15, at 9:00 a.m. indicated R6 tripped over an object on the ground and fell on the grass. R6 did not have a walker with her. There was no apparent injury. - PN for 11/25/15, at 1:30 a.m. indicated the nurse heard and saw R6 on her knees at the top of the stairs and R6 fell over on to her side. R6 was instructed not to go upstairs to toilet. If her bathroom was busy R6 was to put on her call light and staff would help her. Bruises were observed	F 323		

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F 323	Continued From page 42 on her left knee and lower leg. - PN on 1/4/16, at 10:00 a.m. indicated R6 fell in the smoke room. R6 stated she was about to sit down when the chair slid away from her. - PN on 2/22/16, at 10:30 p.m. identified R6's roommate informed the nurse that R6 had fallen in the bathroom. R6 initially denied falling in the bathroom but then told the nurse she had slipped and fell on her knees and arm. R6 had a scrape on her left arm above the elbow. The nurse encouraged R6 to wear proper footwear. R6's sitting blood pressure was 132/80 and standing blood pressure was 104/70. Vital signs were faxed to the physician's assistant. The medical record lacked any follow up information with R6's physician 28 millimeters of mercury (mm HG) drop in systolic blood pressure, a diastolic drop in blood pressure of 10 mm HG, and the two hypertensive medications and the clozapine use. R6's quarterly Minimum Data Set (MDS) dated 2/5/16, indicated R6 was cognitively intact and was independent with all activities of daily living except dressing and personal hygiene. The MDS also indicated R6 was unsteady when going from sitting to standing or turning around, did not use any mobility devices and R6 became short of breath with walking. R6's MDS indicated R6 had diagnoses of anemia, diabetes, hypertension and schizophrenia. The Physician's order Sheet dated 3/24/16, noted R6 received amlodipine for hypertension daily, benazepril for hypertension twice daily, and clozapine for schizophrenia twice daily. The medical record was void of any documentation that the facility looked at R6's medication regarding the falls and her stated feeling of being "dizzy."	F 323		

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F 323	Continued From page 43	F 323		

During interview on 4/15/16, at 2:19 p.m. the interim director of nurses (IDON) said, all falls are investigated and care planned with new interventions identified.

The package insert for amlodipine besylate revised on 5/2012, by Lake Erie Medical & Surgical Supply DBA Quality Care Products LLC noted the following side effects. Most side effects are mild or moderate: headache, swelling of your legs or ankles, tiredness, extreme sleepiness, stomach pain, nausea, dizziness, flushing (hot or warm feeling in your face),
arrhythmia (irregular heartbeat) and heart palpitations (very fast heartbeat)."

The package insert for clozapine by Caraco Pharmaceutical Laboratories, Ltd. revised on 8/2/13, insructed staff to inform "patients and caregivers about the risk of orthostatic hypotension and syncope, especially during the period of initial dose titration. Instruct them to strictly follow the clinicianâ Euro (Trademark)s instructions for dosage and administration. Advise patients to consult their clinician immediately if they feel faint, lose consciousness or have signs or symptoms suggestive of bradycardia or arrhythmia."

The Centers for Disease Control dated 9/30/15, the section for Stopping Elderly Deaths and Injuries (STEADI) noted orthostatic blood pressure to be "drop in bp [blood pressure] of =20 mm Hg, or in diastolic bp of =10 mm Hg, or experiencing lightheadedness or dizziness is considered abnormal." R6 had both drops in blood pressure and the medical record lacked any follow up with the physician.

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	00208	A. BUILDING: ______ B. WING ______	04/18/2016

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3 000	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME 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: 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 Boarding Care Homes.	3 000		

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

Electronically Signed — 05/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00208	A. BUILDING: ____ B. WING ____	04/18/2016

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3 000	Continued From page 1 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. A complaint investigation was initiated to investigate case #HE150005 and correction orders are issued. Please be advised, the orders have been revised.	3 000		
31130	MN Rule 4655.7830 Subp. 1 Medication Containers; Labeled containers Subpart 1. Storage in labeled containers. All medications shall be kept in their original container bearing the original label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration dates of all time-dated drugs, directions for use, resident's name, physician's name, date of original issue or in the case of a	31130		6/9/16

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31130	Continued From page 2	31130		

refill, the most recent date thereof, and name and address of the licensed pharmacy which issued the medications. It shall be the responsibility of the boarding care home to secure the prescription number and name of the medication if these are not on the label.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure all medications were properly labeled with resident's names, directions for use and date opened for 1 of 2 residents (R17) that had diabetes.

Corrected

Findings include:

On 4/12/16, at 12:07 p.m. during the medication storage observation a Victoza (a medication to improve blood sugars) injectable pen was in a plastic bag labeled with a first name. There was no label on the pen or bag. There was no date opened on the pen.

R17's annually Minimum Data Set (MDS) dated 3/27/16, indicated R17 had a diagnosis of diabetes. The MDS indicated R17 had received insulin injections seven out of seven days.

The Physician Order Sheet dated 3/24/16, indicated R17 was to receive Victoza 1.8 milligrams (mg) injection daily at noon for diabetes.

During interview on 4/12/16, at 12:07 p.m. the licensed practical nurse (LPN)-A stated Victoza had been removed from the refrigerator yesterday but had not been used yet. LPN-A said, "I do not know why it does not have a name on it or a

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00208	A. BUILDING: ______ B. WING ______	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	**3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
31130	Continued From page 3	31130		

date."

The Victoza manufactures package insert by Novo Nordisk dated 3/9/15, instructed users, "Use a Victoza pen for only 30 days. Throw away a used Victoza pen after 30 days, even if some medicine is left in the pen."

Facility Internal Med Cart Audits policy updated 5/1/14, instructed staff, "To ensure the accuracy of the medications administered to the residents, each resident's medications and house medications will be audited internally by nursing every two weeks." Policy instructed staff that items to audited for included:
3. All medications requiring a date opened must have a legible date. It is beginning to smear or becoming hard to read, fix it. If it is illegible, you must discard as if it is expired."

Facility Proper Labeling policy updated 5/5/12, lacked instructions that medications required a label which included resident's name and directions for use.

SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop systems to ensure all medication areas are audited on a routine basis to ensure any medications without an appropriate label are appropriately replaced/disposed of/relabeled. The DON or designee could educate all appropriate staff members on the system. The DON or designee could develop monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty one (21) days

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31145	Continued From page 4	31145		
31145	MN Rule 4655.7830 Subp. 4 Medication Containers;Out of date medications Subp. 4. Out of date medications. Medications having a specific expiration date shall not be used after the date of expiration. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure expired medications were removed from the medication cart. Findings include: On 4/12/16, at 7:04 p.m. during medication storage observation one vial of Lantus (insulin) was observed to be stored ready for use in the top drawer of the medication cart that was labeled with R1's name and dated as opened on 3/14/16, and expired on 4/12/16. That was 30 days from the opened date. LPN-B verified the Lantus expired 28 day after being opened. R1's annually Minimum Data Set (MDS) dated 2/20/16, indicated R1 had a diagnosis of diabetes. The MDS indicated R1 had received insulin injections seven out of seven days. The Physician Order Sheet dated 3/24/16, indicated R1 was to receive Lantus 15 units daily at bedtime for diabetes. Lantus manufactures insert by Sanofi-Aventis dated 7/15, indicated, "Do not use Lantus after the expiration date stamped on the label or 28 days after you first use it."	31145	Corrected	6/9/16

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31145	Continued From page 5 During interview on 4/15/16, at 3:15 p.m. LPN-A stated, "I check every Friday for expired meds. It is the responsibility of every nurse." Facility Internal Med Cart Audits policy updated 5/1/14, instructed staff, "To ensure the accuracy of the medications administered to the residents, each resident's medications and house medications will be audited internally by nursing every two weeks." Policy instructed staff that items to audited for included: "2. Check for and remove expired medications. Dispose of expired medications using proper procedures. 3. All medications requiring a date opened must have a legible date. It is beginning to smear or becoming hard to read, fix it. If it is illegible, you must discard as if it is expired." SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop systems to ensure all medication areas are audited on a routine basis to ensure any medications without an expiration date or beyond the expiration date are appropriately replaced/disposed of/relabeled. The DON or designee could educate all appropriate staff members on the system. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	31145		
31895	MN Rule 144.651 Subd. 23 Patients & Residents of HCF Bill of Rights Subd. 23. Services for the facility. Patients	31895		5/23/16

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31895	Continued From page 6 and residents shall not perform labor or services for the facility unless those activities are included for therapeutic purposes and appropriately goal-related in their individual medical record. This MN Requirement is not met as evidenced by: Based on observation interview and document review, the facility failed to ensure 2 of 2 residents (R17, R13) in the sample who performed services for the facility, did so according to an established plan, and were paid at a prevailing rate. Findings include: R17 was observed at 6:05 p.m. on 4/12/16, passing out trays for 15 residents in the dining room. R17 was interviewed at 3:27 p.m. on 4/14/16. R17 stated she worked one hour a day in the kitchen passing out trays to the residents. She also stated she was upset because her pay had gone from 25 dollars a week, to 15 dollars a week, because the facility had hired a new staff person in the kitchen. When asked whether she received a paycheck from the facility, R17 said she passed out the trays Monday-Friday and was paid cash. R17 also stated R13 passed the trays out on weekends. R17 again stated she was "mad" her pay had gone down. During a follow up interview with R17 on 4/15/16, at 10:49 a.m., R17 stated she got paid every other Monday. The dietary manager was interviewed at 10:30 a.m. on 4/15/16, and produced a calendar schedule of when R17 and R13 passed trays in the dining room. The dietary manager stated she thought the residents had volunteered and stated	31895	Corrected. Also disputing the information that triggered this correction order.	

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31895	Continued From page 7 the job only lasted for ten minutes. During the survey attempts were made to interview R13 however, R13 was unavailable. R17's care plan dated 10/6/15, and R13's care plan dated 10/20/15, were void of any plan for either resident to help in the kitchen. The care plans for both residents lacked any evidence the resident was performing services for the facility, whether the resident was getting paid for the services, and whether the resident had agreed to the work arrangement. The facility's payroll book was reviewed from 3/14/16, going forward and it was determined neither resident was on the facility payroll. The facility provided forms, Resident Volunteer for Meal Set Up dated 3/11, which both residents had signed. R17 had signed a form on 5/24/12, and R13 had signed on 1/8/15. The information indicated the residents agreed to volunteer for meal set-up, would be observed once a quarter, and would follow infection control guidelines. The form lacked any indication as to whether either resident was being paid to perform the service, or any plan for their help having been added to their individualized plans of care. On 4/15/16, at 4:15 p.m. the social worker designee (SWD) and administrator were interviewed. The SWD acknowledged the residents had come to her to ask for jobs and that both were either paid cash, or with gift cards, for the services rendered in the kitchen. The SWD verified R17's and R13's desire to work, work arrangement, and the assigned kitchen duties were not documented on their plans of care.	31895		

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31895	Continued From page 8 Suggested Method of Correction: The director of nursing (DON) or designee could ensure there was a system in place to ensure no resident's work for the facility without appropriate assessment, care planning and pay/volunteer status. The DON or designee could ensure all staff are aware of the facility policies and procedures. The DON or designee could develop monitoring systems to ensure ongoiong compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	31895		
31990	MN Rule 626.557 Subd. 4 Reporting Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by:	31990		6/9/16

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31990	Continued From page 9 Based on observation, interview and document review, the facility failed to report allegations of verbal abuse, injuries of unknown origin, elopement, substance abuse within the facility, and/or falls with significant injury for 5 of 17 residents (R20, R7, R16, R14, R6). Findings include: R20 was admitted to the facility on 3/23/15. A minimum data set (MDS) annual assessment dated 2/6/16 identified R20 as independent with activities of daily living and intact cognition. R20's Community Safety Assessment dated 8/3/15 indicated that R20 had an extensive history of substance abuse, poor decision making, and was currently attending treatment three times per week. The assessment further indicated "since admission has used illegal drugs". The assessment further identified R20 had multiple vulnerable adult (VA) issues since admission related to poor choices. Staff recommendations on the assessment indicated R20 could leave the facility independently. A note dated 12/28/15 in R20's medical record signed by the administrator revealed that R20 admitted to having alcohol in her room which contributed to another resident (R7) going to the emergency room. The note indicated that this was not the first time this has occurred. R20's progress notes were reviewed from 1/16-4/11/16 and revealed on 2/3/16 at 7:30 a.m. R20 was found to be lethargic and unresponsive. Emergency Medical Services (EMS) were activated, the resident was provided Narcan (medication which reverses some overdoses such as Heroin) and transported to the	31990	Corrected. Also disputing some of the information that triggered this correction order.	

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31990	Continued From page 10	31990		

emergency room. R20 was admitted. R20's Hospital Discharge Summary dated 2/8/16 indicated that R20 was admitted to the hospital for altered mental status and accidental heroin overdose.

R20's Mental Health Summary dated 3/5/16-4/5/16 indicated that R20 had a "lengthy history of heroin abuse and methamphetamine abuse" and staff had an order for Narcan if overdose was suspected. The mental health summary further indicated that R20 had a verbal altercation with another resident and resident's family member and "needs to be closely monitored by staff". R20's careplan dated 3/3/16 identified a history of heroin addiction-recent heroin overdose and indicated that the facility now had and order for Narcan.

Interview with the Social Worker Designee (SWD) on 4/14/16 at 2:42 p.m. revealed that she was aware of R20's heroin overdose on 2/3/16. The SWD was unaware if R20 had any other hospitalizations due to overdose. The SWD was asked if R20's heroin overdose with hospitalization was reported to the state agency. The SWD replied the incidents were "not required to be reported , even if hospitalized. We follow a flow chart".

Interview with the Interim Director of Nursing (IDON) on 4/15/16 at 2:28 p.m. revealed that she was the nurse working on 2/3/16 and stated she was aware of R20's previous drug use but was unaware why R20 was unresponsive that morning. The IDON stated she was not familiar with R20 having any similar incidents related to drug use prior to 2/3/16 was not aware of any drugs in the facility. When asked if this incident should be reported to the state agency the DON

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31990	Continued From page 11	31990		

Continued From page 11

replied "I don't know".

R7 was admitted to the facility on 9/30/14 with diagnoses that included but not limited to mood disorder, schizophrenia, and alcohol dependency. R7's Minimum Data Set (MDS) quarterly review assessment dated 1/5/16 indicated R7's cognition was intact and was independent with activities of daily living.

R7's careplan dated 10/19/15 included vulnerable adult (VA) issues of history of promiscuous behavior and chemical use making poor decisions. The care plan identified 12-28-16 (sic-facility dated the care plan as the year 2016) R7 consumed alcohol that resulted in hospitalization.

R7's progress notes were reviewed from 10/21/15-4/11/16 and revealed on 12/27/15 at 9:11 p.m. R7 was found with a "blank stare unable to sit up in bed" and slurred speech. 911 was called and R7 was transported to the hospital. She returned 12/28/15. R7 reportedly got the alcohol from her roommates R20 and R17. An emergency department hospital admission sheet dated 12/17/15 which indicated that R7 was hospitalized for alcohol intoxication.

R7's social service progress notes were also reviewed and indicated on 1/4/16 the social worker designee (SWD) spoke with R7 regarding the drinking incident and resulting hospitalization. R7 got angry and screamed "that was not me".

R7's medical record included a psych appointment referral dated 1/11/16 which included the note that R7 was hospitalized for alcohol intoxication. Roommate gave her alcohol that was hidden in the room.

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An interview with the SWD and administrator on 4/14/16, at 4:03 p.m. indicated the SWD was familiar with R7's chemical dependency issues. The SWD stated the alcohol use was "not a problem, just because something happens once, if it was an ongoing issue I would have put it as a problem on the careplan". The SWD and administrator confirmed the alcohol use and resulting hospitalization were not reported to the state agency. The administrator stated the incident was "not required to be reported, even if hospitalized" and that the facility followed a flow chart for reporting of incidents to the state agency.

An interview with the Interim Director of Nursing (IDON) on 4/15/16 at 2:28 p.m. revealed she thought the facility reported the incident to "where it should be reported to".

R16 was accepted and admitted to the facility 11/9/15, under commitment for chemical dependency. The Minimum Data Set (MDS) dated 12/7/15, indicated R16 was cognitively intact, mildly depressed, had verbal behavioral symptoms directed towards others, and rejected care daily.
The Care Area Assessment (CAA) dated 12/7/15, indicated R16 was receiving anti-psychotic medications for anxiety and verbal aggression.
The undated care plan identified R16 had one missing person report for failure to return to facility at specified time. R16 was able to have leaves of absence (LOA's) and self administer medications.
Nursing progress notes on 11/17/15, at 6:00 p.m. R16 was found to be lethargic and confused. The resident was taken to the emergency room via ambulance. The hospital reported an alcohol level of 0.37. On 11/18/15, it was documented that R16

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31990	Continued From page 13 had been admitted to the hospital. On 11/24/15, R16 returned to the facility. On 12/8/15, at 10:00 R16 left via taxi to the doctor and spend the day with her boyfriend. She had medications through bedtime. She stated she will be back at 10:00 p.m. Although contacted through her boyfriend, R16 did not return to the facility until 12/15/15 at 5:30 p.m. When asked why she didn't return for a week, R16 replied "I had some things I had to take care of." Mental Health Summary dated 12/9/15, indicated: R16 was noncompliant with medications, had a long history of alcohol use and multiple chemical dependencies, treatment programs and long history of unstable housing. R16 was currently getting alcohol from her boyfriend in exchange for favors. On 12/25/15, R16 went on LOA with her boyfriend and medications. R16 stated she would be back that evening. On 12/26/15, at 6:45 p.m. R16 called the facility to inform them she was at the emergency room and was being admitted for pneumonia. The facility verified this with the ER staff. The interim director of nursing (IDON) ' s hand written, undated Discharge/Summary Information identified "Consumption of alcohol, left premises for extended time without notice. Broke court order for no overnights outside of facility." On 4/14/16, at 2:42 p.m. the social work designee (SWD) and administrator were asked for policies for resident LOA's. The SWD stated the residents "Sign LOA form and ask for meds." The SWD stated they complete one community assessment and one self administration of medication assessment. If a resident did not return from the outing, she would utilize the missing person protocol. When asked if the overdoses were reported to the state agency, the SWD stated they were "Not	31990		

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required to be reported, even if hospitalized. We follow a flow chart."
The IDON was not available in the facility, a scheduled phone conversation occurred with IDON at 2:00 on 4/15/16. The IDON had not considered R16 an elopement, but she was a vulnerable adult (VA), "I thought it was reported."
The facility failed to report R16's alcohol intoxication to the SA. The facility also failed to report the elopement from 12/8-12/15/15 to the SA even though the facility reported it to the police on 12/10/15 as a missing person.

Policy

The facility's policy entitled "Vulnerable Adult Maltreatment Prevention Plan" dated 3/6/15, indicated that the facility "does not tolerate any form of maltreatment" which included "any form of physical, verbal, mental or sexual abuse; any form of neglect, involuntary seclusion, corporal punishment or mishandling of resident property". The policy also included the following:
-" An assessment will be made of a prospective resident prior to admission for a known history of potentially dangerous behavior patterns"
-"Individual susceptibility will be assessed and included in the overall resident careplan along with goals and approaches for prevention and safety".
-"If maltreatment is suspected or observed the administrator must be notified immediately".
-"The administrator or representative will use the flowchart to determine the reporting requirements.
-"Nursing completes the internal reporting forms whish [sic] is a collection of information that needs to be submitted to MDH online. The Administrator submits the online report to the Minnesota Department of Health immediately as

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31990	Continued From page 15 available" -"You must make your report directly to the facility Administrator immediately after ensuring resident safety. The facility is responsible to report all reportable incidents and suspected crimes to MDH". R14 quarterly Minimum Data Set (MDS) indicated she was cognitively intact and was independent with all activities of daily living. R14's care plan dated 2/23/16 identified her as a vulnerable adult and indicated no vulnerable adult issues. A review of facility progress notes indicated in 3/20/16, R14 had been called a derogatory name by another resident in the facility three times that day. The noted indicated "this incident was very upsetting" to R14. A progress note dated 4/12/16 indicated R14 had complained of being called derogatory names by another resident "qday" (every day). R14 stated it had happened as recently as the previous day. During an interview on 4/12/16, at 4:26 p.m., R14 further stated a resident in the house is "nasty" to other residents and stated another resident beat that resident up. R14 stated the staff is aware of the situation, but no one did anything about it. During a subsequent interview on 4/14/16, at 10:22 a.m., R14 stated another resident in the house yells all the time and is "bossy" and "hard to deal with." During an interview on 4/15/16, at 2:15 p.m. the social work designee (SWD) stated she was responsible for handling and reporting potential abuse and abuse allegations. She stated when a resident had concerns she would talk to the other person. She stated "you have to separate	31990		

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31990	Continued From page 16	31990		

whether it's happening, or if it is their perception of what's happening." The SWD further stated, "reporting to the state agency isn't always the answer." She stated verbal aggression between resident's is not reportable to the state agency and takes place "frequently" but are not an actual threat to a resident.

R6's quarterly Minimum Data Set (MDS) dated 2/5/16, indicated R6 was cognitively intact with delusions (fixed false beliefs) and was independent with all activities of daily living except dressing and personal hygiene. The MDS also indicated R6 was unsteady when going from sitting to standing or turning around, did not use any mobility devices and that R6 became short of breath with walking. R6's MDS indicated R6 had diagnoses of anemia, diabetes, hypertension, and schizophrenia. Diagnosis of mild mental retardation noted on office visit note dated 4/14/15.

R6's care plan dated 8/26/15, identified R6 as a vulnerable adult and comments dated 11/16/15, and 2/16/16, indicated no vulnerable adult issues. 12/23/15, temporary care plan problem "Fx [fracture]. of proximal phalanx of L [left] 5th finger (etiology unknown-res does not know how it happened)"

Observation on 4/13/16, at 11:40 a.m. identified R6 walking without a cane, limping and stumbling into the smoking room. R6 fell into a chair in the smoking room. At 12:41 p.m. R6 was again observed to stumble and fall into chair in the smoking room.

Review of Incident/Accident Report dated 4/21/15, at 11:29 a.m. indicated "Pt woke up-few hours p[after] being up we noticed her R [right]

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31990	Continued From page 17 eye all puffy and 2 sm [small] lacerations around R [right] eye. She does not remember how it happened." Type of injury listed as "hematoma, abrasion, and swelling." Incident form indicated staff did not know when injury happened and resident did not remember falling. Incident /Accident report did not indicate the administrator or state agency were informed of the injury. Nurses Record and Progress Notes dated 4/21/15, at 12:00 p.m. indicated: "Appears pt [patient] fell against something during the noc [night], has a swollen right eye under each eye and two small lacerations are 3 mm [millimeters] long around eye." "Does not remember what she fell against." Note dated 4/21/15, at 3:00 p.m. ..."is now c/o [complaining of] (unreadable) w c/o headache. States hit head on door going to BR-has flashlight to help guide her." Review of progress notes 4/21/15 through 4/27/15, did not indicate the administrator or SA were notified of the injury of unknown origin. Nurses Record and Progress Notes dated 12/23/15 at 1:30 p.m. indicated R6 came into office and showed nurse her left hand. Nurse noted bruising on the front and back of hand with minor swelling. R6 was sent to urgent care. Physician's Progress Notes dated 12/23/15, indicated R6 is in clinic for assessment of bruising and swelling of left hand and that R6 did not remember hitting hand or banging it. Progress note indicated X-ray showed fracture of proximal phalanx of left fifth finger splint placed and orthopedic follow up with in next week recommended.	31990		

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The Serious Injury Report dated 12/23/15, sent to the Office of the Ombudsman for Mental Health and Mental Retardation, indicated R6 had sustained an fracture of the fifth finger of the left hand. Description of how the injury happened indicated "resident does not know what happened. Nurse observed swelling and bruising of left hand." The section triggering others to be notified including medical, OHFC [Office of Health Facility Complaints - state agency] and adult protection were blank.

At time of the injury R6 was unable to state what happened. While the Office of the Ombudsman was notified there was no evidence that the state agency was notified of the significant injury of unknown origin.

During interview on 4/14/16, at 10:25 a.m. the social worker designee (SWD) stated the injury for R6 was reported to the ombudsman's office but not to the state agency because they were not vulnerable adult issues.

During interview on 4/15/16, at 9:25 a.m. Licensed practical nurse (LPN)-A said "We do not document notifying the administrator. If there is a fracture we do not notify administrator on the weekend or nights because we have dealt with it. If the resident were admitted to the hospital we would let them know."

During interview on 4/15/16, at 9:27 a.m. the SWD said "I don't think they would bother calling the administrator because it was not a vulnerable adult issue, it was a serious injury. [Administrator] would need to know about fractures if it were a vulnerable adult issue like the fracture was due to being beaten. Do not need to know if it is due to a fall."

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31990	Continued From page 19 During interview on 4/15/16, at 2:15 p.m. the administrator said, "I ask them to chart notifying me. I expect them to notify me about fractures." During interview on 4/15/16, at 2:19 p.m. the interim director of nurses (IDON) stated, the facility reported injuries of unknown origin. Reporting fractures depended on whether or not we know where the resident had been. The IDON said, "If there have not been any incidents then it is not reportable. We report to where ever we are supposed to." When asked about reporting injuries of unknown origin to the state agency versus the office of the ombudsman the IDON said, "I have always reported to the same place." SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop systems to ensure potential abuse/neglect/misappropriation of funds allegations are reported immediately to the administrator and state agency. The administrator or designee could educate all staff om this system. The administrator could monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	31990		
32000	MN Rule 626.557 Subd. 14 Reporting Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an	32000		6/9/16

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32000	Continued From page 20 assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person ' s susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility ' s ongoing assessments of the	32000		

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32000	Continued From page 21 vulnerable adult. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to operationalize their policy for reporting of allegations of verbal abuse, injuries of unknown origin, elopement, substance abuse within the facility, and/or falls with significant injury for 5 of 17 residents (R20, R7, R16, R14, R6). Findings include: The facility's policy entitled "Vulnerable Adult Maltreatment Prevention Plan" dated 3/6/15, indicated that the facility "does not tolerate any form of maltreatment" which included "any form of physical, verbal, mental or sexual abuse; any form of neglect, involuntary seclusion, corporal punishment or mishandling of resident property". The policy also included the following: -" An assessment will be made of a prospective resident prior to admission for a known history of potentially dangerous behavior patterns" -"Individual susceptibility will be assessed and included in the overall resident careplan along with goals and approaches for prevention and safety". -"If maltreatment is suspected or observed the administrator must be notified immediately". -"The administrator or representative will use the flowchart to determine the reporting requirements. -"Nursing completes the internal reporting forms whish [sic] is a collection of information that needs to be submitted to MDH online. The Administrator submits the online report to the Minnesota Department of Health immediately as	32000	Corrected.	

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available"
-"You must make your report directly to the facility Administrator immediately after ensuring resident safety. The facility is responsible to report all reportable incidents and suspected crimes to MDH".
Based on observation, interview and document review, the facility failed to report allegations of verbal abuse, injuries of unknown origin, elopement, substance abuse within the facility, and/or falls with significant injury for 6 of 17 residents (R20, R7, R16, R14, R6, R8).

R20 was admitted to the facility on 3/23/15. A minimum data set (MDS) annual assessment dated 2/6/16 identified R20 as independent with activities of daily living and intact cognition.

R20's Community Safety Assessment dated 8/3/15 indicated that R20 had an extensive history of substance abuse, poor decision making, and was currently attending treatment three times per week. The assessment further indicated "since admission has used illegal drugs". The assessment further identified R20 had multiple vulnerable adult (VA) issues since admission related to poor choices. Staff recommendations on the assessment indicated R20 could leave the facility independently.

A note dated 12/28/15 in R20's medical record signed by the administrator revealed that R20 admitted to having alcohol in her room which contributed to another resident (R7) going to the emergency room. The note indicated that this was not the first time this has occurred.

R20's progress notes were reviewed from 1/16-4/11/16 and revealed on 2/3/16 at 7:30 a.m. R20 was found to be lethargic and unresponsive.

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Emergency Medical Services (EMS) were activated, the resident was provided Narcan (medication which reverses some overdoses such as Heroin) and transported to the emergency room. R20 was admitted. R20's Hospital Discharge Summary dated 2/8/16 indicated that R20 was admitted to the hospital for altered mental status and accidental heroin overdose.

R20's Mental Health Summary dated 3/5/16-4/5/16 indicated that R20 had a "lengthy history of heroin abuse and methamphetamine abuse" and staff had an order for Narcan if overdose was suspected. The mental health summary further indicated that R20 had a verbal altercation with another resident and resident's family member and "needs to be closely monitored by staff". R20's careplan dated 3/3/16 identified a history of heroin addiction-recent heroin overdose and indicated that the facility now had and order for Narcan.

Interview with the Social Worker Designee (SWD) on 4/14/16 at 2:42 p.m. revealed that she was aware of R20's heroin overdose on 2/3/16. The SWD was unaware if R20 had any other hospitalizations due to overdose. The SWD was asked if R20's heroin overdose with hospitalization was reported to the state agency. The SWD replied the incidents were "not required to be reported, even if hospitalized. We follow a flow chart."

Interview with the Interim Director of Nursing (IDON) on 4/15/16, at 2:28 p.m. revealed that she was the nurse working on 2/3/16 and stated she was aware of R20's previous drug use but was unaware why R20 was unresponsive that morning. The IDON stated she was not familiar

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with R20 having any similar incidents related to drug use prior to 2/3/16 was not aware of any drugs in the facility. When asked if this incident should be reported to the state agency the DON replied "I don't know".

R7 was admitted to the facility on 9/30/14 with diagnoses that included but not limited to mood disorder, schizophrenia, and alcohol dependency. R7's Minimum Data Set (MDS) quarterly review assessment dated 1/5/16 indicated R7's cognition was intact and was independent with activities of daily living.

R7's careplan dated 10/19/15 included vulnerable adult (VA) issues of history of promiscuous behavior and chemical use making poor decisions. The care plan identified 12-28-16 (sic-facility dated the care plan as the year 2016) R7 consumed alcohol that resulted in hospitalization.

R7's progress notes were reviewed from 10/21/15-4/11/16 and revealed on 12/27/15 at 9:11 p.m. R7 was found with a "blank stare unable to sit up in bed" and slurred speech. 911 was called and R7 was transported to the hospital. She returned 12/28/15. R7 reportedly got the alcohol from her roommates R20 and R17. An emergency department hospital admission sheet dated 12/17/15 which indicated that R7 was hospitalized for alcohol intoxication.

R7's social service progress notes were also reviewed and indicated on 1/4/16 the social worker designee (SWD) spoke with R7 regarding the drinking incident and resulting hospitalization. R7 got angry and screamed "that was not me".

R7's medical record included a psych appointment referral dated 1/11/16 which

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included the note that R7 was hospitalized for alcohol intoxication. Roommate gave her alcohol that was hidden in the room.

An interview with the SWD and administrator on 4/14/16, at 4:03 p.m. indicated the SWD was familiar with R7's chemical dependency issues. The SWD stated the alcohol use was "not a problem, just because something happens once, if it was an ongoing issue I would have put it as a problem on the careplan". The SWD and administrator confirmed the alcohol use and resulting hospitalization were not reported to the state agency. The administrator stated the incident was "not required to be reported, even if hospitalized" and that the facility followed a flow chart for reporting of incidents to the state agency.

An interview with the Interim Director of Nursing (IDON) on 4/15/16 at 2:28 p.m. revealed she thought the facility reported the incident to "where it should be reported to".

R16 was accepted and admitted to the facility 11/9/15, under commitment for chemical dependency. The Minimum Data Set (MDS) dated 12/7/15, indicated R16 was cognitively intact, mildly depressed, had verbal behavioral symptoms directed towards others, and rejected care daily.
The Care Area Assessment (CAA) dated 12/7/15, indicated R16 was receiving anti-psychotic medications for anxiety and verbal aggression.
The undated care plan identified R16 had one missing person report for failure to return to facility at specified time. R16 was able to have leaves of absence (LOA's) and self administer medications.
Nursing progress notes on 11/17/15, at 6:00 p.m.

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32000	Continued From page 26 R16 was found to be lethargic and confused. The resident was taken to the emergency room via ambulance. The hospital reported an alcohol level of 0.37. On 11/18/15, it was documented that R16 had been admitted to the hospital. On 11/24/15, R16 returned to the facility. On 12/8/15, at 10:00 R16 left via taxi to the doctor and spend the day with her boyfriend. She had medications through bedtime. She stated she will be back at 10:00 p.m. Although contacted through her boyfriend, R16 did not return to the facility until 12/15/15 at 5:30 p.m. When asked why she didn't return for a week, R16 replied "I had some things I had to take care of." Mental Health Summary dated 12/9/15, indicated: R16 was noncompliant with medications, had a long history of alcohol use and multiple chemical dependencies, treatment programs and long history of unstable housing. R16 was currently getting alcohol from her boyfriend in exchange for favors. On 12/25/15, R16 went on LOA with her boyfriend and medications. R16 stated she would be back that evening. On 12/26/15, at 6:45 p.m. R16 called the facility to inform them she was at the emergency room and was being admitted for pneumonia. The facility verified this with the ER staff. The interim director of nursing (IDON) ' s hand written, undated Discharge/Summary Information identified "Consumption of alcohol, left premises for extended time without notice. Broke court order for no overnights outside of facility." On 4/14/16, at 2:42 p.m. the social work designee (SWD) and administrator were asked for policies for resident LOA's. The SWD stated the residents "Sign LOA form and ask for meds." The SWD stated they complete one community assessment and one self administration of medication assessment. If a resident did not	32000		

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return from the outing, she would utilize the missing person protocol.
When asked if the overdoses were reported to the state agency, the SWD stated they were "Not required to be reported, even if hospitalized. We follow a flow chart."
The IDON was not available in the facility, a scheduled phone conversation occurred with IDON at 2:00 on 4/15/16. The IDON had not considered R16 an elopement, but she was a vulnerable adult (VA), "I thought it was reported."
The facility failed to report R16's alcohol intoxication to the SA. The facility also failed to report the elopement from 12/8-12/15/15 to the SA even though the facility reported it to the police on 12/10/15 as a missing person.
R14 quarterly Minimum Data Set (MDS) indicated she was cognitively intact and was independent with all activities of daily living. R14's care plan dated 2/23/16 identified her as a vulnerable adult and indicated no vulnerable adult issues.

A review of facility progress notes indicated in 3/20/16, R14 had been called a derogatory name by another resident in the facility three times that day. The noted indicated "this incident was very upsetting" to R14. A progress note dated 4/12/16 indicated R14 had complained of being called derogatory names by another resident "qday" (every day). R14 stated it had happened as recently as the previous day.

During an interview on 4/12/16, at 4:26 p.m., R14 further stated a resident in the house is "nasty" to other residents and stated another resident beat that resident up. R14 stated the staff is aware of the situation, but no one did anything about it.

During a subsequent interview on 4/14/16, at 10:22 a.m., R14 stated another resident in the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
32000	Continued From page 28	32000		

house yells all the time and is "bossy" and "hard to deal with."

During an interview on 4/15/16, at 2:15 p.m. the social work designee (SWD) stated she was responsible for handling and reporting potential abuse and abuse allegations. She stated when a resident had concerns she would talk to the other person. She stated "you have to separate whether it's happening, or if it is their perception of what's happening." The SWD further stated, "reporting to the state agency isn't always the answer." She stated verbal aggression between resident's is not reportable to the state agency and takes place "frequently" but are not an actual threat to a resident.

R6's quarterly Minimum Data Set (MDS) dated 2/5/16, indicated R6 was cognitively intact with delusions (fixed false beliefs) and was independent with all activities of daily living except dressing and personal hygiene. The MDS also indicated R6 was unsteady when going from sitting to standing or turning around, did not use any mobility devices and that R6 became short of breath with walking. R6's MDS indicated R6 had diagnoses of anemia, diabetes, hypertension, and schizophrenia. Diagnosis of mild mental retardation noted on office visit note dated 4/14/15.

R6's care plan dated 8/26/15, identified R6 as a vulnerable adult and comments dated 11/16/15, and 2/16/16, indicated no vulnerable adult issues. 12/23/15, temporary care plan problem "Fx [fracture]. of proximal phalanx of L [left] 5th finger (etiology unknown-res does not know how it happened)"

Observation on 4/13/16, at 11:40 a.m. identified

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00208	A. BUILDING: ____ B. WING ____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	**3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
32000	Continued From page 29	32000		

R6 walking without a cane, limping and stumbling into the smoking room. R6 fell into a chair in the smoking room. At 12:41 p.m. R6 was again observed to stumble and fall into chair in the smoking room.

Review of Incident/Accident Report dated 4/21/15, at 11:29 a.m. indicated "Pt woke up-few hours p[after] being up we noticed her R [right] eye all puffy and 2 sm [small] lacerations around R [right] eye. She does not remember how it happened." Type of injury listed as "hematoma, abrasion, and swelling." Incident form indicated staff did not know when injury happened and resident did not remember falling. Incident /Accident report did not indicate the administrator or state agency were informed of the injury.

Nurses Record and Progress Notes dated 4/21/15, at 12:00 p.m. indicated: "Appears pt [patient] fell against something during the noc [night], has a swollen right eye under each eye and two small lacerations are 3 mm [millimeters] long around eye." "Does not remember what she fell against."

Note dated 4/21/15, at 3:00 p.m. ..."is now c/o [complaining of] (unreadable) w c/o headache. States hit head on door going to BR-has flashlight to help guide her." Review of progress notes 4/21/15 through 4/27/15, did not indicate the administrator or SA were notified of the injury of unknown origin.

Nurses Record and Progress Notes dated 12/23/15 at 1:30 p.m. indicated R6 came into office and showed nurse her left hand. Nurse noted bruising on the front and back of hand with minor swelling. R6 was sent to urgent care.

REVISED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00208	A. BUILDING: ____ B. WING ____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	**3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409**

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32000	Continued From page 30	32000		

Physician 's Progress Notes dated 12/23/15, indicated R6 is in clinic for assessment of bruising and swelling of left hand and that R6 did not remember hitting hand or banging it. Progress note indicated X-ray showed fracture of proximal phalanx of left fifth finger splint placed and orthopedic follow up with in next week recommended.

The Serious Injury Report dated 12/23/15, sent to the Office of the Ombudsman for Mental Health and Mental Retardation, indicated R6 had sustained an fracture of the fifth finger of the left hand. Description of how the injury happened indicated "resident does not know what happened. Nurse observed swelling and bruising of left hand" The section triggering others to be notified including medical, OHFC [Office of Health Facility Complaints - state agency] and adult protection were blank.

At time of the injury R6 was unable to state what happened. While the Office of the Ombudsman was notified there was no evidence that the state agency was notified of the significant injury of unknown origin.

During interview on 4/14/16, at 10:25 a.m. the social worker designee (SWD) stated the injury for R6 was reported to the ombudsman's office but not to the state agency because they were not vulnerable adult issues.

During interview on 4/15/16, at 9:25 a.m. Licensed practical nurse (LPN)-A said "We do not document notifying the administrator. If there is a fracture we do not notify administrator on the weekend or nights because we have dealt with it. If the resident were admitted to the hospital we would let them know."

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00208	A. BUILDING: ________ B. WING ________	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409

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32000	Continued From page 31	32000		

During interview on 4/15/16, at 9:27 a.m. the SWD said "I don't think they would bother calling the administrator because it was not a vulnerable adult issue, it was a serious injury. [Administrator] would need to know about fractures if it were a vulnerable adult issue like the fracture was due to being beaten. Do not need to know if it is due to a fall."

During interview on 4/15/16, at 2:15 p.m. the administrator said, "I ask them to chart notifying me. I expect them to notify me about fractures."

During interview on 4/15/16, at 2:19 p.m. the interim director of nurses (IDON) stated, the facility reported injuries of unknown origin. Reporting fractures depended on whether or not we know where the resident had been. The IDON said, "If there have not been any incidents then it is not reportable. We report to where ever we are supposed to." When asked about reporting injuries of unknown origin to the state agency versus the office of the ombudsman the IDON said, "I have always reported to the same place."

SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop systems to ensure the abuse/neglact plan/policy is operationalized. The administrator or designee could educate all staff om this system. The administrator could monitor to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty One (21) days

REVISED

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: WCGU
Facility ID: 00208

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **24E150**

2. STATE VENDOR OR MEDICAID NO. (L2) **950842200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRAND AVENUE REST HOME**
(L4) **3956 GRAND AVENUE S0UTH**
(L5) **MINNEAPOLIS, MN** (L6) **55409**

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 **6/30/2016** (L34)

7. PROVIDER/SUPPLIER CATEGORY 10 (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

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

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
X 8. Patient Room Size
__ 9. Beds/Room

* Code: B,8 (L12)

12.Total Facility Beds **20** (L18)

13.Total Certified Beds **20** (L17)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		20		
(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 :
Gloria Derfus, Unit Supervisor 7/8/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 07/8/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/31/1974** (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. (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **06/24/2016** (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

July 8, 2016

Mr. Allen Soderbeck, Administrator
Grand Avenue Rest Home
3956 Grand Avenue S0uth
Minneapolis, Minnesota 55409

RE: Project Number SE150025 and Complaint Number HE150007

Dear Mr. Soderbeck:

On June 21, 2016, the Department recommended to the State Medicaid Agency that the following enforcement remedy be imposed:

- Mandatory denial of payment for new Medicaid admissions effective July 18, 2016, 2016. (42 CFR 488.417 (b))

Also, we notified you in our letter of June 21, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 18, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on April 18, 2016, and lack of verification of the health deficiencies at the time of the June 21, 2016 notice. The most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 1, 2016 the Minnesota Department of Health, Office of Health Facility Complaints completed an abbreviated standard survey to verify that your facility had achieved and maintained compliance with federal certification deficiencies. The most serious deficiencies in your facility were found 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

As a result of finding that your facility has not achieved substantial compliance, the following Category 1 remedy is being imposed:

- State Monitoring effective July 13, 2016. (42 CFR 488.422)

In addition, this Department recommended to the CMS Region V Office the following action related to the remedy recommended in our letter dated June 21, 2016.

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 18, 2016 remain in effect. (42 CFR 488.417 (b))

Also, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 18, 2016.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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:

Annette Winters, Supervisor
Office of Health Facility Complaints
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4204 Fax: (651) 281-9796

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

-Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 18, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel ree to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 21, 2016

Mr. Allen Soderbeck, Administrator
Grand Avenue Rest Home
3956 Grand Avenue S0uth
Minneapolis, MN 55409

RE: Project Number SE150025 & Complaint Number HE150005

Dear Mr. Soderbeck:

On May 4, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 18, 2016 that included an investigation of complaint number HE150005. 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 June 3, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 18, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 10, 2016. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on April 18, 2016.

However, compliance with the health deficiencies issued pursuant to the April 18, 2016 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

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

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective July 18, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective July 18, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 18, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Grand Avenue Rest Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 18, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644

Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 18, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
24E150		6/30/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409

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 F0164 Reg. # 483.10(e), 483.75(l)(4) LSC	Correction Completed 05/11/2016	ID Prefix F0169 Reg. # 483.10(h) LSC	Correction Completed 05/23/2016	ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	Correction Completed 06/09/2016
ID Prefix F0226 Reg. # 483.13(c) LSC	Correction Completed 06/09/2016	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 06/10/2016	ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 06/09/2016
ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 06/09/2016	ID Prefix F0354 Reg. # 483.30(b) LSC	Correction Completed 05/16/2016	ID Prefix F0356 Reg. # 483.30(e) LSC	Correction Completed 04/18/2016
ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 06/09/2016	ID Prefix F0514 Reg. # 483.75(l)(1) LSC	Correction Completed 06/03/2016	ID Prefix F0520 Reg. # 483.75(o)(1) LSC	Correction Completed 06/03/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	7/8/2016	18623	6/30/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/18/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
24E150	A. Building 01 - MAIN BUILDING 01 B. Wing	6/3/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409

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 K0012	Correction Completed 05/05/2016	ID Prefix Reg. # NFPA 101 LSC K0032	Correction Completed 05/05/2016	ID Prefix Reg. # NFPA 101 LSC K0033	Correction Completed 05/05/2016
ID Prefix Reg. # NFPA 101 LSC K0039	Correction Completed 05/05/2016	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 04/20/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	6/20/2016	19251	6/3/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
4/12/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: WCGU
Facility ID: 00208

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **24E150**

2. STATE VENDOR OR MEDICAID NO. (L2) **950842200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRAND AVENUE REST HOME**
(L4) **3956 GRAND AVENUE S0UTH**
(L5) **MINNEAPOLIS, MN** (L6) **55409**

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 **04/18/2016** (L34)

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)

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

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

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
x 9. Beds/Room

* Code: B, 9 (L12)

12.Total Facility Beds **20** (L18)

13.Total Certified Beds **20** (L17)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		20		
(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):
Facility's request for continuing waivers involving tag 0458 (Bedrooms measure at least 70 sq ft) has been recommended to CMS. A FSES survey was completed on April 21, 2016 and the facility received a passing score. Refer to enclosed FSES/HS for additional information.

17. SURVEYOR SIGNATURE Date :
Carrie Euerle, HFE NE II 06/23/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 06/24/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/31/1974** (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. (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **06/24/2016** (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions) 020499

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 4, 2016

Mr. Allen Soderbeck, Administrator
Grand Avenue Rest Home
3956 Grand Avenue S0uth
Minneapolis, MN 55409

RE: Project Number SE150025 & Complaint Number HE150005

Dear Mr. Soderbeck:

On April 18, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the April 18, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number HE150005.

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

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained**

at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 28, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 28, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the

Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 18, 2016 (three months after the

identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 18, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections

Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING ______ B. WING ______	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	**3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey." An investigation of complaint HE150005 was completed. The complaint was substantiated and deficiencies were cited at F225, F226, F315, and F323. Please be advised, this statement of deficiencies has been revised.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private	F 164		5/11/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 05/14/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING ______ B. WING ______	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	**3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409**

(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 164	Continued From page 1 room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure privacy for 3 of 15 residents (R2, R17, R7) residing in shared rooms who stated they would like additional privacy. Findings include: R2's annual Minimum Data Set (MDS) dated 3/11/16, indicated she was cognitively intact and independent with all activities of daily living. During an observation on 4/12/16, at 7:00 p.m., R2's bedroom bed was to the right of the door upon entrance to the room. R2 had one bed parallel to and another bed across from hers. No privacy curtains or partitions were evident in the	F 164	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any fasts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the facility has prepared this Plan of Corrections prior to resolution of	

(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 164	Continued From page 2 room. During an interview on 4/13/16, at 8:37 a.m., R2 stated she had to go into the bathroom to change her clothes. She stated her roommate leaves the light on by her bed at night and the strong light keeps her awake and hurts her head. R2 stated no one had ever offered her a privacy curtain and stated, "I don't know if they would do that." R7 was admitted to the facility 9/30/14, with diagnoses that included but not limited to mood disorder, schizophrenia, and alcohol dependency. The MDS dated 1/5/16, indicated R7 was cognitively intact, minimally depressed and independent with all activities of daily living. On 4/12/16, at 4:44 p.m. R7 stated she would like more privacy. R7 stated she changed her clothes in front of the closet doors, because of her roommates. In addition there were three people living in the room with two mobile privacy curtains. R7 stated the curtains couldn't be moved because they fall apart. R17's MDS dated 3/27/16, indicated R17 was cognitively intact and independent with all activities of daily living. R17 stated on 4/12/16, at 7:02 p.m. there was not enough privacy and she would like more. R17 stated there was a moveable privacy screen but it did not enough privacy. Further it broke and came apart when tried to move it. A facility document titled Resident Rules and Responsibilities, undated, indicated "because residents share bedrooms without {sic} other residents, residents are allowed a privacy screen	F 164	any dispute resolution which must be filed because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the delivery of the CMS-2567 allegations of deficiencies as a condition to participate in the programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. This was originally cited under F460, but the facility was initially certified on 3/31/1974, long before 3/31/92 so that tag is invalid. The tag was then changed to F164. We do not believe that the change is tag is fair or appropriate. The reason that F460 has a implementation date is for facilities such as ours to be grandfathered so we are requesting an IDR. Our facility is a home-like setting and does have shared bedrooms. We do understand that we have some privacy issues that might bother a resident or potential resident and have addressed that in policies and procedures. Prior to admission, we discuss privacy with potential residents at length during the facility tour. We also conduct a privacy assessment with each resident during the quarterly assessment cycle to inquire and if needed address privacy concerns of the residents. In past cases, we have moved residents within the facility to provide for additional privacy. R2s privacy assessment most recent privacy assessment dated 3/30/16 and signed by the resident shows that the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING ______ B. WING ______	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409

(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 164	Continued From page 3 in bedroom." Staff to discuss and review privacy with the resident quarterly. When the social worker designee was asked about the privacy curtains on 4/15/16, at 3:15 p.m. she indicated they do have privacy curtains in some rooms. There was no maintenance log available for the the needed maintenance of the mobile privacy curtain.	F 164	resident is aware that they can request a privacy screen for the bedroom. A specific note included "I like my roommates. We have been together a long time." At no time has a privacy screen been requested. This document was provided to the survey team. The "strong" light above the other resident's bed consists of a 60 watt bulb. During an interview with resident R2 on 5/11/16, R2 told us that "she was upset" with roommate R12 that day and she was "mixed up". R2 told us that the roommates "work it out" instead of reporting issues to staff and that she had not reported this to staff before. We discussed the privacy policy again with R2 and she understands and signed it again. She does not want a privacy screen and all is well with the roommate. The bedroom of R7 has many windows. The room has windows on three sides, not two. There are blinds on every single window. There is no requirement for a "curtain". The blinds provide privacy from the outside if the residents choose to use them. It is also our policy that bedroom blinds or curtains are closed during darkness and monitor by nursing every day. If R7 chooses to change clothes by her closet it is her choice. There are three residents in the room. Both other residents have privacy screens. Many residents choose to change clothes in one of the bathrooms due to the shared bedrooms. R17 shares the same bedroom with R7.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING ______ B. WING ______	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409

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F 164	Continued From page 4	F 164	R17 does have a privacy curtain. On 7/14/15, resident requested a privacy screen and one was provided. R17 has signed privacy assessments on 10/6/15, 1/6/16, and 4/18/16 that she has no privacy concerns. The 4/18/16 document was provided to the survey team. It is likely the R7 and R17 are referring to the same privacy screen that "came apart" since they are roommates. This was not reported to any staff at the facility. The survey comments mention that there was no maintenance log available. They fail to mention that they never asked for one. Even if they had asked, since we knew nothing about the privacy curtain falling apart, it would not be on the maintenance log. To assure compliance with this the following plan has been put into place. We discussed the privacy policy again with R2 on 5/11/16 and she understands and signed the privacy assessment again. R2 does not want a privacy screen and all is well with the roommate. We discussed the privacy policy again with R7 on 5/11/16 and she understands and signed the privacy assessment again. R7 does not want a privacy screen and all is well with the roommate. Also on 5/11/16, SWD asked R7 if she wanted to change rooms and she declined. R17 has a privacy screen and there is no additional available privacy for that bed. SWD asked R17 if she wanted to change rooms and she declined. The Administrator	

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F 164	Continued From page 5	F 164	looked at the privacy screen in question and repaired it. We have reviewed every resident's privacy assessment and all have signed them with no issues. We have not had any complaints to the facility. We will continue to speak to potential residents about the privacy policy and conduct privacy assessments with all residents quarterly as part of their regular assessment cycle. The SWD is responsible to assess resident issues like this and the Administrator will monitor.	
F 169 SS=D	483.10(h) RIGHT TO PERFORM FACILITY SERVICES OR REFUSE The resident has the right to refuse to perform services for the facility; or perform services for the facility, if he or she chooses, when the facility has documented the need or desire for work in the plan of care; the plan specifies the nature of the services performed and whether the services are voluntary or paid; compensation for paid services is at or above prevailing rates; and the resident agrees to the work arrangement described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 2 residents (R17, R13) in the sample who performed services for the facility, did so according to an established plan, and were paid at a prevailing rate. Findings include:	F 169	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents, or other	5/23/16

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F 169 Continued From page 6

R17 was observed at 6:05 p.m. on 4/12/16, passing out trays for 15 residents in the dining room.

R17 was interviewed at 3:27 p.m. on 4/14/16. R17 stated she worked one hour a day in the kitchen passing out trays to the residents. She also stated she was upset because her pay had gone from 25 dollars a week, to 15 dollars a week, because the facility had hired a new staff person in the kitchen. When asked whether she received a paycheck from the facility, R17 said she passed out the trays Monday-Friday and was paid cash. R17 also stated R13 passed the trays out on weekends. R17 again stated she was "mad" her pay had gone down. During a follow up interview with R17 on 4/15/16, at 10:49 a.m., R17 stated she got paid every other Monday.

The dietary manager was interviewed at 10:30 a.m. on 4/15/16, and produced a calendar schedule of when R17 and R13 passed trays in the dining room. The dietary manager stated she thought the residents had volunteered and stated the job only lasted for ten minutes.

During the survey attempts were made to interview R13 however, R13 was unavailable.

R17's care plan dated 10/6/15, and R13's care plan dated 10/20/15, were void of any plan for either resident to help in the kitchen. The care plans for both residents lacked any evidence the resident was performing services for the facility, whether the resident was getting paid for the services, and whether the resident had agreed to the work arrangement.

F 169

individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any fasts alleged or the correctness of any conclusions set forth in the allegations.
Accordingly, the facility has prepared this Plan of Corrections prior to resolution of any dispute resolution which must be filed because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the delivery of the CMS-2567 allegations of deficiencies as a condition to participate in the programs. This Plan of Correction is submitted as the facility’s credible allegation of compliance.
The survey team either failed to include all information regarding this deficiency. The interview with R17 failed to establish the fact that the payment reduction R17 received after the dietary aide was hired was directly due to the job duties and time spent were significantly reduced. The Administrator provided information regarding a job time study and confirmed by the dietary manager that the daily activity was 6-10 minutes per day, not the hour as quoted in the surveyor interview of R17. The administrator also provided the calculations for how the pay was established and that the residents were effectively earning at or above minimum wage. These pertinent facts are missing. It is correct that the dietary manager was unaware of the pay the residents were receiving since that was being handled by

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F 169	Continued From page 7 The facility's payroll book was reviewed from 3/14/16, going forward and it was determined neither resident was on the facility payroll. The facility provided forms, Resident Volunteer for Meal Set Up dated 3/11, which both residents had signed. R17 had signed a form on 5/24/12, and R13 had signed on 1/8/15. The information indicated the residents agreed to volunteer for meal set-up, would be observed once a quarter, and would follow infection control guidelines. The form lacked any indication as to whether either resident was being paid to perform the service, or any plan for their help having been added to their individualized plans of care. On 4/15/16, at 4:15 p.m. the social worker designee (SWD) and administrator were interviewed. The SWD acknowledged the residents had come to her to ask for jobs and that both were either paid cash, or with gift cards, for the services rendered in the kitchen. The SWD verified R17's and R13's desire to work, work arrangement, and the assigned kitchen duties were not documented on their plans of care.	F 169	social service. The residents are not forced and did volunteer to do this work, meaning that they were doing this without being forced. Whether paid or not, the duties are the same from the dietary manager perspective. SWD provided many pages of notes that were kept on the training and performance of the residents. This documentation was recommended by a previous survey team. In the end, the base evidence of this deficiency is because a line was missing from a specific form. The correction for this deficiency is to discontinue the program.	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or	F 225		6/9/16

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F 225	Continued From page 8 other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to report allegations of verbal abuse, injuries of unknown origin, neglect of supervision for elopement and substance abuse within the facility for 5 of 17 residents (R20, R7, R16, R14, R6). Findings include: R20 was admitted to the facility on 3/23/15. A	F 225	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of	

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F 225	Continued From page 9 Minimum Data Set (MDS) annual assessment dated 2/6/16, identified R20 as independent with activities of daily living and intact cognition. R20's Community Safety Assessment dated 8/3/15, indicated R20 had an extensive history of substance abuse, poor decision making, and was currently attending treatment three times per week. The assessment further indicated "since admission has used illegal drugs." The assessment further identified R20 had multiple vulnerable adult (VA) issues since admission related to poor choices. Staff recommendations on the assessment indicated R20 could leave the facility independently. A note dated 12/28/15, in R20's medical record signed by the administrator revealed that R20 admitted to having alcohol in her room which contributed to another resident (R7) going to the emergency room. The note indicated that this was not the first time this has occurred. R20's progress notes were reviewed from 1/16 through 4/11/16, and revealed on 2/3/16, at 7:30 a.m. R20 was found to be lethargic and unresponsive. Emergency Medical Services (EMS) were activated, the resident was provided Narcan (medication which reverses some overdoses such as Heroin) and transported to the emergency room. R20 was admitted. R20's Hospital Discharge Summary dated 2/8/16 indicated that R20 was admitted to the hospital for altered mental status and accidental heroin overdose. R20's Mental Health Summary dated 3/5/16 through 4/5/16, indicated R20 had a "lengthy history of heroin abuse and methamphetamine	F 225	this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any fasts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the facility has prepared this Plan of Correction prior to resolution of any dispute resolution which must be filed because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the delivery of the CMS-2567 allegations of deficiencies as a condition to participate in the programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. To assure compliance with this the following plan has been put into place. The Administrator met with OHFC management to clarify the reporting criteria for Vulnerable adult reports between federal and state requirements. Incident and investigation reports have been submitted to OFHC for R7, R16, and R20. We have updated our reporting policy and workflow charts for reporting. We have begun retraining the staff on the requirement to report these going forward. We have modified our vulnerable adult staff in-service material to add this clarity and address these issues. Internal reporting was done correctly in these cases, but DON and Administrator will continue to monitor staff for compliance in reporting internally. We have also recommended changes to	

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F 225	Continued From page 10 abuse" and staff had an order for Narcan if overdose was suspected. The mental health summary further indicated that R20 had a verbal altercation with another resident and resident's family member and "needs to be closely monitored by staff". R20's careplan dated 3/3/16, identified a history of heroin addiction-recent heroin overdose and indicated that the facility now had and order for Narcan. Interview with the social worker designee (SWD) on 4/14/16 at 2:42 p.m. revealed that she was aware of R20's heroin overdose on 2/3/16. The SWD was unaware if R20 had any other hospitalizations due to overdose. The SWD was asked if R20's heroin overdose with hospitalization was reported to the state agency. The SWD replied the incidents were "not required to be reported , even if hospitalized. We follow a flow chart." Interview with the interim director of nursing (IDON) on 4/15/16 at 2:28 p.m. revealed that she was the nurse working on 2/3/16, and stated she was aware of R20's previous drug use but was unaware why R20 was unresponsive that morning. The IDON stated she was not familiar with R20 having any similar incidents related to drug use prior to 2/3/16, was not aware of any drugs in the facility. When asked if this incident should be reported to the state agency the IDON replied "I don't know." R7 was admitted to the facility on 9/30/14, with diagnoses included but not limited to mood disorder, schizophrenia, and alcohol dependency. R7's MDS quarterly review assessment dated 1/5/16, indicated R7's cognition was intact and was independent with activities of daily living.	F 225	OHFC in their reporting process and documentation to include this information to clarify the confusion between state and federal requirements.	

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R7's careplan dated 10/19/15, included VA issues of history of chemical use making poor decisions. The care plan identified 12/28/16 (sic- facility dated the care plan as the year 2016) R7 consumed alcohol that resulted in hospitalization.

R7's progress notes were reviewed from 10/21/15 through 4/11/16, and revealed on 12/27/15, at 9:11 p.m. R7 was found with a "blank stare unable to sit up in bed" and slurred speech. 911 was called and R7 was transported to the hospital. She returned 12/28/15. R7 reportedly got the alcohol from her roommates R20 and R17. An emergency department hospital admission sheet dated 12/17/15, which indicated that R7 was hospitalized for alcohol intoxication.

R7's medical record included a psych appointment referral dated 1/11/16, which included the note that R7 was hospitalized for alcohol intoxication. Roommate gave her alcohol that was hidden in the room.

An interview with the SWD and administrator on 4/14/16, at 4:03 p.m. indicated the SWD was familiar with R7's chemical dependency issues. The SWD stated the alcohol use was "not a problem, just because something happens once, if it was an ongoing issue I would have put it as a problem on the careplan." The SWD and administrator confirmed the alcohol use and resulting hospitalization were not reported to the state agency. The administrator stated the incident was "not required to be reported, even if hospitalized" and that the facility followed a flow chart for reporting of incidents to the state agency.

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F 225	Continued From page 12 An interview with the IDON on 4/15/16, at 2:28 p.m. revealed she thought the facility reported the incident to "where it should be reported to." R16 was accepted and admitted to the facility 11/9/15, under commitment for chemical dependency. The MDS dated 12/7/15, indicated R16 was cognitively intact, mildly depressed, had verbal behavioral symptoms directed towards others, and rejected care daily. The Care Area Assessment (CAA) dated 12/7/15, indicated R16 was receiving anti-psychotic medications for anxiety and verbal aggression. The undated care plan identified R16 had one missing person report for failure to return to facility at specified time. R16 was able to have leaves of absence (LOA's) and self administer medications. Nursing progress notes on 11/17/15, at 6:00 p.m. R16 was found to be lethargic and confused. The resident was taken to the emergency room via ambulance. The hospital reported an alcohol level of 0.37. On 11/18/15, it was documented that R16 had been admitted to the hospital. On 11/24/15, R16 returned to the facility. On 12/8/15, at 10:00 R16 left via taxi to the doctor and spend the day with her boyfriend. She had medications through bedtime. She stated she will be back at 10:00 p.m. Although contacted through her boyfriend, R16 did not return to the facility until 12/15/15 at 5:30 p.m. When asked why she didn't return for a week, R16 replied "I had some things I had to take care of." Mental Health Summary dated 12/9/15, indicated: R16 was noncompliant with medications, had a long history of alcohol use and multiple chemical dependencies, treatment programs and long history of unstable housing. R16 was currently getting alcohol from her boyfriend in exchange for	F 225		

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F 225	Continued From page 13 favors. On 12/25/15, R16 went on LOA with her boyfriend and medications. R16 stated she would be back that evening. On 12/26/15, at 6:45 p.m. R16 called the facility to inform them she was at the emergency room and was being admitted for pneumonia. The facility verified this with the ER staff. The IDON's hand written, undated Discharge/Summary Information identified "Consumption of alcohol, left premises for extended time without notice. Broke court order for no overnights outside of facility." On 4/14/16, at 2:42 p.m. the SWD and administrator were asked for policies for resident LOA's. The SWD stated the residents "Sign LOA form and ask for meds." The SWD stated they complete one community assessment and one self administration of medication assessment. If a resident did not return from the outing, she would utilize the missing person protocol. When asked if the overdoses were reported to the state agency, the SWD stated they were "Not required to be reported, even if hospitalized. We follow a flow chart." The IDON was not available in the facility, a scheduled phone conversation occurred with IDON at 2:00 on 4/15/16. The IDON had not considered R16 an elopement, but she was a VA, "I thought it was reported." The facility failed to report R16's alcohol intoxication to the State agency (SA). The facility also failed to report the elopement from 12/8 through 12/15/15, to the SA even though the facility reported it to the police on 12/10/15, as a missing person. R14 quarterly MDS indicated she was cognitively intact and was independent with all activities of daily living. R14's care plan dated 2/23/16,	F 225		

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identified her as a vulnerable adult and indicated no vulnerable adult issues.

A review of facility progress notes indicated in 3/20/16, R14 had been called a derogatory name by another resident in the facility three times that day. The noted indicated "this incident was very upsetting" to R14. A progress note dated 4/12/16, indicated R14 had complained of being called derogatory names by another resident "qday" (every day). R14 stated it had happened as recently as the previous day.

During an interview on 4/12/16, at 4:26 p.m., R14 further stated a resident in the house is "nasty" to other residents and stated another resident beat that resident up. R14 stated the staff is aware of the situation, but no one did anything about it.

During a subsequent interview on 4/14/16, at 10:22 a.m., R14 stated another resident in the house yells all the time and is "bossy" and "hard to deal with."

During an interview on 4/15/16, at 2:15 p.m. the SWD stated she was responsible for handling and reporting potential abuse and abuse allegations. She stated when a resident had concerns she would talk to the other person. She stated "you have to separate whether it's happening, or if it is their perception of what's happening." The SWD further stated, "reporting to the state agency isn't always the answer." She stated verbal aggression between resident's is not reportable to the state agency and takes place "frequently" but are not an actual threat to a resident.
R6's quarterly MDS dated 2/5/16, indicated R6 was cognitively intact with delusions (fixed false

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beliefs) and was independent with all activities of daily living except dressing and personal hygiene. The MDS also indicated R6 was unsteady when going from sitting to standing or turning around, did not use any mobility devices and that R6 became short of breath with walking. R6's MDS indicated R6 had diagnoses of anemia, diabetes, hypertension, and schizophrenia. Diagnosis of mild mental retardation noted on office visit note dated 4/14/15.

R6's care plan dated 8/26/15, identified R6 as a vulnerable adult and comments dated 11/16/15, and 2/16/16, indicated no vulnerable adult issues. 12/23/15, temporary care plan problem "Fx [fracture]. of proximal phalanx of L [left] 5th finger (etiology unknown-res does not know how it happened)"

Observation on 4/13/16, at 11:40 a.m. identified R6 walking without a cane, limping and stumbling into the smoking room. R6 fell into a chair in the smoking room. At 12:41 p.m. R6 was again observed to stumble and fall into chair in the smoking room.

Review of Incident/Accident Report dated 4/21/15, at 11:29 a.m. indicated "Pt woke up-few hours p[after] being up we noticed her R [right] eye all puffy and 2 sm [small] lacerations around R [right] eye. She does not remember how it happened." Type of injury listed as "hematoma, abrasion, and swelling." Incident form indicated staff did not know when injury happened and resident did not remember falling. Incident /Accident report did not indicate the administrator or state agency were informed of the injury.

Nurses Record and Progress Notes dated

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4/21/15, at 12:00 p.m. indicated: "Appears pt [patient] fell against something during the noc [night], has a swollen right eye under each eye and two small lacerations are 3 mm [millimeters] long around eye." "Does not remember what she fell against."

Note dated 4/21/15, at 3:00 p.m. ..."is now c/o [complaining of] (unreadable) w c/o headache. States hit head on door going to BR-has flashlight to help guide her." Review of progress notes 4/21/15 through 4/27/15, did not indicate the administrator or SA were notified of the injury of unknown origin.

Nurses Record and Progress Notes dated 12/23/15, at 1:30 p.m. indicated R6 came into office and showed nurse her left hand. Nurse noted bruising on the front and back of hand with minor swelling. R6 was sent to urgent care.

Physician' Progress Notes dated 12/23/15, indicated R6 was in clinic for assessment of bruising and swelling of left hand and that R6 did not remember hitting hand or banging it. Progress note indicated X-ray showed fracture of proximal phalanx of left fifth finger splint placed and orthopedic follow up with in next week recommended.

The Serious Injury Report dated 12/23/15, sent to the Office of the Ombudsman for Mental Health and Mental Retardation, indicated R6 had sustained an fracture of the fifth finger of the left hand. Description of how the injury happened indicated "resident does not know what happened. Nurse observed swelling and bruising of left hand" The section triggering others to be notified including medical, OHFC [Office of Health

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Facility Complaints - State agency] and adult protection were blank.

At time of the injury R6 was unable to state what happened. While the Office of the Ombudsman was notified there was no evidence that the state agency was notified of the significant injury of unknown origin.

During interview on 4/14/16, at 10:25 a.m. the social worker designee (SWD) stated the injury for R6 was reported to the ombudsman's office but not to the state agency because they were not vulnerable adult issues.

During interview on 4/15/16, at 9:25 a.m. licensed practical nurse (LPN)-A said "We do not document notifying the administrator. If there is a fracture we do not notify administrator on the weekend or nights because we have dealt with it. If the resident were admitted to the hospital we would let them know."

During interview on 4/15/16, at 9:27 a.m. the SWD said "I don't think they would bother calling the administrator because it was not a vulnerable adult issue, it was a serious injury. [Administrator] would need to know about fractures if it were a vulnerable adult issue like the fracture was due to being beaten. Do not need to know if it is due to a fall."

During interview on 4/15/16, at 2:15 p.m. the administrator said, "I ask them to chart notifying me. I expect them to notify me about fractures."

During interview on 4/15/16, at 2:19 p.m. the IDON stated, the facility reported injuries of unknown origin. Reporting fractures depended on

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whether or not we know where the resident had been. The IDON said, "If there have not been any incidents then it is not reportable. We report to where ever we are supposed to." When asked about reporting injuries of unknown origin to the state agency versus the office of the ombudsman the IDON said, "I have always reported to the same place."

The facility's policy entitled "Vulnerable Adult Maltreatment Prevention Plan" dated 3/6/15, indicated that the facility "does not tolerate any form of maltreatment" which included "any form of physical, verbal, mental or sexual abuse; any form of neglect, involuntary seclusion, corporal punishment or mishandling of resident property". The policy also included the following:
-" An assessment will be made of a prospective resident prior to admission for a known history of potentially dangerous behavior patterns"
-"Individual susceptibility will be assessed and included in the overall resident careplan along with goals and approaches for prevention and safety".
-"If maltreatment is suspected or observed the administrator must be notified immediately".
-"The administrator or representative will use the flowchart to determine the reporting requirements.
-"Nursing completes the internal reporting forms whish [sic] is a collection of information that needs to be submitted to MDH online. The Administrator submits the online report to the Minnesota Department of Health immediately as available"
-"You must make your report directly to the facility Administrator immediately after ensuring resident safety. The facility is responsible to report all reportable incidents and suspected crimes to

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F 225	Continued From page 19 MDH."	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to operationalize their policy for reporting of allegations of verbal abuse, injuries of unknown origin, neglect of supervision of elopement, substance abuse within the facility for 5 of 17 residents (R20, R7, R16, R14, R6). Findings include: The facility's policy entitled "Vulnerable Adult Maltreatment Prevention Plan" dated 3/6/15, indicated that the facility "does not tolerate any form of maltreatment" which included "any form of physical, verbal, mental or sexual abuse; any form of neglect, involuntary seclusion, corporal punishment or mishandling of resident property". The policy also included the following: -" An assessment will be made of a prospective resident prior to admission for a known history of potentially dangerous behavior patterns" -"Individual susceptibility will be assessed and included in the overall resident careplan along with goals and approaches for prevention and safety". -"If maltreatment is suspected or observed the	F 226	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any fasts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the facility has prepared this Plan of Correction prior to resolution of any dispute resolution which must be filed because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the delivery of the CMS-2567 allegations of deficiencies as a condition to participate in the programs. This Plan of Correction is submitted as the facility's	6/9/16

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F 226	Continued From page 20 administrator must be notified immediately". -"The administrator or representative will use the flowchart to determine the reporting requirements. -"Nursing completes the internal reporting forms whish [sic] is a collection of information that needs to be submitted to MDH online. The Administrator submits the online report to the Minnesota Department of Health immediately as available" -"You must make your report directly to the facility Administrator immediately after ensuring resident safety. The facility is responsible to report all reportable incidents and suspected crimes to MDH". R20 was admitted to the facility on 3/23/15. A minimum data set (MDS) annual assessment dated 2/6/16 identified R20 as independent with activities of daily living and intact cognition. R20's Community Safety Assessment dated 8/3/15 indicated that R20 had an extensive history of substance abuse, poor decision making, and was currently attending treatment three times per week. The assessment further indicated "since admission has used illegal drugs". The assessment further identified R20 had multiple vulnerable adult (VA) issues since admission related to poor choices. Staff recommendations on the assessment indicated R20 could leave the facility independently. A note dated 12/28/15 in R20's medical record signed by the administrator revealed that R20 admitted to having alcohol in her room which contributed to another resident (R7) going to the emergency room. The note indicated that this was not the first time this has occurred.	F 226	credible allegation of compliance. To assure compliance with this the following plan has been put into place. The Administrator met with OHFC management to clarify the reporting criteria for Vulnerable adult reports between federal and state requirements. Incident and investigation reports have been submitted to OFHC for R7, R16, and R20. We have updated our reporting policy and workflow charts for reporting. We have begun retraining the staff on the requirement to report these going forward. We have modified our vulnerable adult staff in-service material to add this clarity and address these issues. Internal reporting was done correctly in these cases, but DON and Administrator will continue to monitor staff for compliance in reporting internally. We have also recommended changes to OHFC in their reporting process and documentation to include this information to clarify the confusion between state and federal requirements.	

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F 226	Continued From page 21 R20's progress notes were reviewed from 1/16-4/11/16 and revealed on 2/3/16 at 7:30 a.m. R20 was found to be lethargic and unresponsive. Emergency Medical Services (EMS) were activated, the resident was provided Narcan (medication which reverses some overdoses such as Heroin) and transported to the emergency room. R20 was admitted. R20's Hospital Discharge Summary dated 2/8/16 indicated that R20 was admitted to the hospital for altered mental status and accidental heroin overdose. R20's Mental Health Summary dated 3/5/16-4/5/16 indicated that R20 had a "lengthy history of heroin abuse and methamphetamine abuse" and staff had an order for Narcan if overdose was suspected. The mental health summary further indicated that R20 had a verbal altercation with another resident and resident's family member and "needs to be closely monitored by staff". R20's careplan dated 3/3/16 identified a history of heroin addiction-recent heroin overdose and indicated that the facility now had and order for Narcan. Interview with the Social Worker Designee (SWD) on 4/14/16 at 2:42 p.m. revealed that she was aware of R20's heroin overdose on 2/3/16. The SWD was unaware if R20 had any other hospitalizations due to overdose. The SWD was asked if R20's heroin overdose with hospitalization was reported to the state agency. The SWD replied the incidents were "not required to be reported , even if hospitalized. We follow a flow chart". Interview with the Interim Director of Nursing	F 226		

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(IDON) on 4/15/16 at 2:28 p.m. revealed that she was the nurse working on 2/3/16 and stated she was aware of R20's previous drug use but was unaware why R20 was unresponsive that morning. The IDON stated she was not familiar with R20 having any similar incidents related to drug use prior to 2/3/16 was not aware of any drugs in the facility. When asked if this incident should be reported to the state agency the DON replied "I don't know".

R7 was admitted to the facility on 9/30/14 with diagnoses that included but not limited to mood disorder, schizophrenia, and alcohol dependency. R7's Minimum Data Set (MDS) quarterly review assessment dated 1/5/16 indicated R7's cognition was intact and was independent with activities of daily living.

R7's careplan dated 10/19/15 included vulnerable adult (VA) issues of history of promiscous behavior and chemical use making poor decisions. The care plan identified 12-28-16 (sic-facility dated the care plan as the year 2016) R7 consumed alcohol that resulted in hospitalization.

R7's progress notes were reviewed from 10/21/15 through 4/11/16, and revealed on 12/27/15, at 9:11 p.m. R7 was found with a "blank stare unable to sit up in bed" and slurred speech. 911 was called and R7 was transported to the hospital. She returned 12/28/15. R7 reportedly got the alcohol from her roommates R20 and R17. An emergency department hospital admission sheet dated 12/17/15, which indicated that R7 was hospitalized for alcohol intoxication.

R7's social service progress notes were also reviewed and indicated on 1/4/16, the social

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worker designee (SWD) spoke with R7 regarding the drinking incident and resulting hospitalization. R7 got angry and screamed "that was not me."

R7's medical record included a psych appointment referral dated 1/11/16, which included the note that R7 was hospitalized for alcohol intoxication. Roommate gave her alcohol that was hidden in the room.

An interview with the SWD and administrator on 4/14/16, at 4:03 p.m. indicated the SWD was familiar with R7's chemical dependency issues. The SWD stated the alcohol use was "not a problem, just because something happens once, if it was an ongoing issue I would have put it as a problem on the careplan". The SWD and administrator confirmed the alcohol use and resulting hospitalization were not reported to the state agency. The administrator stated the incident was "not required to be reported, even if hospitalized" and that the facility followed a flow chart for reporting of incidents to the state agency.

An interview with the Interim Director of Nursing (IDON) on 4/15/16 at 2:28 p.m. revealed she thought the facility reported the incident to "where it should be reported to".

R16 was accepted and admitted to the facility 11/9/15, under commitment for chemical dependency. The Minimum Data Set (MDS) dated 12/7/15, indicated R16 was cognitively intact, mildly depressed, had verbal behavioral symptoms directed towards others, and rejected care daily.
The Care Area Assessment (CAA) dated 12/7/15, indicated R16 was receiving anti-psychotic

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F 226	Continued From page 24 medications for anxiety and verbal aggression. The undated care plan identified R16 had one missing person report for failure to return to facility at specified time. R16 was able to have leaves of absence (LOA's) and self administer medications. Nursing progress notes on 11/17/15, at 6:00 p.m. R16 was found to be lethargic and confused. The resident was taken to the emergency room via ambulance. The hospital reported an alcohol level of 0.37. On 11/18/15, it was documented that R16 had been admitted to the hospital. On 11/24/15, R16 returned to the facility. On 12/8/15, at 10:00 R16 left via taxi to the doctor and spend the day with her boyfriend. She had medications through bedtime. She stated she will be back at 10:00 p.m. Although contacted through her boyfriend, R16 did not return to the facility until 12/15/15 at 5:30 p.m. When asked why she didn't return for a week, R16 replied "I had some things I had to take care of." Mental Health Summary dated 12/9/15, indicated: R16 was noncompliant with medications, had a long history of alcohol use and multiple chemical dependencies, treatment programs and long history of unstable housing. R16 was currently getting alcohol from her boyfriend in exchange for favors. On 12/25/15, R16 went on LOA with her boyfriend and medications. R16 stated she would be back that evening. On 12/26/15, at 6:45 p.m. R16 called the facility to inform them she was at the emergency room and was being admitted for pneumonia. The facility verified this with the ER staff. The interim director of nursing (IDON) ' s hand written, undated Discharge/Summary Information identified "Consumption of alcohol, left premises for extended time without notice. Broke court	F 226		

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F 226	Continued From page 25 order for no overnights outside of facility." On 4/14/16, at 2:42 p.m. the social work designee (SWD) and administrator were asked for policies for resident LOA's. The SWD stated the residents "Sign LOA form and ask for meds." The SWD stated they complete one community assessment and one self administration of medication assessment. If a resident did not return from the outing, she would utilize the missing person protocol. When asked if the overdoses were reported to the state agency, the SWD stated they were "Not required to be reported, even if hospitalized. We follow a flow chart." The IDON was not available in the facility, a scheduled phone conversation occurred with IDON at 2:00 on 4/15/16. The IDON had not considered R16 an elopement, but she was a vulnerable adult (VA), "I thought it was reported." The facility failed to report R16's alcohol intoxication to the SA. The facility also failed to report the elopement from 12/8-12/15/15 to the SA even though the facility reported it to the police on 12/10/15 as a missing person. R14 quarterly Minimum Data Set (MDS) indicated she was cognitively intact and was independent with all activities of daily living. R14's care plan dated 2/23/16 identified her as a vulnerable adult and indicated no vulnerable adult issues. A review of facility progress notes indicated in 3/20/16, R14 had been called a derogatory name by another resident in the facility three times that day. The noted indicated "this incident was very upsetting" to R14. A progress note dated 4/12/16 indicated R14 had complained of being called derogatory names by another resident "qday" (every day). R14 stated it had happened as recently as the previous day.	F 226		

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During an interview on 4/12/16, at 4:26 p.m., R14 further stated a resident in the house is "nasty" to other residents and stated another resident beat that resident up. R14 stated the staff is aware of the situation, but no one did anything about it.

During a subsequent interview on 4/14/16, at 10:22 a.m., R14 stated another resident in the house yells all the time and is "bossy" and "hard to deal with."

During an interview on 4/15/16, at 2:15 p.m. the social work designee (SWD) stated she was responsible for handling and reporting potential abuse and abuse allegations. She stated when a resident had concerns she would talk to the other person. She stated "you have to separate whether it's happening, or if it is their perception of what's happening." The SWD further stated, "reporting to the state agency isn't always the answer." She stated verbal aggression between resident's is not reportable to the state agency and takes place "frequently" but are not an actual threat to a resident.
R6's quarterly Minimum Data Set (MDS) dated 2/5/16, indicated R6 was cognitively intact with delusions (fixed false beliefs) and was independent with all activities of daily living except dressing and personal hygiene. The MDS also indicated R6 was unsteady when going from sitting to standing or turning around, did not use any mobility devices and that R6 became short of breath with walking. R6's MDS indicated R6 had diagnoses of anemia, diabetes, hypertension, and schizophrenia. Diagnosis of mild mental retardation noted on office visit note dated 4/14/15.

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R6's care plan dated 8/26/15, identified R6 as a vulnerable adult and comments dated 11/16/15, and 2/16/16, indicated no vulnerable adult issues. 12/23/15, temporary care plan problem "Fx [fracture]. of proximal phalanx of L [left] 5th finger (etiology unknown-res does not know how it happened)"

Observation on 4/13/16, at 11:40 a.m. identified R6 walking without a cane, limping and stumbling into the smoking room. R6 fell into a chair in the smoking room. At 12:41 p.m. R6 was again observed to stumble and fall into chair in the smoking room.

Review of Incident/Accident Report dated 4/21/15, at 11:29 a.m. indicated "Pt woke up-few hours p[after] being up we noticed her R [right] eye all puffy and 2 sm [small] lacerations around R [right] eye. She does not remember how it happened." Type of injury listed as "hematoma, abrasion, and swelling." Incident form indicated staff did not know when injury happened and resident did not remember falling. Incident /Accident report did not indicate the administrator or state agency were informed of the injury.

Nurses Record and Progress Notes dated 4/21/15, at 12:00 p.m. indicated: "Appears pt [patient] fell against something during the noc [night], has a swollen right eye under each eye and two small lacerations are 3 mm [millimeters] long around eye." "Does not remember what she fell against."

Note dated 4/21/15, at 3:00 p.m. ..."is now c/o [complaining of] (unreadable) w c/o headache. States hit head on door going to BR-has flashlight to help guide her." Review of progress notes

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4/21/15 through 4/27/15, did not indicate the administrator or SA were notified of the injury of unknown origin.

Nurses Record and Progress Notes dated 12/23/15 at 1:30 p.m. indicated R6 came into office and showed nurse her left hand. Nurse noted bruising on the front and back of hand with minor swelling. R6 was sent to urgent care.

Physician's Progress Notes dated 12/23/15, indicated R6 is in clinic for assessment of bruising and swelling of left hand and that R6 did not remember hitting hand or banging it. Progress note indicated X-ray showed fracture of proximal phalanx of left fifth finger splint placed and orthopedic follow up with in next week recommended.

The Serious Injury Report dated 12/23/15, sent to the Office of the Ombudsman for Mental Health and Mental Retardation, indicated R6 had sustained an fracture of the fifth finger of the left hand. Description of how the injury happened indicated "resident does not know what happened. Nurse observed swelling and bruising of left hand" The section triggering others to be notified including medical, OHFC [Office of Health Facility Complaints - state agency] and adult protection were blank.

During interview on 4/15/16, at 9:25 a.m. Licensed practical nurse (LPN)-A said "We do not document notifying the administrator. If there is a fracture we do not notify administrator on the weekend or nights because we have dealt with it. If the resident were admitted to the hospital we would let them know."

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GRAND AVENUE REST HOME	3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409

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F 226	Continued From page 29 During interview on 4/15/16, at 9:27 a.m. the SWD said "I don't think they would bother calling the administrator because it was not a vulnerable adult issue, it was a serious injury. [Administrator] would need to know about fractures if it were a vulnerable adult issue like the fracture was due to being beaten. Do not need to know if it is due to a fall." During interview on 4/15/16, at 2:15 p.m. the administrator said, "I ask them to chart notifying me. I expect them to notify me about fractures." During interview on 4/15/16, at 2:19 p.m. the interim director of nurses (IDON) stated, the facility reported injuries of unknown origin. Reporting fractures depended on whether or not we know where the resident had been. The IDON said, "If there have not been any incidents then it is not reportable. We report to where ever we are supposed to." When asked about reporting injuries of unknown origin to the state agency versus the office of the ombudsman the IDON said, "I have always reported to the same place."	F 226		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280		6/10/16

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F 280	Continued From page 30 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to update/revise individual resident care plans related to accidents, and/or substance abuse for 4 of 18 residents (R20, R7, R16, R6). Findings include: R20 was admitted to the facility on 3/23/15. An annual Minimum Data Set (MDS) assessment dated 2/6/16, indicated R20 was independent with activities of daily living and had intact cognition. R20's Community Safety Assessment dated 8/3/15, indicated that R20 had a history of making poor decisions, had chemical dependency issues and was currently attending treatment three times per week. The assessment further indicated that R20 had a history of substance abuse and was a "former heroin addict" and indicated, "since admission has used illegal drugs." The assessment further indicated that R20 had multiple VA (vulnerable adult) issues since admission related to poor choices. However, staff recommendations on the assessment indicated R20 could leave the facility independently.	F 280	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any fasts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the facility has prepared this Plan of Corrections prior to resolution of any dispute resolution which must be filed because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the delivery of the CMS-2567 allegations of deficiencies as a condition to participate in the programs. This Plan of Correction is submitted as the facility s credible allegation of compliance.	

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F 280	Continued From page 31 R20's careplan dated 3/3/16, identified a history of heroin addiction-recent heroin overdose and indicated that the facility now had Narcan orders for possible heroin overdose. The careplan further indicated that staff were to monitor for signs and symptoms of drug overdose. R20 hospitalization on 2/3/16, for heroin overdose and initiation of off-site treatment on 2/29/16, was indicated on careplan. The care plan failed to identify interventions for the use of methamphetamine use, ongoing alcohol use, or the recent THC lab results. A note dated 12/28/15, in R20's medical record signed by the administrator revealed that R20 admitted to having alcohol in her room which contributed to another resident (R7) going to the emergency room. The note indicated that this was not the first time this had occurred. The note further stated that additional interventions were required to ensure the safety of R20 and other residents. Interview with the Social Service Designee (SWD) on 4/14/16 at 2:42 p.m. revealed she was aware of R20's heroin overdose on 2/3/16. The SWD was unaware if R20 had any other hospitalizations due to overdose. The SWD was aware of R20's past drug use and stated that R20 had tested positive for marijuana once before and confirmed that this was not indicated on R20's careplan. The SWD stated that there were no drugs or alcohol in the facility and that R20 was in treatment for past drug addiction, which she attended as ordered. The SWD stated R20 had alcohol in her room and when R20 had left the room, R7 consumed the whole bottle. The SWD confirmed that R7 was hospitalized due to alcohol intoxication and that she had discussed the	F 280	To assure compliance with this the following plan has been put into place. R16 has been discharged. R20 is in the process of discharge. We are looking for a suitable discharge location that can address all her needs. R6 saw a physician on 5/2/16 and orthopedic surgeon 5/5/16. The result of that visit was to receive cortisone shots in her left knee to improve her gait due to osteoarthritis and will follow up every four months for review. The Medical Director and Consulting Pharmacist reviewed R6 record and medications on 5/19/16. The Medical Director did not add any interventions but recommended R6 begin physical therapy or we consider discharging to a higher level of care. The Consulting Pharmacist wrote one medication change recommendation to the physician. R6 agreed to start attending PT so she can stay in our facility. A new fall assessment was started. R7 has been stable before the incident and since. We do believe that the interventions that we have in place are sufficient given the resident wishes and history. Actions taken to identify other potential residents having similar occurrences. We have reviewed other resident diagnoses for history of addictive behavior and updated the community assessments and care plan interventions for each as necessary. We will continue to screen residents and increase our research on issues of alcohol	

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F 280	Continued From page 32 incident with R20. The SWD stated that she was not aware of R20's alcohol use in the facility and when asked if alcohol use or interventions to prevent alcohol use were addressed on R20's care plan the SWD stated "I don't know what you want me to do. I can say if you don't follow the rules you have to leave. She is not committed to any program, I don't have any leverage on these people." R7 was admitted to the facility on 9/30/14, with diagnoses that included but not limited to mood disorder, schizophrenia, and alcohol dependency. R7's Minimum Data Set (MDS) quarterly review assessment dated 1/5/16, indicated R7's cognition was intact and was independent with activities of daily living. R7's careplan dated 10/19/15, included vulnerable adult issues of history of promiscuous behavior and chemical use/making poor decisions. Interventions included invite to yearly Inservice and educate quarterly. R7's care plan did not identify any interventions to minimize the risk of alcohol use including supervising and monitoring for use. R7's progress notes for 12/27/15, at 9:11 p.m. revealed R7 was found with a "blank stare unable to sit up in bed" and slurred speech. The nurse asked R7 if she had been drinking and she did not answer. 911 was called. R7 was taken to the emergency room and returned on 12/28/15. An emergency department hospital admission sheet dated 12/17/15 indicated that R7 was hospitalized for alcohol intoxication. Interview with the social service designee (SWD) and the administrator on 4/14/16, at 4:03 p.m.	F 280	and chemical addictions. The DON and SWD will continue to qualify residents that are within the scope of a Board and Care home. The Administrator will monitor that we maintaining compliance by assisting in the decision process for new residents.	

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F 280	Continued From page 33	F 280		

indicated that the SWD was familiar with R7's alcohol issues and dependency issues. The SWD stated that she was unaware the R7's roommate had alcohol. The SWD stated that alcohol searches are completed with room checks once per week. The SWD completed R7's care plan and stated that alcohol use was addressed in R7's careplan the alcohol use was "not a problem, just because something happens once, if it was an ongoing issue I would have put it as a problem on the careplan".

R16 was accepted and admitted to the facility on 11/9/15, under commitment for chemical dependency.
The Minimum Data Set (MDS) dated 12/7/15, indicated R16 was cognitively intact, mildly depressed, had verbal behavioral symptoms directed towards others, and rejected care daily. R16 was independent with activities of daily living, and had a diabetic diet.
The Care Area Assessment (CAA) dated 12/7/15, indicated R16 was receiving anti-psychotic medications for anxiety and she had verbal aggression. In addition to the extensive chemical dependency issues, R16 had a history of repeated falls and nutritional risk.
The undated care plan indicated alcoholism with alcohol intoxication, alcoholic gastritis, and homelessness. The goal was to attend treatment three times weekly, therapy once a week, and would not drink. Approaches included scheduled appointments and rides as needed, checking resident bags if out of the facility and boyfriend's bags when coming into the facility, screening as needed, case manager involvement, hold meds if intoxicated, notify MD and get instruction, and received naltrexone for alcohol urges. Vulnerable Adult issues included none since admission, but

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F 280	Continued From page 34 did have one missing person report for failure to return to facility at specified time. The care plan also indicated R16 was able to self administer medications. Physicians Progress Notes dated 11/25/15, identified a recent hospitalization due to alcohol intoxication with return 11/24/15. Physicians Progress Notes dated 12/2/15, Ok to do toxicology screen at facility discretion. Mental Health Summary dated 12/9/15, indicated R16 was noncompliant with medications, had a long history of alcohol use and multiple chemical dependency treatment programs and a long history of unstable housing. Continued to drink and recent hospitalization 11/17-11/24 due to alcohol intoxication. R16 had a boyfriend that was supplying her with alcohol for favors. Physicians Progress Notes dated 12/31/15, identified R16 continued to consume alcohol-concealed it in a bottle of crystal light. On 4/14/16, at 2:42 p.m. the SWD (social work designee) stated when they knew R16 was drinking, she had called the case manager, searched R16 ' s room, and searched her boyfriend. The SWD stated staff would search once a week and as needed. The facility's policy entitled "Vulnerable Adult Maltreatment Prevention Plan" dated 3/6/15, included: "An assessment will be made of a prospective resident prior to admission for a known history of potentially dangerous behavior patterns" "Individual susceptibility will be assessed and included in the overall resident careplan along with goals and approaches for prevention and safety. The careplan is reviewed at least quarterly. Revisions are made as changes in status occur".	F 280		

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F 280	Continued From page 35	F 280		

Continued From page 35

"Careplan's include information regarding history of aggressive behaviors, wandering or self-injurious behaviors"
R6's quarterly Minimum Data Set (MDS) dated 2/5/16, indicated R6 was cognitively intact and was independent with all activities of daily living except dressing and personal hygiene. The MDS also indicated R6 was unsteady when going from sitting to standing or turning around, did not use any mobility devices and R6 became short of breath with walking. R6's MDS indicated R6 had diagnoses of anemia, diabetes, hypertension and schizophrenia.

Grand Avenue Residence Accident Prevention Plan (APP) completed 8/18/15, indicated potential problems included balance problems, dizziness, poor choices regarding clothing and foot wear and not wearing glasses. R6 had multiple falls in the previous year and R6 reported "sometimes I get dizzy I don't know why I fall". Identified interventions included suspenders when wearing pants, proper fitting footwear, walker when leaving the facility, night light in bathroom, and call light next to bed. The APP indicated R6 did not always comply with wearing suspenders, proper fitting shoes and glasses. Intervention dated 11/25/15, and added to the APP, "do not use upstairs B.R.[bathroom] during noc[night]. If B.R. being used pull lite [call light] for nurse to assist accompany to room to use B.R."

R6's care plan dated 8/26/15, indicated R6 was at risk for falls due to gait, medications, vision. Approaches included Fall risk assessment, vitals three times weekly, labs as ordered, suspenders if wearing pants, wear glasses and proper footwear, and night light on at night in bedroom.

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F 280	Continued From page 36 On 4/12/16 at 6:35 p.m. R6 was observed walking from the dining room table to the bathroom, just off the living room. R6 had a halting gait stumbling and reaching for furniture. R6 was not using any device. During random observation 4/13/16, at 11:40 a.m. R6 was observed walking without a cane, limping and stumbling into the smoking room. R6 fell into a chair in the smoking room. At 12:41 p.m. R6 was again observed to stumble and fall into a chair in smoking room. Review of Nurses' Record and Progress Notes (PN) from 7/2/15. until 4/13/16, indicated R6 fell on 7/23/15, 11/25/15, 1/4/16, and 2/22/16. There was no evidence the care plan was updated with appropriate interventions following multiple falls. During interview on 4/15/16, at 2:19 p.m. interim director of nurses (IDON) said, "All falls are investigated and care planned with new interventions identified." Facility MDS Care Planning policy updated 10/29/15, identified it lacked direction for updating the care plan with new issues between MDS reviews.	F 280		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate	F 315		6/9/16

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F 315	Continued From page 37 treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess, identify appropriate interventions and provide assistance with toileting, for 1 of 1 residents (R6) reviewed for incontinence. Findings include: R6's quarterly Minimum Data Set (MDS) dated 2/5/16, indicated R6 was cognitively intact, and experienced incontinence of bowel and bladder requiring assistance with personal hygiene. However, the MDS further indicated R6 had become continent with staff assistance at night. R6's diagnoses included developmental delays and incontinence. A bladder assessment dated 2/11/16, indicated R6 had urinary frequency and nocturia. R6's care plan dated 2/11/16, indicated R6 experienced urinary incontinence with frequency to toilet, and indicated R6 had no incontinence with scheduled toileting at night. During an observation on 4/12/16, at 5:28 p.m. R6 was observed to independently remove urine soiled slacks and underclothing and placed them in a laundry basket in her room. No staff assistance was provided to R6 at that time. During an interview on 4/13/16, at 3:25 p.m. R6 stated her incontinence had improved but that she still experienced incontinence if she was out of the facility for a period of time.	F 315	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any fasts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the facility has prepared this Plan of Corrections prior to resolution of any dispute resolution which must be filed because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the delivery of the CMS-2567 allegations of deficiencies as a condition to participate in the programs. This Plan of Correction is submitted as the facility s credible allegation of compliance. Survey Team information written is incorrect and we are requesting a IDR. To assure compliance with this the following plan has been put into place. We have interviewed R6 and she reports	

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F 315	Continued From page 38 During an interview on 4/15/16, at 8:21 a.m., housekeeper (HK)-A stated she did the residents' laundry and stated R6's underclothes were often soiled. HK-A stated, "I don't think [R6] cleans herself appropriately." During an interview on 4/15/16, at 8:29 a.m. licensed practical nurse (LPN)-A stated R6's incontinence was "up and down" and verified R6 still had incontinence at times. LPN-A verified R6's care plan approach stating, "We wake her up at night for toileting, but not during the day." R6's plan of care had not been revised to include approaches for helping R6 improve her continence during the day, nor to encourage/assist R6 with personal hygiene following incontinence. During an interview on 4/15/16, at 2:08 p.m. the interim director of nursing (IDON) stated R6 had been incontinent over the years but stated the last several years she had been incontinent mostly at night. The DON stated R6's incontinence "has been fairly under control." Therefore, her care plan had not been revised to include regular assistance with helping R6 manage the incontinence. There was no current assessment which accurately reflected R6's pattern for continence, and needs for toileting and grooming assistance located in her record.	F 315	being completely continent. R6 saw a urologist and had a medical procedure completed to 5/17/16 to help R6 to help decrease urgency. Our new DON completed a new bladder assessment on R6. The results were that the resident is continent with the existing overnight toileting plan. Actions taken to identify other potential residents having similar occurrences. Each resident has a bladder assessment as part of their medical record. We have reviewed the bladder assessments for all other residents and have determined that no changes are needed. The quality assurance committee, including the Medical Director, reviewed the bladder assessment form and determined that no changes are needed. Nursing will continue to monitor incontinence and notify the DON when there is a change in status as well as chart in the resident medical record. The DON will continue to complete bladder assessments upon admission, quarterly, or more often as needed. The DON will continue to take actions as necessary when changes in a bladder assessment is warranted. We have added incontinence monitoring to the weekly DON checklist. The Administrator will monitor to maintain compliance by monitoring the weekly DON checklist.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		6/9/16

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F 323	Continued From page 39 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to supervise and provide interventions to prevent injury and hospitalizations for 4 of 4 residents (R20, R7, R16, R6) reviewed for accidents. Findings include: R20 was admitted to the facility on 3/23/15. An annual minimum data set (MDS) assessment dated 2/6/16, identified R20 as independent with activities of daily living and intact cognition. R20's Community Safety Assessment dated 8/3/15, indicated R20 had a history of making poor decisions, chemical dependency issues and was currently attending treatment three times per week. The assessment further indicated that R20 had a history of substance abuse and was a "former heroin addict" and that "since admission has used illegal drugs". The assessment also indicated R20 had made multiple poor choices. However, staff recommendations identified on the assessment indicated R20 could leave the facility independently. The facility had not developed a plan to minimize safety risks when R20 was out of the facility. In addition, the facility had not developed a plan with appropriate interventions to minimize the risk of R20 obtaining and using alcohol and/or illegal drugs in the facility.	F 323	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any fasts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the facility has prepared this Plan of Corrections prior to resolution of any dispute resolution which must be filed because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the delivery of the CMS-2567 allegations of deficiencies as a condition to participate in the programs. This Plan of Correction is submitted as the facility s credible allegation of compliance. To assure compliance with this the following plan has been put into place. R6	

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F 323	Continued From page 40 A note dated 12/28/15, in R20's medical record signed by the administrator revealed that R20 admitted to having alcohol in her room which contributed to another resident (R7) going to the emergency room. The note indicated this was not the first time this had occurred and that this was a violation of the facility policy. The note further stated that additional interventions were required to ensure the safety of R20 and the other residents and suggested that R20 was now subject to random room checks and a room change. R20's medical record did not identify previous dates or incidents related to alcohol use. R20's progress notes were reviewed from 1/1/16-4/11/16, and revealed the following: 2/3/16, at 7:30 a.m. resident appeared lethargic although able to respond to questions if asked. Given 5 ounces of apple juice and stated "I'm just so thirsty". One half hour later R20 states she couldn't eat breakfast and "felt sick to her stomach". R20 was checked again after the nurse was called by roommates stating they "were worried" about R20. Nurse found resident "laying across bed with head and neck hyperextended. Res. warm and breathing, pulse approx [sic] 80/bpm and strong. Res. just not responsive-pupils dilated. 911 was called-attendants gave Narcan (a medication to reverse drugs like heroin) and resident responded and taken to ER". Physician and family notified. 2/3/16, a "Postnote" was written below the above entry that indicated that "EMTS [sic] state they found a suicide note and took it with them. Res. not reported any suicidal thoughts to this nurse on duty from 7 am-3 pm [sic] . EMTS [sic] state	F 323	saw a physician on 5/2/16 and orthopedic surgeon 5/5/16. The result of that visit was to receive cortisone shots in her left knee to improve her gait due to osteoarthritis and will follow up every four months for review. R6, R7, and R20 were specifically reviewed at the QA meeting on 5/19/16. R6 was recommended for physical therapy to improve her gait. She had previous refused, but after explaining the seriousness of this need for PT, she has now agreed to attend. R7 has been stable before the incident and since. R16 has been discharged. R20's care plan and community assessment have been updated. Actions taken to identify other potential residents having similar occurrences. We have reviewed other resident diagnoses for history of addictive behavior and will updated the community assessments and care plan interventions for each as necessary. We will continue to screen residents and increase our research on issues of alcohol and chemical addictions. The DON and SWD will continue to qualify residents that are within the scope of a Board and Care home. We do screen and have not accepted four potential residents in the past six months. We have retrained the nursing staff on the importance of the orthostatic pressures and have updated our Fall Scene Investigation report to include more details on reporting of drops in orthostatic blood pressures and the followup required before the completion of	

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F 323	Continued From page 41 resident admitted for snorting heroin". 2/3/15, at 5:00 p.m. R20 admitted to hospital There was no follow up documentation to the information regarding R20's suicide note in R20's medical record. R20's Hospital Discharge Summary dated 2/8/16, indicated that R20 was admitted to the hospital for altered mental status and accidental heroin overdose. Review of R20's MDS assessments indicated a discharge summary was also completed on 1/9/16. In addition an entry tracking record MDS was completed on 1/13/16. When asked for the 1/9/16 hospital discharge summary and documentation, the SWD stated the hospital did not provide them with any written summary. Licensed practical nurse (LPN-A) stated "We only need the medication list, we shred the rest." R20's Mental Health Summary dated 3/5/16-4/5/16, indicated that R20 had a "lengthy history of heroin abuse and methamphetamine abuse" and staff had an order for Narcan (reverses an overdose for some medications) if overdose was suspected. The mental health summary further indicated that R20 had a verbal altercation with another resident and resident's family member and "needs to be closely monitored by staff". R20's careplan dated 3/3/16, identified a history of heroin addiction-recent heroin overdose and indicated that the facility now has Narcan orders	F 323	the form. We have a new DON in place and she will be reviewing each new fall form for completion, correctness and followup. The DON will implement these changes and the Administrator will monitor that we maintaining compliance by reviewing the Fall Scene Investigation reports during the QA meetings.	

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F 323	Continued From page 42 for possible heroin overdose. The careplan further indicated staff was to monitor for signs and symptoms of drug overdose. R20's hospitalization on 2/3/16, for heroin overdose and initiation of off-site treatment on 2/29/16, was identified on the careplan. R20's careplan further identified the resident had no vulnerable adult issues this past quarter. The careplan did not identify concerns with alcohol possession or use. R20's labs were reviewed which indicated that R20 tested positive for THC (marijuana) on 3/26/16. R20's medical record did not indicate any further follow up with the positive lab result. R20 was interviewed on 4/14/16, at 3:15 p.m. and stated that she did not write a suicide note, that it was a love letter to her boyfriend who had committed suicide. R20 also confirmed that she had been given alcohol as a gift. R20, R16 and R7 had a few drinks and when she and R16 left for a cigarette, R7 had "gotten into it" and "glugged down the whole bottle". R20 stated that she and R16 contacted the nurse when they came back and found R7 was intoxicated and had "wet herself". R20 also stated she had knowingly used Heroin laced with Fentanyl, just like her boyfriend who overdosed. Interview with the Social Service Designee (SWD) on 4/14/16 at 2:42 p.m. revealed she was aware of R20's heroin overdose on 2/3/16. The SWD did not know if R20 had any other hospitalizations due to overdose. The SWD stated she had followed up with the hospital on the note that the EMT's found, which she indicated the hospital nurse stated was a love letter and not a suicide note. The SWD confirmed there was no documentation of follow up in R20's medical record about the note. However the SWD	F 323		

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F 323	Continued From page 43 further stated she discussed the incident with R20 who stated she "wanted to live". The SWD was aware of R20's past drug use and stated that R20 had tested positive for marijuana once before and confirmed this was not indicated on R20's careplan. The SWD stated there were no drugs or alcohol in the facility. She further stated R20 was in treatment for past drug addiction, which she attended as ordered. The SWD stated R20 had alcohol in her room and when R20 had left the room, R7 consumed the whole bottle. The SWD confirmed R7 was hospitalized due to alcohol intoxication and she had discussed the incident with R20. The SWD went on to say that R20 did not have a room change as R7 stated upon her hospital return that she "loved her roommates". The SWD stated that alcohol is not allowed in the facility. She was not aware of R20's alcohol use in the facility and when asked if alcohol use or interventions to prevent alcohol use were addressed on R20's care plan the SWD stated "I don't know what you want me to do. I can say if you don't follow the rules you have to leave. She is not committed to any program, I don't have any leverage on these people." Interview with the Interim Director of Nursing (IDON) on 4/15/16 at 2:28 p.m. revealed she was the nurse working on 2/3/16, and she was aware of R20's previous drug use. The IDON was unaware why R20 was unresponsive that morning. The IDON stated that she was not familiar with R20 having any similar incidents related to drug use prior to 2/3/16. Further, she was not aware of any drugs in the facility. The IDON stated she did not observe a suicide note the morning of 2/3/16, and was only aware of the information from the EMT's. The IDON stated someone at the facility followed up	F 323		

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with the hospital and found out the note was actually a "love letter" and not a suicide note. The IDON stated this information should have been followed up in R20's medical record.

R7 was admitted to the facility on 9/30/14, with diagnoses that included mood disorder, schizophrenia, and alcohol dependency.

R7's careplan dated 10/19/15, included the vulnerable adult issues of "hx of promiscuous behavior. Chemical use making poor decisions". The care plan identified "12/28/16 (sic- facility dated the care plan as the year 2016) consumed alcohol that resulted in hospitalization Prognosis favorable. Not a typical behavior". For the dates 1/11/16 and 4/11/16 "No VA issues" were identified. R7's care plan did not identify appropriate interventions to minimize alcohol use or monitoring R7 for incidents of use.

R7's progress notes were reviewed from 10/21/15-4/11/16 and revealed the following:

12/27/15 at 9:11 p.m. revealed the nurse received a call from [R7]'s sister who stated she was on the phone with [R7] and her speech was slurred. The nurse went to R7's room and found R7 with a "blank stare unable to sit up in bed" with slurred speech. The nurse asked R7 if she had been drinking and she did not answer. 911 was called.

12/27/15 at 9:20 p.m. 911 arrived and R7 was "unable to stand and walk on her own, speech was slurred and she was carried down to the first floor by paramedics". R7 was transported to the hospital at 9:30 p.m. R7's family notified and administrator updated.

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F 323	Continued From page 45 12/27/15 at 9:35 p.m. R7's roommates (R20, R17) came to nurse and informed that R7 had drank 24 ounces of Vodka that they left in the room when they went out to smoke. When they returned the 24 ounce bottle of Vodka was empty. Administrator notified. 12/27/15 at 9:40 p.m. nurse updated emergency room (E.R.) on R7's consumption of alcohol. 12/28/15 at 3:20 p.m. R7 returned from the hospital via transport. No further incidents of alcohol use were identified in R7's progress notes or medical record. however, an emergency department hospital admission sheet dated 12/17/15, identified R7 was hospitalized for alcohol intoxication. R7's social service progress notes identified the following: 1/4/16, writer spoke with resident regarding drinking incident and hospitalization. Resident got upset and starting screaming loudly saying "that was not me". Resident continued to be agitated and writer did not continue conversation. 1/11/16, care conference held today. Resident had 1 hospitalization due to alcohol poisoning-liquor was given to her by her roommate. Resident counseled and educated on incident along with roommate. No VA issues this past quarter. R7's medical record included a mental health appointment referral dated 1/11/16, which included the note that R7 was hospitalized for alcohol intoxication. The not identified R7's blood	F 323		

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alcohol level was >0.3.

An interview with the SWD and administrator on 4/14/16 at 4:03 p.m. indicated the SWD was familiar with R7's alcohol and dependency issues. The SWD stated she was unaware R7's roommate had alcohol. Alcohol was not allowed in the house. The SWD stated alcohol searches were completed with room checks once a week. The SWD confirmed there was no documentation of room checks and was not aware of any residents that were currently using alcohol. SWD completed R7's care plan and stated alcohol use was addressed in R7's careplan. Alcohol use was "not a problem, just because something happens once, if it was an ongoing issue I would have put it as a problem on the careplan". The SWD stated she discussed the alcohol use with R7 and she declined treatment. R7 said she "would not do it again" and she "believes her". SWD stated she informed R7's roommates (R20, R17) they could not have alcohol in the house nor provide alcohol to other residents.

An interview with the Interim Director of Nursing (IDON) on 4/15/16 at 2:28 p.m. revealed she was aware of R7's alcohol intoxication and hospitalization. However she was not working the day the incident occurred.

The undated facility document entitled "Resident Rules and Responsibilities" included no alcoholic beverages were allowed in the home unless prior approval from the physician and no illegal drugs were allowed in the home.

R16 was admitted to the facility on a court commitment for chemical dependency. The

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facility failed to ensure R16 had appropriate supervision and interventions in place to minimize the risk for elopement and ongoing chemical use. had been committed for chemical dependency initially on 8/5/14, and commitment was continued on 12/30/14. R16 was granted a provisional discharge on 3/31/15, however she violated the material conditions of her provisional discharge. R16 missed many appointments at the primary clinic and continued to consume alcohol which contributed to multiple falls and hip injuries. R16 required a full hip replacement on 9/16/15. The hospital record identified alcohol intoxication upon admission at that time. On 10/13/15 a hospital discharge planning note indicated social worker (SW)-B called and left a message with social work designee (SWD), "Director at Grand Ave Residence."

A Hennepin County Human Services and Public Health Department, Behavioral Services Case Management, Case information letter dated 11/10/15, identified a long history of R16 being asked to leave treatment centers related to unstable blood sugars. It also identified a long history of unstable housing, with R16 currently at another facility under chemical dependency commitment until 1/16. An Individual Community Support Plan (ICSP) dated 11/10/15-5/8/16, from Hennepin County stated the contact person was [SWD] a "nurse at Grand Ave Residence ". The ICSP indicated the longest period of sobriety was 364 days and R16 expressed interest in sobriety. The identified goal was to be sober and feel better. The documented strategies included: complete a Rule 25, return to Huss recovery, re-connect with women for sobriety, maybe AA, look into dealing with mental health issues, socialize with peers at Grand Avenue, manage

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F 323	Continued From page 48 blood sugars and count carbohydrates. R16 was also identified with anxiety and depression, but did not have a diagnosis of severe mental illness. The ICSP indicated R16 had 2 children, both with fetal alcohol syndrome, due to her drinking while pregnant. R16 had sustained head injuries and other physical health injuries related to high levels of alcohol consumption. R16 was placed at Grand Ave Residence in order to help encourage sobriety and to closely monitor blood sugar levels. R16 was accepted and admitted to the facility on 11/9/15, under commitment for chemical dependency until 1/1/16. The Minimum Data Set (MDS) dated 12/7/15, indicated R16 was cognitively intact, mildly depressed, had verbal behavioral symptoms directed towards others, and rejected care daily. R16 was independent with activities of daily living, and had a diabetic diet. The undated care plan included: Alcoholism-alcohol intoxication, alcoholic gastritis, and homelessness. The goal was will attend treatment three times weekly, therapy once a week, and will not drink. The approaches were to schedule appointments and rides as needed. Check resident bags upon return if out of facility. Check boyfriend's bags when coming to facility. Screening at facilities discretion. Keep case manager involved. Hold meds if intoxicated, notify MD and get instructions. Received naltrexone for alcohol urges. Comments included: Resident was attending treatment three times weekly, and therapy. Had been intoxicated since admission resulting in one hospitalization. Mental Health issues included anxiety, resident was taking mental health medications and attending appointments. Resident has had no vulnerable adult issues since admission, but did have one	F 323		

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F 323	Continued From page 49 missing person report for failure to return to facility at specified time. The Social Service Assessment dated 11/13/15, indicated anxiety and "when intoxicated resident can made poor decisions and behaviors change." The identified expectations were "Attend outpatient treatment and therapy, stay sober." Nursing progress notes (PN) included: PN11/17/15, at 6:00 p.m. writer went to resident's room to get blood sugar. Did not come to office for glucose monitoring. Had stated was not going to eat supper. Found resident in (R17's) bed. Was very difficult to arouse. Resident appeared confused and did not understand writer when trying to redirect to room-unable to sit up in bed with assist of one. Blood sugar level 222. Call placed to paramedics, questioned resident if she had any alcohol today, and denied alcohol usage. PN 6:15 p.m. Paramedics here to assess resident. PN 6:30 p.m. Paramedics transporting resident to Fairview University Hospital. PN 11/17/15 ETOH intoxication [alcohol concentration] level 0.37 per nurse [more than 3 times the legal limit]. PN 11/18/15 Writer placed call to FVR [hospital]: verified ER, R16 was to be admitted. PN 11/18/15, continued. Paramedics were told by resident here at Grand that R16 had been drinking vodka all day-writer informed nurse we are alcohol free residents are (circle with I) [intoxicated]. PN 11/24/15 Resident returned from hospital via cab. Resident stated "thanks for taking me back". PN 11/25/15 2:00 a.m. resting sound, did awaken to name, denies pain. At 4:00 a.m. Awake, sitting upstairs sitting area with roommate, stated can't sleep, drinking crystal clear. No alcohol smelled on R16 or Beverage. Instructed smoke room	F 323		

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F 323	Continued From page 50 open soon. Remain calm. Cooperative. Physicians Progress Notes dated 11/25/15, indicated recent hospitalization due to alcohol intoxication-returned yesterday 11/24/15. Rule 25 assessment. PN 11/27/15 at 9:30 a.m. Resident going on LOA [leave of absence] with oral meds, accucheck machine and Novolog insulin pen. Has demonstrated to writer proper use of pen and verbalizes understanding of sliding scale. Is knowledgeable about her medications and has approval by clinic. 11:50 a.m. Left with boyfriend for LOA, took bus. The undated Resident Rules and Responsibilities signed by R16 on 12/1/15, included: 21. There will be no alcoholic beverages allowed in the home unless prior approval from the physician. 22. There will be no illegal drugs allowed in the home. 38. We need to know where residents are at all times. Residents are required to sign out/in when leaving the home. Information needed includes destination, contact information, and expected time of return. The sign out book is located in the dining room on the fireplace mantel. 41. When planning to be gone from the facility for the day, staff must be given 2 hour notice. When planning to be absent from the facility overnight, staff requires a 24 hour notice. When planning to be away for more than a full day, a 3 day notice is required. Physicians Progress Notes dated 12/2/15, identified Ok to do toxicology screen at facility discretion. Please discontinue Novolog order [I unit/10 gram of carbs], "Do not do Carb Counting at facility. " [Consultant pharmacist recommendation "the current order is 1 unit/10 grams of carbs. Making this assessment	F 323		

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F 323	Continued From page 51 accurately is not possible in the home"]. PN 12/8/15, 10:00 patient left via taxi to doctor then spend day with boyfriend. She has meds till HS [bedtime]. She states she will be back at 10:00 p.m. PN 12/8/15, at 11:00 has not returned as planned. Reported to 11-7 shift. PN 12/9/15, at 1:00 a.m. R16 had not returned from outing. PN 12/9/15, at 5:00 a.m. R16 had not returned from outing with her boyfriend. PN 12/9/15, at 4:30 p.m. Residents boyfriend called and said resident will not be coming back to facility until tomorrow at 1:00 p.m. "Stated having car trouble " Mental Health Summary dated 12/9/15, indicated: R16 was noncompliant with medications, had a long history of alcohol use and multiple chemical dependencies, treatment programs and long history of unstable housing, currently has therapy at Nystroms Associates for alcohol dependency. Continues to drink and recent hospitalizations 11/17-11/24 due to alcohol intoxication. Has a boyfriend that is currently supplying [R16] with alcohol for favors. PN 12/10/15, (untimed) writer left message on [boyfriend] voice mail as R16 had not returned this a.m. No return call writer also called [aunt] who is resident's aunt. [Aunt] said she would also call boyfriend and leave message that resident must contact us within 2 hours (from 12:15-2:15). No call back at 2:30 p.m. writer reported resident as missing person. PN 12/10/15, 5 p.m. patrol officer came to make report. PN 12/11/15 7:40 p.m. writer, nurse called [boyfriend's] number, he answered and handed the telephone to R16 she states she will be back to (Grand around 8:p.m. this evening, they do	F 323		

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	24E150	A. BUILDING ______ B. WING ______	04/18/2016

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F 323	Continued From page 52 have a working car). PN 12/11/15, called boyfriend's phone to contact. PN 10:30 a.m. resident [R16] left voice mail. PN 12/11/15, 9 p.m. resident did not return at 8:00 p.m. (late entry). PN 12/14/15, at 5 p.m. Writer/nurse placed a call to [boyfriend's] cell phone and left a voicemail for him to have R16 call us back to let us know when she is returning. PN 12/14/15, at 5:15 p.m. writer/nurse received a call from [R16], she states she will be back this evening at around 9 p.m. PN 12/14/15, at 8:00 p.m. Resident called writer/nurse to report she will not be back until tomorrow am because something came up. Resident reports she is not drinking. PN 12/15/15, at 5:30 p.m. resident returned from LOA-stated had "insulin needles" at boyfriends house was able to give self-insulin. Writer asked why she did not return for a week, replied "I had some things I had to take care of". An undated handwritten note stated: "Tis the season to be jolly ...and I was wondering ...if when I go to [boyfriend's] on Christmas Day, if it would be alright if I spent the night? I promise I'll be back on the 26th before 10 p.m.!! Also no Drinking!!! I understand if you say " NO", as I realize what I did wrong before!![sic] Can you "Please" just take it into consideration? As it would mean a lot to my man and I!!![sic]" PN 12/25/15, Pt went on LOA with meds. Stated she will be back Friday evening. PN 12/25/15, at 10:30 p.m. writer/nurse call [R16's] boyfriends cell phone, [boyfriend] stated [R16] was sleeping and will be back in the am. PN 12/26/15, 11:00 a.m. Called left message to return call at boyfriends phone number. PN 12/26/15, at 5:00 p.m. phone call from boyfriend's number writer answered but no one	F 323		

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F 323	Continued From page 53 on the line. PN 12/26/15, at 6:45 p.m. writer/nurse received a call from [R16], she states she is at Fairview riverside ER to get pain meds for her hip pain until she can have her surgery done. She states she will she will be back later this evening. PN 12/26/15, 10:09 writer /nurse received a call from [R16] she states she is being admitted for pneumonia, they are starting her on IV ' s and plan to do a further work up on her hip pain. PN 12/26/15, at 10:30 p.m. writer/nurse call FV riverside ER and spoke with [R16's] emergency room nurse. He states she is being admitted for pneumonia. Physicians Progress Notes dated 12/31/15, [R16] continues to consume alcohol-conceals in bottle of crystal light. Attended treatment for a first session. PN 1/7/16, Resident discharged today, family member [aunt} came for belongings at 5:00 p.m. The interim director of nursing (IDON) ' s hand written, undated Discharge/Summary Information, " Currently in hospital, history alcohol abuse, peripheral neuropathy, a vascular necrosis, of hip bone, bladder incontinent, esophageal reflux, diabetes type II (DM II). Secondary Hip Dislocation. Psychiatric Conditions: depression, ETOH abuse, chronic pain. Behavior problems: Consumption of alcohol, left premises for extended time without notice. Broke court order for no overnights outside of facility. Needs continued therapy for chemical dependency, needs clinic involvement for management of DM II. "[R16] was admitted on 11/9/15, from FVR hospital. During course of stay, resident remained non-compliant with facility rules, concerning alcohol on premises and leaving facility without notification. Although compliant with medical appointment & treatment programs on course of	F 323		

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F 323	Continued From page 54 improvement. " On 4/14/16, at 2:42 p.m. the social work designee (SWD) and administrator were asked for assessments and policies for resident LOA's. The SWD stated the residents, "sign LOA form and ask for meds". The SWD stated they completed one community assessment and one medicine assessment. "If someone does not return from the outing, I have the missing person's protocol." At 3:00 p.m. the SWD stated the assessment for LOA ability was usually a doctors order for the LOA. The SWD stated sometimes she would talk to the case manager if they had one (LICSW), and the resident had to pass medication self-administration. The facility did not have a LOA assessment. The SWD stated when they knew R16 was drinking, she had called the case manager [LICSW], searched R16's room, and searched the boyfriend. After the elopement the facility lacked reassessments on R16's ability to continue with LOA's. SWD stated " We can't restrict them from going out legally. Then you have to look at discharge or commitment proceedings if that's what you're going to do." The administrator stated "Many times if they want to go [out] even in a snow storm you let them go." The SWD stated she "did not think they [R16] had to be there at night." The case manager wanted her here for 1 week without any outings, then just day outings and then to step mothers or boyfriends. The IDON was not available in the facility, so a scheduled phone conversation occurred with her on 4/15/16 at 2:00 p.m.. The IDON stated she did not have notes with her and did not want to contradict herself, but R16 had alcohol intoxication and was admitted to the hospital because of that "I guess, she is VA (vulnerable	F 323		

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F 323	Continued From page 55 adult) no matter what." The IDON further stated that the leave of absence was not an assessment but was based on other assessments such as community safety that the SWD did. The IDON stated she only worked one day per week, she would give bullet points to SWD who filled out paperwork and then the IDON signed her name. R6 was observed on 4/12/16, at 6:35 p.m. walking from dining room table to bathroom, just off the living room. R6 had a halting gait, was stumbling and reaching for furniture. R6 was not using any device to assist with ambulation. During random observation 4/13/16, at 11:40 a.m. R6 was observed walking without a cane, limping and stumbling into the smoking room. R6 fell into chair in the smoking room. At 12:41 p.m. R6 was again observed to stumble and fall into a chair in smoking room. R6's Grand Avenue Residence Accident Prevention Plan (APP) completed 8/18/15, indicated potential problems included balance problems, dizziness, poor choices regarding clothing and foot wear, and not wearing glasses. R6 had multiple falls in previous year and R6 reported, "Sometimes I get dizzy I don't know why I fall. " The interventions listed on the APP included suspenders when wearing pants, proper fitting footwear, walker when leaving the facility, night light in bathroom, and a call light next to bed. The APP indicated R6 did not always comply with wearing suspenders, proper fitting shoes and glasses. APP was reviewed by staff on 11/18/15, with no falls identified and on 2/11/16, two falls were identified for 11/25/15, and 1/4/16. Interventions added to the APP and dated	F 323		

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F 323	Continued From page 56 11/25/15, added included, "do not use upstairs B.R. [bathroom] during noc [night]. If B.R. being used pull lite [call light] for nurse to assist accompany to room to use B.R." R6's care plan dated 8/26/15, indicated R6 was at risk for fall due to gait, medications, and vision. R6 was to utilize a walker when out of the facility. Approaches listed on care plan included Fall risk assessment, vitals three times weekly, labs as ordered, suspenders if wearing pants, wear glasses and proper footwear, and night light on at night in bedroom. The 11/25/15, fall with new intervention was listed on care plan. The 1/4/16, fall was listed on care plan with no new interventions. The 2/22/16, fall was not on care plan. Review of Nurses' Record and Progress Notes (PN) from 7/2/15 through 4/13/16, indicated R6 fell on 7/23/15, 11/25/15, 1/4/16, and 2/22/16. - PN on 7/23/15, at 9:00 a.m. indicated R6 tripped over an object on the ground and fell on the grass. R6 did not have a walker with her. There was no apparent injury. - PN for 11/25/15, at 1:30 a.m. indicated the nurse heard and saw R6 on her knees at the top of the stairs and R6 fell over on to her side. R6 was instructed not to go upstairs to toilet. If her bathroom was busy R6 was to put on her call light and staff would help her. Bruises were observed on her left knee and lower leg. - PN on 1/4/16, at 10:00 a.m. indicated R6 fell in the smoke room. R6 stated she was about to sit down when the chair slid away from her. - PN on 2/22/16, at 10:30 p.m. identified R6's roommate informed the nurse that R6 had fallen in the bathroom. R6 initially denied falling in the bathroom but then told the nurse she had slipped	F 323		

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F 323	Continued From page 57 and fell on her knees and arm. R6 had a scrape on her left arm above the elbow. The nurse encouraged R6 to wear proper footwear. R6's sitting blood pressure was 132/80 and standing blood pressure was 104/70. Vital signs were faxed to the physician's assistant. The medical record lacked any follow up information with R6's physician 28 millimeters of mercury (mm HG) drop in systolic blood pressure, a diastolic drop in blood pressure of 10 mm HG, and the two hypertensive medications and the clozapine use. R6's quarterly Minimum Data Set (MDS) dated 2/5/16, indicated R6 was cognitively intact and was independent with all activities of daily living except dressing and personal hygiene. The MDS also indicated R6 was unsteady when going from sitting to standing or turning around, did not use any mobility devices and R6 became short of breath with walking. R6's MDS indicated R6 had diagnoses of anemia, diabetes, hypertension and schizophrenia. The Physician's order Sheet dated 3/24/16, noted R6 received amlodipine for hypertension daily, benazepril for hypertension twice daily, and clozapine for schizophrenia twice daily. The medical record was void of any documentation that the facility looked at R6's medication regarding the falls and her stated feeling of being "dizzy." During interview on 4/15/16, at 2:19 p.m. the interim director of nurses (IDON) said, all falls are investigated and care planned with new interventions identified. The package insert for amlodipine besylate revised on 5/2012, by Lake Erie Medical &	F 323		

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F 323	Continued From page 58 Surgical Supply DBA Quality Care Products LLC noted the following side effects. Most side effects are mild or moderate: headache, swelling of your legs or ankles, tiredness, extreme sleepiness, stomach pain, nausea, dizziness, flushing (hot or warm feeling in your face), arrhythmia (irregular heartbeat) and heart palpitations (very fast heartbeat)." The package insert for clozapine by Caraco Pharmaceutical Laboratories, Ltd. revised on 8/2/13, insructed staff to inform "patients and caregivers about the risk of orthostatic hypotension and syncope, especially during the period of initial dose titration. Instruct them to strictly follow the clinicianâ Euro (Trademark)s instructions for dosage and administration. Advise patients to consult their clinician immediately if they feel faint, lose consciousness or have signs or symptoms suggestive of bradycardia or arrhythmia." The Centers for Disease Control dated 9/30/15, the section for Stopping Elderly Deaths and Injuries (STEADI) noted orthostatic blood pressure to be "drop in bp [blood pressure] of =20 mm Hg, or in diastolic bp of =10 mm Hg, or experiencing lightheadedness or dizziness is considered abnormal." R6 had both drops in blood pressure and the medical record lacked any follow up with the physician.	F 323		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.	F 354		5/16/16

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F 354	Continued From page 59 Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide registered nurse (RN) coverage for eight consecutive hours, seven days a week, and did not have an RN waiver. This had the potential to affect all the 17 residents in the facility requiring care and services. Findings include: Nursing hours were reviewed from 3/15/16 to 4/15/16. The review identified there was consistently no RN coverage. - The weeks of 3/14 through 3/27/16, revealed there was no RN coverage: 3/15, 3/17, 3/20, and 3/24. - The weeks of 3/29 through 4/10/16, revealed no RN coverage on 3/29, 4/5, 4/6, 4/7, and 4/10. - The week of 4/11 through 4/15/16, revealed no RN coverage on 4/12/16. On 4/12/16, at 12:00 p.m. the business office manager acknowledged there was no RN coverage as noted and a new director of nursing would be starting "next week."	F 354	Our former DON retired and we have had a difficult time finding a suitable replacement. We have had a few that didn't work out in our facility with our residents. Because we had been unable to find a full-time replacement DON, we were using a retired former DON as the interim. She was filling in full time up until the end of March when she had to go to part-time. We were not able to full this full-time role though employees, pool, or headhunters. This will also resolve the issue of the full-time DON and at that point we will also have RN coverage for at least 8 hours per day. To assure compliance with this the following plan has been put into place. A new permanent DON starting on 5/16/16. When the DON starts will also have RN coverage for at least 8 hours per day. We are aware of the coverage requirements. As nursing openings occur we will continue to aggressive advertise, search for and hire nurses to maintain this requirement. Those responsible to maintain compliance	

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F 354	Continued From page 60	F 354	will be the DON and supervised by the Administrator.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	F 356		4/18/16

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F 356	Continued From page 61 Based on interview and document review, the facility failed to post the actual hours worked for nursing staff directly responsible for resident care per shift on each day of the survey. This had the potential to affect all the 17 residents in the facility requiring care and services. Findings include: A review of the posted Grand Avenue Residence Direct Care Staff hours were reviewed from 3/15/16 to 4/12/16. The review identified there was no differentiation between the registered nurse/licensed practical nurse (RN/LPN) coverage during the week. - The staff posting dated 3/22 through 3/24/16, indicated the facility had eight hours of coverage of "RN/LPN" on the day shift. The review identified there was no differentiation between the RN/LPN coverage during those days. - The week on 4/11 through 4/15/16, revealed no RN coverage on 4/12/16. The staff posting dated 4/12/16, indicated the facility had eight hours of coverage of "RN/LPN" on the day shift. The review identified there was no differentiation between the RN/LPN coverage during that day. On 4/12/16, at 12:00 p.m. the business office manager acknowledged there was no RN coverage and a new director of nursing would be starting next week.	F 356	We were documenting the RN and LPN hours together. A simple change to the form was all that was required. Now, each shift has a spot to record LPN and spot to record RN hours. Nursing was trained in the change in use of the form. To assure compliance with this the following plan has been put into place. We were documenting the RN and LPN hours together. A simple change to the form was all that was required. Now, each shift has a spot to record LPN and spot to record RN hours. Actions taken to identify other potential residents having similar occurrences. We have updated the form and shredded copies of the outdated form. The DON will monitor this daily and is responsible to maintain the records for review. The Administrator will ensure we maintain compliance.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431		6/9/16

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F 431	Continued From page 62 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure expired medications were removed from the medication cart for 1 of 2 residents (R17) with diabetes. In addition, that all medications were properly labeled with resident's names, directions for use and date opened for 1 of 2 residents (R1) with	F 431	The Victoza insulin pen found in the med cart on 4/12/16 had not been opened or used yet. It is unfortunate that the pharmacy delivered this medication without proper labeling. Upon internal investigation we discovered that a nurse discovered the issue with the label and	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 63 diabetes. Findings include: On 4/12/16, at 12:07 p.m. during the medication storage observation a Victoza (a medication to improve blood sugars) injectable pen was in a plastic bag labeled with a first name. There was no label on the pen or bag. There was no date opened on the pen. R17's annually Minimum Data Set (MDS) dated 3/27/16, indicated R17 had a diagnosis of diabetes. The MDS indicated R17 had received insulin injections seven out of seven days. The Physician Order Sheet dated 3/24/16, indicated R17 was to receive Victoza 1.8 milligrams (mg) injection daily at noon for diabetes. During interview on 4/12/16, at 12:07 p.m. the licensed practical nurse (LPN)-A stated Victoza had been removed from the refrigerator yesterday but had not been used yet. LPN-A said, "I do not know why it does not have a name on it or a date." The Victoza manufactures package insert by Novo Nordisk dated 3/9/15, instructed users, "Use a Victoza pen for only 30 days. Throw away a used Victoza pen after 30 days, even if some medicine is left in the pen." On 4/12/16, at 7:04 p.m. during medication storage observation one vial of Lantus (insulin) was observed to be stored ready for use in the top drawer of the medication cart that was labeled with R1's name and dated as opened on 3/14/16,	F 431	had brought it to the med cart to correct the issue and then forgot to follow up on it. Nursing inspected the remaining pens and found them all to be labeled properly and discarded the pen without the label. We acknowledge that all medications must be properly labeled and have changed our procedure for checking in of medications from the pharmacy to include verifying the labeling and to send the medication back immediately to the pharmacy if improperly labeled. The open Lantus bottle with dated open date of 3/14/16 and expiration date of 4/11/16. It should have been last used on 4/11/16 with a 28 day expiration. We have begun retraining off all the nurses about medications that are expired should immediately be discarded. This retraining will be completed by the date indication for the correction. We have updated the medication cart audit policy to include monitoring the expired date for all medications as well as opened dates. This monitoring occurs at least every other week. The Director of Nursing will monitor this for compliance by spot checking the medication cart. The Administrator will also oversee this with the DON.	

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	24E150	A. BUILDING ______ B. WING ______	**04/18/2016**

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GRAND AVENUE REST HOME	**3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409**

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F 431	Continued From page 64 and expired on 4/12/16. That was 30 days from the opened date. LPN-B verified the Lantus expired 28 day after being opened. R1's annually Minimum Data Set (MDS) dated 2/20/16, indicated R1 had a diagnosis of diabetes. The MDS indicated R1 had received insulin injections seven out of seven days. The Physician Order Sheet dated 3/24/16, indicated R1 was to receive Lantus 15 units daily at bedtime for diabetes. Lantus manufactures insert by Sanofi-Aventis dated 7/15, indicated, "Do not use Lantus after the expiration date stamped on the label or 28 days after you first use it." During interview on 4/15/16, at 3:15 p.m. LPN-A stated, "I check every Friday for expired meds. It is the responsibility of every nurse." Facility Internal Med Cart Audits policy updated 5/1/14, instructed staff, "To ensure the accuracy of the medications administered to the residents, each resident's medications and house medications will be audited internally by nursing every two weeks." Policy instructed staff that items to audited for included: "2. Check for and remove expired medications. Dispose of expired medications using proper procedures. 3. All medications requiring a date opened must have a legible date. It is beginning to smear or becoming hard to read, fix it. If it is illegible, you must discard as if it is expired." Facility Proper Labeling policy updated 5/5/12, lacked instructions that medications required a	F 431		

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F 431	Continued From page 65 label which included resident's name and directions for use.	F 431		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide at least 80 square feet per resident in three resident bedrooms (101, 102, 103) affecting eight residents (R1, R2, R4, R6, R8, R9, R12, R18) whose bedroom had fewer than the required footage. Findings include: 1) Room 101 had three residents residing in the room with 211.33 square feet of floor space. A large wooden wardrobe was built into the room, which measured 13.5 square feet, leaving 197.83 square feet of usable space or 66 square feet for each resident. 2) Room 102 had three residents residing in the room with 232 square feet of floor space or 77.3 feet per resident. 3) Room 103 had two residents residing in the room had 238.26 square feet of floor space. Three wooden wardrobes were built into the room. One wardrobe measured 6 square feet; another measured 5.3 square feet and the third measured 6.25 square feet. That resulted in	F 458	A waiver is requested for rooms 101,102 and 103 because they do not meet the requirements of 80 square feet per resident. We are requesting the waiver because: We have operated over 40 years in the same facility. During this time, there have been no adverse effects due to the room sizes. Our residents are generally satisfied. Our resident concerns are minimal. When a resident does have a concern it is generally because they came to our facility from an apartment or home and we cannot accommodate as many of their belongings as they would prefer. We do try to accommodate them to the extent possible. All of our residents are ambulatory. We do not have wheel chairs in the facility and have not encountered any safety or health problems due to the existing room sizes. The residents have the opportunity to decorate their room and put up different personal items of enjoyment. Our residents have ample room for personal possessions. Each resident has a custom-made locking wardrobe cabinet.	5/13/16

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F 458	Continued From page 66 220.71 square feet of useable floor space or 73.7 square feet per resident. On 4/12/16, at 12:00 p.m. the administrator verified the facility was aware of the space requirements, and planned to request a federal waiver regarding the room measurements. On 4/12/16, at approximately 8:45 a.m. the residents residing in those rooms were interviewed and all expressed satisfaction with the space provided.	F 458	There is enough room for chairs and other preferred furniture to the extent possible. The beds in our rooms fit the space very well and allow for exit and entry without issue. Nursing has not had any problems providing nursing care. The waiver request letter was uploaded to the ePOC system.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure retention of complete and accurate medical records for 1 of 3 (R20) residents who had been hospitalized. Findings include:	F 514	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or	6/3/16

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GRAND AVENUE REST HOME	**3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409**

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F 514	Continued From page 67 R20 was admitted to the facility on 3/23/15. A Minimum Data Set (MDS) annual assessment dated 2/6/16, identified R20 as independent with activities of daily living and had intact cognition. R20's Community Safety Assessment (CSA) dated 8/3/15, indicated R20 had a history of making poor decisions, chemical dependency issues and was currently attending treatment three times per week. The assessment further indicated R20 had a history of substance abuse and was a "former heroin addict" and that "since admission has used illegal drugs." The assessment further indicated that R20 had multiple Vulnerable Adult (VA) issues since admission related to poor choices. Staff recommendations on the assessment indicated R20 could leave the facility independently. R20's medical record lacked documentation of use of illegal drugs from the time of admission (3/23/15 through 8/3/15) as identified in the CSA. A note dated 12/28/15, in R20's medical record signed by the administrator revealed R20 admitted to having alcohol in her room which contributed to another resident (R7) going to the emergency room. The note indicated that was not the first time that had occurred and that was a violation of the facility policy. The note further stated that additional interventions were required to ensure the safety of R20 and the other residents and suggested R20 was now subject to random room checks and a room change. R20's medical record did not identify previous dates or incidents related to alcohol use. R20's Progress Notes were reviewed from 1/16 through 4/11/16, and revealed the following:	F 514	any employees, agents, or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any fasts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the facility has prepared this Plan of Corrections prior to resolution of any dispute resolution which must be filed because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the delivery of the CMS-2567 allegations of deficiencies as a condition to participate in the programs. This Plan of Correction is submitted as the facility s credible allegation of compliance. We are disputing this tag in the informal dispute resolution process to correct the many inaccuracies reported. To assure compliance with this the following plan has been put into place. R16 has been discharged. We have verified that the 1/9/16 hospital discharge summary is in the medical record and complete. Actions taken to identify other potential residents having similar occurrences. We have reviewed each hospitalization in 2016 and verified that the medical record includes the entire hospital discharge summary. We have retrained the nurses that all information in a discharge summary must be included in the resident medical	

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F 514	Continued From page 68 On 2/3/16, at 7:30 a.m. resident appeared lethargic although able to respond to questions if asked. R20 was given five ounces of apple juice and stated "I'm just so thirsty." One half hour later, R20 states she could not eat breakfast and "felt sick to her stomach." R20 was checked again after the nurse was called by roommates which stated they "were worried" about R20. The nurse found resident "laying across bed with head and neck hyperextended. Res. [resident] warm and breathing, pulse approx [approximately] 80/bpm [beats per minute] and strong. Res. just not responsive-pupils dilated. 911 was called-attendants gave Narcan [a heroin reversal agent] and resident responded and was taken to ER [emergency room]." The physician and family were notified. On 2/3/16, a "Postnote" was written below the above entry that indicated "EMTS [sic] state they found a suicide note and took it with them. R20 not reported any suicidal thoughts to this nurse on duty from 7am-3pm. EMTS [sic] state resident admitted for snorting heroin." On 2/3/16, at 5:00 p.m. R20 was admitted to hospital for heroin overdose. There was no follow up documentation to the information regarding R20's suicide note in R20's medical record. R20's Hospital Discharge Summary dated 2/8/16, indicated R20 had previously required hospitalization for altered mental status and accidental overdose. R20's medical record revealed no documentation of any other recent hospitalization. However, a review of R20's MDS assessments indicated a discharge summary was completed on 1/9/16, and an entry tracking record MDS was completed on 1/13/16. When asked about the 1/9/16 discharge summary and documentation on	F 514	record. The DON is responsible for implementation and regular monitoring and spot checking of this going forward. The Administrator is responsible to maintain compliance and will do this by spot checking with the DON periodically.	

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GRAND AVENUE REST HOME	**3956 GRAND AVENUE S0UTH** **MINNEAPOLIS, MN 55409**

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F 514	Continued From page 69 4/14/16, at 2:40 p.m. the social work designee (SWD) stated the hospital had not provided them with any written summary. Licensed practical nurse (LPN)-A stated they only needed the medication list, so the rest was shredded. R20's labs were reviewed which indicated R20 tested positive for THC (marijuana) on 3/26/16. R20's medical record did not indicate any further follow up for the positive lab result. An interview with the SWD on 4/14/16, at 2:42 p.m. revealed she was aware of R20's heroin overdose on 2/3/16. The SWD was unaware if R20 had any other hospitalizations due to overdose. The SWD stated she had followed up with the hospital on the note that the EMT's found, which she indicated was a love letter and not a suicide note. The SWD confirmed there was no documentation of follow up in R20's medical record about the note, however stated she discussed the incident with R20 who stated she "wanted to live." The SWD was aware of R20's past drug use and stated R20 had tested positive for marijuana once before and confirmed that was not indicated on R20's care plan. Interview with the interim director of nursing (IDON) on 4/15/16, at 2:28 p.m. revealed someone at the facility followed up with the hospital on the "suicide note" and found out the note was actually a "love letter" and not a suicide note. The IDON stated the information should have been documented in R20's medical record.	F 514		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		6/3/16

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F 520	Continued From page 70 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Quality Assessment (QA) committee recognized and developed action plans to address potential for injury for 4 of 4 residents (R6, R7, R16, R20) who were required supervision for falls and were known to consume alcohol and use illegal drugs in the facility. Findings include: Refer to F323: the facility did not supervise and	F 520	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by	

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F 520 Continued From page 71

provide interventions to prevent injuries and hospitalizations for 4 of 4 residents R6, R7, R16 and R20.

The Social Service Designee (SWD) was interviewed on 4/15/16, at 5:03 p.m. with the administrator present and confirmed there was a QA committee that met quarterly to identify facility issues, discuss new happenings in the industry and struggles of the facility.

The SWD was interviewed on 4/14/16, at 2:42 p.m. regarding the hospitalization for R20's heroin overdose and R7's alcohol intoxication and interviewed at 3:00 p.m. for R16's alcohol use and elopement. The SWD was aware of R20's history of drug use, and R7 and R16's past alcohol dependence. The SWD stated that alcohol and drugs were not allowed in the facility at anytime and was not aware of any residents that were currently using alcohol, however confirmed R7, R16 and R20 were hospitalized due to the use of drugs and alcohol.

F 520

the facility of the truth of any fasts alleged or the correctness of any conclusions set forth in the allegations.
Accordingly, the facility has prepared this Plan of Corrections prior to resolution of any dispute resolution which must be filed because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the delivery of the CMS-2567 allegations of deficiencies as a condition to participate in the programs. This Plan of Correction is submitted as the facility s credible allegation of compliance.
We are disputing this tag in the informal dispute resolution process.

This deficiency is related to the accidents cited in tag F323 of which we are also disputing some of the information.
In the case of R6, the QA committee has discussed this resident many times over the course of her stay.

To assure compliance with this the following plan has been put into place. R6, R7, R16 and R20 incidents were specifically reviewed at the QA meeting on 5/19/16. Each situation and additional interventions were discussed. We did add additional interventions for R6 to reduce falls. R16 has previously been discharged. R20 is in process of discharge.

Actions taken to identify other potential residents having similar occurrences. During the scheduled QA meeting on

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F 520	Continued From page 72	F 520	5/19/16, the team reviewed falls and incidents for the past year. We already do this for the past quarter for each QA meeting. We determined no additional interventions required for other residents. We will continue to review incidents and falls at each quarterly QA meeting, determine if any of the incidents require closer scrutiny, investigate and implement interventions as necessary. We will also begin documenting this in a separate form within the QA documents so we can provide them for review if this issue comes up again. Implementation of changes will be by the DON as the primary manager with assistance from the SWD and other members of the QA team as needed. Ongoing, this will be monitored by the Administrator during QA meetings.	

GRAND AVENUE REST HOME INC.
3956 Grand Avenue South
Minneapolis, MN 55409
(612) 824-1434

May 13, 2015

Minnesota Department of Health
Licensing and Certification Program
ATTN: Gloria Derfus
P.O. Box 64900
St. Paul, MN 55164-0900

RE: Provider ID 24E150, F-458 Waiver Request, CMS-2567 Survey Completed 04/15/2016

We request a room size waiver for rooms 101, 102 and 103. These rooms are close to the requirement, but do not meet the requirements of 80 square feet per resident.

We are requesting the waiver because:

1. We have operated over 40 years in the same facility. During this time, there have been no adverse effects due to the room sizes. Our residents are generally very satisfied as continually shown in the resident satisfaction surveys. Our resident concerns are minimal. When a resident does have a concern it is generally because they came to our facility from an apartment or home and we cannot accommodate as many of their belongings as they would prefer. We do try to accommodate them to the extent possible.

2. All of our residents are ambulatory. We do not have wheel chairs in the facility.

3. We have not encountered any safety or health problems due to the existing room sizes.

4. The residents have the opportunity to decorate their room and put up different personal items of enjoyment.

5. Our residents have ample room for personal possessions. Each resident has a large wardrobe cabinet which is part of the reason for the reduced room size.

6. There is enough room for chairs and other preferred furniture to the extent possible.

7. The beds in our rooms fit the space very well and provide room for entry and exit without issue.

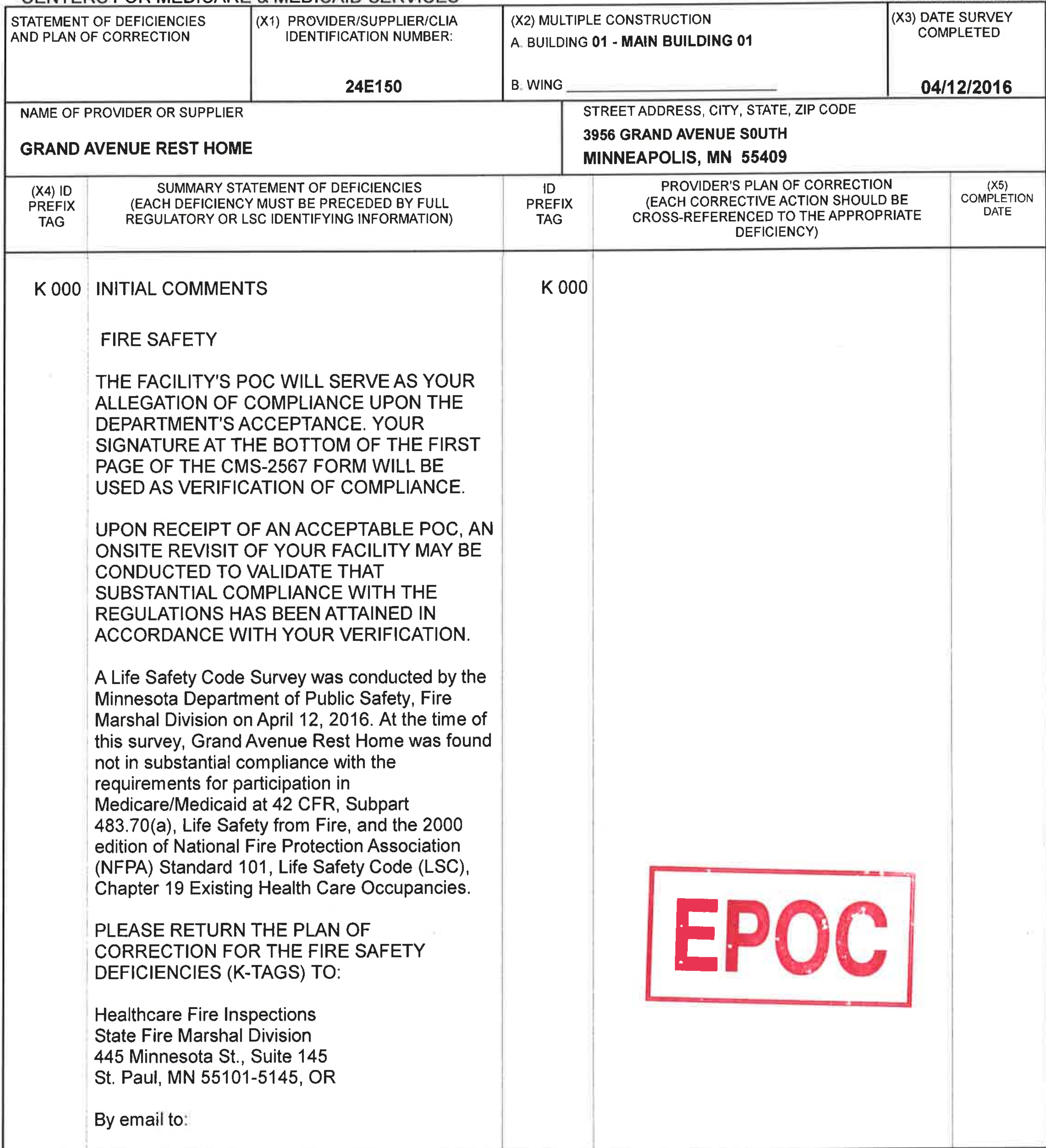
8. Nursing has not had any problems providing care.

This has been an approved ongoing waiver for many years.

Sincerely,

Allen Soderbeck
Administrator

FE150024



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	24E150	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**04/12/2016**

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GRAND AVENUE REST HOME	**3956 GRAND AVENUE SOUTH** **MINNEAPOLIS, MN 55409**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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, Fire Marshal Division on April 12, 2016. At the time of this survey, Grand Avenue Rest Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. 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 By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/09/2016

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

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	24E150	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409

(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	Continued From page 1 Marian.Whitney@state.mn.us, and Angela Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 2-story building was determined to be of Type V(000) construction. It has a basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to corridors which is monitored for automatic fire department notification. The facility has a capacity of 20 beds and had a census of 20 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and interview, this building does not meet the requirements for construction type and height. This deficient practice could affect all residents. Findings include:	K 012	Correction not needed. Grand Avenue Rest Home has achieved a passing FSES score (see enclosed FSES/HC)	5/5/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**04/12/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	**3956 GRAND AVENUE SOUTH** **MINNEAPOLIS, MN 55409**

(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 012	Continued From page 2 During a tour of the facility between 11:30 AM and 2:00 PM on 4/12/2016, observation revealed that this 1903, 2-story, fully fire sprinklered building of Type V(000) construction does not meet the minimum construction requirements of the code for type and height. This deficient practice was verified by the Administrator Assistant at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 012		
K 032 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: Based on observation and interview, two approved remote exits are not provided from the second floor. This deficient practice could affect all residents. Findings include: During a tour of the facility between 11:30 AM and 2:00 PM on 4/12/2016, observation revealed that the outside fire escape stairs do not provide the required two (2) remote exits from the second floor.	K 032	Correction not needed. Grand Avenue Rest Home has achieved a passing FSES score (see enclosed FSES/HC)	5/5/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**04/12/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	**3956 GRAND AVENUE SOUTH** **MINNEAPOLIS, MN 55409**

(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 050	Continued From page 5 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility did not conduct fire drills under varying times. This could affect the staff response to evacuate all 20 residents in the event of a fire or an emergency in accordance with LSC section 19.7.1.2. Findings include: On facility tour between the hours of 11:30 AM and 2:00 PM on 4/12/2016, during documentation review it was revealed that the facility conducted Night-shift fire drills between the hours of 6:30 AM, 5:00 AM, 6:10 AM, 6:20 AM not varied times as required. This deficient practice was verified by the Administrator Assistant at the time of the inspection.	K 050	Night shift fire drills will be conducted at varied times. A fire drill schedule has been developed for the remainder of 2016 and for use ongoing to ensure that fire drills are conducted at times of increased variation. (see attached) To ensure that times continue to be varied, Administrator will review times of the preceding year's fire drills prior to establishing the fire drill schedule for the following years to prevent a reoccurrence of this deficiency.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**04/12/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	**3956 GRAND AVENUE SOUTH** **MINNEAPOLIS, MN 55409**

(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 039 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observation and interview, the second floor corridor does not meet the minimum 48" width requirement. This deficient practice could affect all residents. Findings include: During a tour of the facility between 11:30 AM and 2:00 PM on 4/12/2016, observation revealed that the second floor corridor is only 39 inches in clear width and not the 48 inches required for this type of facility. This deficient practice was verified by the Administrator Assistant at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 039	Correction not needed. Grand Avenue Rest Home has achieved a passing FSES score (see enclosed FSES/HC)	5/5/16
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established 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.	K 050		4/20/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**04/12/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	**3956 GRAND AVENUE SOUTH** **MINNEAPOLIS, MN 55409**

(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 032	Continued From page 3 This deficient practice was verified by the Administrator Assistant at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 032		
K 033 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit enclosures (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation and interview, the stairway enclosure of this facility does not meet the required one (1) hour fire resistive construction. This deficient practice could affect all residents. Findings include: During a tour of the facility between 11:30 AM and 2:00 PM on 4/12/2016, observation revealed that wall construction of the stair enclosure is constructed of plaster on wood lath on wood studs, which does not meet the one (1) hour fire resistive construction requirements for this type of facility. This deficient practice was verified by the Administrator Assistant at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 033	Correction not needed. Grand Avenue Rest Home has achieved a passing FSES score (see enclosed FSES/HC)	5/5/16

Report of Consultant FSES Findings

Grand Avenue Rest Home

3956 Grand Avenue South

Minneapolis, MN 55409

Provider No. 24E150

Date of Survey: April 21, 2016

Prepared by:
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Mr. Allen Soderbeck
Administrator
Grand Avenue Rest Home
3956 Grand Avenue South
Minneapolis, Minnesota 55409

May 5, 2016

RE: FSES at Grand Avenue Rest Home

Dear Mr. Soderbeck:

Enclosed please find the survey information relating to the fire safety evaluation of Grand Avenue Rest Home, 3956 Grand Avenue South in Minneapolis conducted on 04/21/2016. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(01), *Guide to Alternative Approaches to Life Safety*.

As you're aware, the FSES is a rating system designed to evaluate the level of fire/life safety in health care facilities and serves as a method to demonstrate alternative compliance with the 2000 edition of the *Life Safety Code*® (NFPA 101). The FSES was made necessary in this case because of deficiencies cited against the facility relating to:

- Construction type and height (K012),
- Fire escape stairs (K032),
- Stair enclosure construction (K033), and
- Corridor width (K039).

The following factors served as the basis for this evaluation:

- The building, constructed in 1930, was considered an existing building.
- Grand Avenue Rest Home is two stories in height and has a full basement. For purposes of this FSES, each of the three levels was treated as a separate zone.
- For purposes of this FSES, it was assumed that the basement level does not involve resident housing, treatment or customary access.

Based on the conditions found during the FSES evaluation conducted on 04/21/2016, all four parameters in Table 7 of the FSES worksheets, ZONE FIRE SAFETY EQUIVALENCY EVALUATION, in all three zones evaluated were found to have a score of zero or greater. *Fire Safety Resources* finds, therefore, that Grand Avenue Rest Home has achieved a passing FSES score.

Should you have any questions or need additional information, please don't hesitate to get back to me.

Wishing you a safe day!

Robert L. Imholte
President, *Fire Safety Resources, LLC*

Enclosures
RLI/rli

FIRE SAFETY EVALUATION

Name of Facility: Grand Avenue Rest Home
Address: 3956 Grand Avenue South, Minneapolis, MN 55409
Phone: 612-824-1434
Licensed capacity: 20
Census at time of survey: 18

Evaluator: Robert L. Imholte, President, *Fire Safety Resources, LLC*

What follows is a report on the findings of a fire safety evaluation of the above-named facility that was conducted during an on-site visit to the facility between 0920 hours and 1225 hours on 04/21/2016. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(01), *Guide to Alternative Approaches to Life Safety*. Based on this evaluation, Grand Avenue Rest Home **has** achieved a passing score on the FSES.

In addition to the on-site visit on 04/21/2016, the findings outlined herein are based on information provided by Mr. Allen Soderbeck, Administrator, Ms. Nancy Soderbeck; and a review of the Statement of Deficiencies from a fire/life safety recertification survey conducted on 04/12/2016.

Initial Comments:
The building housing Grand Avenue Rest Home was constructed in 1930 with an addition in 2001. It is considered an existing building for federal certification purposes and was, therefore, treated as such for assigning values on the FSES worksheets.

Because of the noncombustible exterior walls and protected wood frame interior structural members, the major portion of the building was found to be of Type III(000) construction. While interior walls and ceilings are constructed of plaster on wood lath on wood studs, exposed wood joists were found in the ceiling in various areas of the basement. The 2001 addition to the east side of the building was found to be of protected wood frame construction, but, again, exposed wood joists were found in the ceiling of the basement crawl space. As a result, for purposes of this FSES, Grand Avenue Rest Home was considered to be of Type V(000) construction.

The facility's residents are not allowed in the basement. For purposes of this FSES, therefore, it was assumed that this level does not involve resident housing, treatment or customary access and it was scored accordingly in performing the FSES calculations.

Grand Avenue Rest Home is two stories in height and has a full basement. For purposes of this FSES, each of the three levels was treated as a separate zone. With the exception of Table 8, which applies to all zones, this narrative will address each of the three zones separately.

The facility has a manual fire alarm system, which is monitored for automatic fire department notification. Corridor smoke detection is provided on the First and Second Floors. In addition, there are system-connected automatic smoke detectors in the storage and laundry room areas located at the west end of the basement. Based on documentation review, the fire alarm system and smoke detectors are being inspected, tested and maintained in accordance with NFPA 72.

The building is protected by a supervised, dry-pipe automatic fire sprinkler system consisting of quick-response sprinklers. Based on documentation review, the system is being inspected, tested and maintained in accordance with NFPA 25.

The following narrative is intended to serve as an explanation of the scores entered on Tables 1, 4 and 8 of the FSES worksheets (i.e. Forms CMS-2786T) for the facility as it was found on 04/21/2016. The score assigned to each item is noted in brackets ([ ]). It must be noted that numbers were rounded to the nearest tenth of a point and that measurements of over one-half inch were rounded to the nearest inch. To ensure that the FSES addresses the "worst-case scenario", the product of the multiplication in Table 3B (i.e. value of "R") was rounded up to the nearest whole number. Code references are provided where appropriate. Codes referenced include the 2001 edition of NFPA 101A and the 2000 edition of the *Life Safety Code*® (NFPA 101).

All Levels – TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

In accordance with NFPA 101A(01), Sec. 4.7, Step 8, only one copy of this table is required to be filled out for the building. All items in Table 8 could be checked 'Met' with the exception of Items B and L. Because Grand Avenue Rest Home is an existing facility and does not meet the definition of a high rise, Items B and L were checked 'Not Applicable'.

The remaining items were identified as 'Met' based on the following:

- Building utilities and heating and air conditioning systems appeared to be in conformance with NFPA 101(00), Sec. 9.1 and 9.2.
- The facility has a policy in place restricting the use of portable space heaters to non-sleeping staff areas only. Based on review, the policy was found to be in conformance with the exception to NFPA 101(00), Sec. 19.7.8.
- No incinerator was found in the building.
- The facility's evacuation plan and fire drill records were reviewed and appeared to be in order.

  Surveyor Note: A review of the Statement of Deficiencies from the 04/12/2016 fire/life safety recertification survey revealed that the facility was cited for failure to sufficiently vary the times that fire drills were conducted on the night shift (see data tag K050). Documentation review conducted during this FSES survey revealed that the facility has developed a Plan of Correction stating that fire drills will be conducted at more varied times.
- The facility restricts smoking inside the building to the smoking lounge on Second Floor. Smoking is also allowed on the porch at the southwest exterior of the building. The facility's smoking regulations were reviewed and appeared to be in order.
- Documentation was provided certifying that the facility's drapes and curtains were treated with Burn Barrier FPR Spray-On Fire Retardant to render them flame resistant.
- Portable fire extinguishers, EXIT signage and emergency lighting appeared to be provided and maintained in accordance with applicable requirements.

<u>Zone 1 – Basement Level</u>:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

The facility's residents are not allowed in the basement. For purposes of this FSES, therefore, it was assumed that this level did not involve resident housing, treatment or customary access. The basement was found to house storage rooms, the facility heating plant and a laundry room. As a result, in accordance with instruction given in NFPA 101A(01), Sec. 4.3.2(4)a, only Item 3, Zone Location (*L*), of Table 1 was addressed and the value of factor *F* in Table 2, OCCUPANCY RISK FACTOR CALCULATION, was assigned a factor of 1.6 (i.e. the value assigned to basements in factor *L* of Table 1).

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -7]:
   The building was assigned a Type V(000) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Interior finish in spaces that could be considered part of a corridor was plaster, acoustical tile and wood paneling. Based on interview with the administrator, all acoustical tile and wood paneling was treated with Flame Control No. 20-20A Flat Latex Intumescent Fire Retardant Paint and/or Flame Control No. 40-40A Low Gloss Latex Fire Resistant Coating to achieve a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Interior finish was found to consist of plaster, acoustical tile and wood paneling. Based on interview with the administrator, all acoustical tile and wood paneling was treated with Flame Control No. 20-20A Flat Latex Intumescent Fire Retardant Paint and/or Flame Control No. 40-40A Low Gloss Latex Fire Resistant Coating to achieve a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +1]:
   For purposes of this FSES, the basement level was treated as a single hazardous area consisting of multiple rooms. The wall separating the basement from the exitway was reported to be constructed of plaster on wood lath on wood studs, which likely provides a fire resistance of at least ½ hour.
5. Doors to Corridor [Score: +2]:
   For purposes of this FSES, the door at the bottom of the stairway leading from the basement was treated as a corridor door. The door, of 1¾-inch-thick solid wood construction in a wood frame, was found to be automatic-closing.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. The building measures approximately 60 feet in length. Due to a lack of complying means of egress, Parameter 10 was scored at -8.
7. Vertical Openings [Score: 0]:
   A 1¾-inch-thick solid wood automatic-closing door in a wood frame was found at the bottom of the basement stairs. The door at the top of the stairway was found to be of wood panel construction.
8. Hazardous Areas [Score: 0]:
   Again, for purposes of this FSES, the basement level was treated as a single hazardous area consisting of multiple rooms. This level is sprinkler protected throughout as required by NFPA 101A(01), Sec. 4.6.8.2 and smoke-separated as required by NFPA 101(00), Sec. 19.3.2.1.
9. Smoke Control [Score: 0]:
   This score was assigned per Footnote c to this Table and the fact that residents are not allowed on this level.

10. Emergency Movement Routes [Score: -8]:
    - There is only one way out of the basement, which does not meet the requirements of NFPA 101(00), Sec. 19.2.4.1. The path of travel is up a stairway located at the west end of the basement that is enclosed with construction having less than 1-hour fire resistance as described in Parameter 7, Vertical Openings, above.
    - The door to the exterior at the landing between First Floor and the basement was found to be only 28 inches in clear width, which does not meet the requirements of NFPA 101(00), Sec. 19.2.3.5. The door was found to be equipped with both passage hardware and a security chain. As a result, when locked, this door requires more than one releasing operation to open, which does not meet the requirements of NFPA 101(00), Sec. 7.2.1.5.4.
    - It was found that the stairway from the basement narrows to only 26½ inches in clear width. As a result, this path of travel could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2].
11. Manual Fire Alarm [Score: +2]:
    There is a manual fire alarm pull station adjacent to the door at the bottom of the stairway from the basement. The fire alarm system is monitored by Trans-Alarm.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in NFPA 101A(01), Sec. 4.6.13.4.3 and Footnote *g* to this Table. The zone is protected with quick-response sprinklers. System-connected smoke detectors were found in the storage and laundry room areas located at the west end of the basement. Because this coverage is not included in any of the categories of NFPA 101A(01), Sections 4.6.12.2 through 4.6.12.5, this Parameter was scored as "None".
13. Automatic Sprinklers [Score: +10]:
    The building is protected by a supervised, dry-pipe automatic sprinkler system consisting of quick-response sprinklers.

<u>Zone 2 – First Floor</u>:
TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 1.0]: It was reported that all residents housed in this zone are mobile and capable of removing themselves from danger exclusively by their own efforts. A review of the facility's Form CMS-672, dated 04/12/2016, revealed that all 18 residents are classified as "Independently ambulatory". A review of the facility's admission policy and interview with the administrator confirmed that the facility will only admit residents who are ambulatory and capable of going up and down stairs without assistance.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to nine (9) residents in this zone. The zone also contains the facility living/dining room, which is available for use by all residents.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 4.0]: It was reported that there is one (1) staff person on duty on the night shift. Because this staff person leaves the floor to make hourly rounds of the building, this Parameter was scored as "One or More over None". There are at least two staff persons on duty during meal times.
5. Patient Average Age (*A*) [Value assigned = 1.2]: It was reported that four (4) residents housed in this zone are age 65 years and over. Five (5) other residents who use the living/dining room areas are also age 65 years and over.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -2]:
   The building was assigned a Type V(000) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Based on interview with the administrator, all wood paneling in areas serving as part of the corridor/exit system was treated with Flame Control No. 20-20A Flat Latex Intumescent Fire Retardant Paint and/or Flame Control No. 40-40A Low Gloss Latex Fire Resistant Coating to achieve a Class A (25 or less) flame spread rating. Documentation was provided certifying that the drop-in acoustical ceiling tiles carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +1]:
   Based on interview with the administrator, some of the wood paneling in rooms was treated with Flame Control No. 20-20A Flat Latex Intumescent Fire Retardant Paint and/or Flame Control No. 40-40A Low Gloss Latex Fire Resistant Coating to achieve a Class A (25 or less) flame spread rating. The remaining room paneling was treated with Flame Control Fire Retardant Varnish No. 129 to achieve a Class B (75 or less) flame spread rating. Documentation was provided certifying that the drop-in acoustical ceiling tiles carry a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +1]:
   Corridor walls are constructed of ½-inch thick plaster on wood lath on both sides of wood studs, which likely provides a fire resistance of at least ½-hour.
5. Doors to Corridor [Score: 0]:
   Corridor doors were found to be of wood panel and solid wood core construction.
6. Zone Dimensions [Score: +1]:
   The building measures approximately 60 feet in length on this level.
7. Vertical Openings [Score: 0]:
   A 1¾-inch-thick solid wood automatic-closing door in a wood frame was found at the bottom of the stairs between the basement and First Floor. The door at the top of the stairway was found to be of wood panel construction.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: 0]:
   This score was assigned per Footnote c to this Table (fewer than 31 residents).
10. Emergency Movement Routes [Score: -8]:
    This score was assigned for the following reasons:
    - While there are two ways out of this level, the door from the living room that provides access to the front (east) exit is only 29 inches in clear width. As a result, this path of travel could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2].
    - The corridor doors into the resident rooms on this level were found to measure between 27½ and 31½ inches clear width. As a result, they could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2].
    - An approximately 3-inch grade change was found outside the back (southwest) exit door, which does not meet the requirements of NFPA 101(00), Sec. 7.2.1.3.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations were found at both the front and back doors. The fire alarm system is monitored by Trans-Alarm.

12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in NFPA 101A(01), Sec. 4.6.13.4.3 and Footnote *g* to this Table. The zone is protected with quick-response sprinklers. System-connected smoke detectors were found in the dining room and living room areas, in the hallway leading to the kitchen and at the bottom of the stairs from the Second Floor. This parameter was, therefore, scored as "Corridor Only" smoke detection.
13. Automatic Sprinklers [Score: +10]:
    The building is protected by a supervised, dry-pipe automatic sprinkler system consisting of quick-response sprinklers.

<u>Zone 3 – Second Floor</u>:
TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 1.0]: It was reported that all residents housed in this zone are mobile and capable of removing themselves from danger exclusively by their own efforts. A review of the facility's Form CMS-672, dated 04/12/2016, revealed that all 18 residents are classified as "Independently ambulatory". A review of the facility's admission policy and interview with the administrator confirmed that the facility will only admit residents who are ambulatory and capable of going up and down stairs without assistance.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to eleven (11) residents in this zone. This zone also contains the facility smoking lounge, which, per facility policy, is available for use by an additional three (3) residents at any one time.
3. Zone Location (*L*) [Value assigned = 1.2]: This zone is one floor height above First Floor.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 4.0]: It was reported that there is only one (1) staff person on duty on the night shift. This staff person is located on First Floor, but makes hourly rounds of the building.
5. Patient Average Age (*A*) [Value assigned = 1.2]: It was reported that five (5) residents housed in this zone are age 65 years and over.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES
1. Construction [Score: -7]:
   The building was assigned a Type V(000) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Interior finish in spaces that could be considered part of a corridor was plaster, acoustical tile and wood paneling. Based on interview with the administrator, all acoustical tile and wood paneling was treated with Flame Control No. 20-20A Flat Latex Intumescent Fire Retardant Paint and/or Flame Control No. 40-40A Low Gloss Latex Fire Resistant Coating to achieve a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Interior finish was found to consist of plaster, acoustical tile and wood paneling. Based on interview with the administrator, all acoustical tile and wood paneling was treated with Flame Control No. 20-20A Flat Latex Intumescent Fire Retardant Paint and/or Flame Control No. 40-40A Low Gloss Latex Fire Resistant Coating to achieve a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: 0]:
   Corridor walls are constructed of ½-inch thick plaster on wood lath on both sides of wood studs, which likely provides a fire resistance of at least ½-hour. However, a 36" x 60" plexi-glass vision panel was found in the wall between the smoking room and activity room, which serves as part of the corridor/exit system.

5. Doors to Corridor [Score: 0]:
   Corridor doors were found to be of wood panel, glass panel and solid wood core construction.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. The building measures approximately 60 feet in length. Due to a lack of complying means of egress, Parameter 10 was scored at -8.
7. Vertical Openings [Score: 0]:
   A 1¾-inch-thick solid wood automatic-closing door in a wood frame was found at the bottom of the stairs from this level.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: 0]:
   This score was assigned per Footnote c to this Table (fewer than 31 residents).
10. Emergency Movement Routes [Score: -8]:
    This score was assigned for the following reasons:
    - The front (east) stair enclosure serving this level currently provides protection of less than 1-hour fire resistance, which does not meet the requirements of NFPA 101(00), Sections 7.2.2.5.1 and 7.1.3.2.
    - The front (east) stairway discharges onto first floor, which does not meet the requirements of NFPA 101(00), Sec. 7.7.2 (the first floor is not separated from the basement by minimum 1-hour fire-rated construction).
    - Three of the four resident room doors were found to measure between 27½ and 31 inches in clear width and, therefore, could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2].
    - There is a 29-inch clear width door providing access to a 41-inch clear width fire escape from the activity room; however, fire escapes are not an acceptable means of egress from health care facilities [see NFPA 101(00), Sec. 19.2.2.1]. Access to the fire escape is through the Activity Room. NFPA 101(00), Sec. 19.2.5.9 requires that corridors provide access to not less than two approved exits without passing through any intervening rooms or spaces other than corridors or lobbies.
    - The corridor is only 39 inches in clear width instead of the 48 inches required by the code.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations were found in the corridor (between Resident Rooms 202 and 203) and adjacent to the door to the fire escape. The fire alarm system is monitored by Trans-Alarm.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in NFPA 101A(01), Sec. 4.6.13.4.3 and Footnote *g* to this Table. The zone is protected with quick-response sprinklers. System-connected smoke detectors were found in the corridor and activity room. This parameter was scored as “Corridor Only” smoke detection.
13. Automatic Sprinklers [Score: +10]:
    The building is protected by a supervised, dry-pipe automatic sprinkler system consisting of quick-response sprinklers.

* * * * * * * * * * * *

It must be noted that the scores and values assigned to the parameters in the tables on the FSES worksheets were based on conditions found between 0920 hours and 1225 hours on 04/21/2016. Any changes in those conditions after that date could affect those scores and values, either positively or negatively. Again, based on this evaluation, Grand Avenue Rest Home **has** achieved a passing score on the FSES. No other assessment of the level of safety in this facility is either intended or implied by *Fire Safety Resources, LLC*.

APPROVED
By Tom Linhoff at 9:01 am, May 12, 2016

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

Form Approved
OMB Exempt

ZONE 1 OF 3 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY: GRAND AVENUE REST HOME	BUILDING: 01-MAIN BUILDING
ZONE(S) EVALUATED: BASEMENT	
PROVIDER/VENDOR NO.: 24E150	DATE OF SURVEY: 04/21/2016

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.
A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factors Values					
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility		Not Mobile	Not Movable
	Risk Factor	1.0	1.6		3.2	4.5
2. Patient Density *(D)*	No. of Patients	1–5	6–10		11–30	>30
	Risk Factor	1.0	1.2		1.5	2.0
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	1.1	1.2	1.4	1.6	(1.6)
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0	1.1	1.2	1.5	4.0
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 year			65 Years and Over 1 Year and Younger	
	Risk Factor	1.0			1.2	

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.
A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK		X		X		X		X		=	1.6

Step 3: Compute Adjusted Building Status (R) - Use Table 2.
A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	1.6	=	1.0

*** FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.**

SURVEYOR SIGNATURE	TITLE	DATE
Robert J. [signature] FIRE SAFETY RESOURCES, LLC	PRESIDENT	04/22/2016
FIRE AUTHORITY SIGNATURE: Thomas Linhoff [signature]	TITLE: Fire Safety Supervisor	DATE: 05-12-2016

Step 4: Determine Safety Parameter Values - Use Table 4.

A. Select and circle the safety value for each safety parameter in Table 4 that best describes the conditions in the zone. Choose only one value for each of the 13 parameters. If two or more appear to apply, choose the one with the lowest point value.

TABLE 4.

Safety Parameters	Safety Parameters Values						
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II		
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433
First	-2	0	-2	0	0	2	2
Second	-7	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4

Safety Parameters				
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A	
	-5(0)[f]	0(3)[f]	3	
3. Interior Finish (Rooms)	Class C	Class B	Class A	
	-3(1)[f]	1(3)[f]	3	
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	≥½ to <1 hour	≥1 hour
	-10(0)[a]	0	1(0)[a]	2(0)[a]
5. Doors to Corridor	No Door	<20 min FPR	≥20 min FPR	≥20 min FPR and Auto Clos.
	-10	0	1(0)[d]	2(0)[d]

6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is		
	>100 ft	>50 ft to 100 ft	30 ft to 50 ft	>150 ft	100 ft to 150 ft	<100 ft
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c]	0	1

7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.		
			<1 hr	≥1 hr to <2 hr	≥2 hr
	-14	-10	0	2(0)[e]	3(0)[e]

8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies
	In Zone	Outside Zone	In Zone	In Adjacent Zone	
	-11	-5	-6	-2	0

9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone
	-5(0)[c]	0	3

10. Emergency Movement Routes	<2 Routes	Multiple Routes			
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)
	-8	-2	0	1	5

11. Manual Fire Alarm	No Manual Fire Alarm	Manual Fire Alarm	
		W/O F.D. Conn.	W/F.D. Conn
	-4	1	2

Safety Parameters					
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone
	0(3)[g]	2(3)[g]	3(3)[g]	4	5
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building		
	0	8	10		

NOTE:

[a] Use (0) where parameter 5 is -10.

[b] Use (0) where parameter 10 is -8.

[c] Use (0) on floor with fewer than 31 patients (existing buildings only)

[d] Use (0) where parameter 4 is -10.

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200")

[f] Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

For SI units: 1 ft = 0.3048 m

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as 1/2 the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-7	-7		-7
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	1			1
5. Doors to Corridor	2		2	2
6. Zone Dimensions			0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-8	-8
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 12	S_2= 8	S_3= 5	S_4= 9

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	(9)	17(14)[a]	(6)	10(7)[a]	(3)
4th story or higher	18	9	19(16)[a]	6	11(8)[a]	3

a. Use ( ) in zones that do not contain patient sleeping rooms.

b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: S_a=7, S_b=10, and S_c=7

Step 6: Determine Mandatory Safety Requirement Values - Use Table 6.

A. Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.

B. Transfer the three circled values from Table 6 to the blocks marked S_a, S_b, and S_c in Table 7.

C. For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION					Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 12 - S_a 9 = C 3	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 8 - S_b 6 = E 2	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 5 - S_c 3 = P 2	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 9 - R 1 = G 8	√	

	TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET	Met	Not Met	Not Applic.
	Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.			
A.	Building utilities conform to the requirements of Section 9.1.	√		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			√
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	√		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	√		
E.	There are no flue-fed incinerators.	√		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	√		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	√		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	√		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	√		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	√		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	√		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			√

CONCLUSIONS

1. ☒ All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the *Life Safety Code*.*

2. ☐ One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the *Life Safety Code*.*

*The equivalency covered by this worksheet includes the majority of considerations covered by the *Life Safety Code*. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0242. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

APPROVED By Tom Linhoff at 9:04 am, May 12, 2016

Form Approved
OMB Exempt

ZONE 2 OF 3 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY: GRAND AVENUE REST HOME	BUILDING: 01-MAIN BUILDING
ZONE(S) EVALUATED: FIRST FLOOR	
PROVIDER/VENDOR NO.: 24E150	DATE OF SURVEY: 04/21/2016

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.
A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factors Values					
1. Patient Mobility (M)	Mobility Status	Mobile	Limited Mobility		Not Mobile	Not Movable
	Risk Factor	(1.0) circled	1.6		3.2	4.5
2. Patient Density (D)	No. of Patients	1–5	6–10		11–30	>30
	Risk Factor	1.0	1.2		(1.5) circled	2.0
3. Zone Location (L)	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	(1.1) circled	1.2	1.4	1.6	1.6
4. Ratio of Patients to Attendants (T)	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0	1.1	1.2	1.5	(4.0) circled
5. Patient Average Age (A)	Age	Under 65 Years and Over 1 year			65 Years and Over 1 Year and Younger	
	Risk Factor	1.0			(1.2) circled	

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.
A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	1.0	X	1.5	X	1.1	X	4.0	X	1.2	=	7.9

Step 3: Compute Adjusted Building Status (R) - Use Table 2.
A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	7.9	=	4.7 = 5

* FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.

SURVEYOR SIGNATURE	TITLE	DATE
Robert W. Imholte, FIRE SAFETY RESOURCES, LLC	PRESIDENT	04/22/2016
FIRE AUTHORITY SIGNATURE	TITLE	DATE
Thomas Linhoff	Fire Safety Supervisor	05-12-2016

Step 4: Determine Safety Parameter Values - Use Table 4.

A. Select and circle the safety value for each safety parameter in Table 4 that best describes the conditions in the zone. Choose only one value for each of the 13 parameters. If two or more appear to apply, choose the one with the lowest point value.

TABLE 4.

Safety Parameters — **Safety Parameters Values**

1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II		
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433
First	-2	0	-2	0	0	2	2
Second	-7	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4

2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A
	-5(0)[f]	0(3)[f]	3

3. Interior Finish (Rooms)	Class C	Class B	Class A
	-3(1)[f]	1(3)[f]	3

4. Corridor Partitions/Walls	None or Incomplete	<½ hour	≥½ to <1 hour	≥1 hour
	-10(0)[a]	0	1(0)[a]	2(0)[a]

5. Doors to Corridor	No Door	<20 min FPR	≥20 min FPR	≥20 min FPR and Auto Clos.
	-10	0	1(0)[d]	2(0)[d]

6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is		
	>100 ft	>50 ft to 100 ft	30 ft to 50 ft	>150 ft	100 ft to 150 ft	<100 ft
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c]	0	1

7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.		
			<1 hr	≥1 hr to <2 hr	≥2 hr
	-14	-10	0	2(0)[e]	3(0)[e]

8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies
	In Zone	Outside Zone	In Zone	In Adjacent Zone	
	-11	-5	-6	-2	0

9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone
	-5(0)[c]	0	3

10. Emergency Movement Routes	<2 Routes	Multiple Routes			
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)
	-8	-2	0	1	5

11. Manual Fire Alarm	No Manual Fire Alarm	Manual Fire Alarm	
		W/O F.D. Conn.	W/F.D. Conn
	-4	1	2

12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone
	0(3)[g]	2(3)[g]	3(3)[g]	4	5

13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building
	0	8	10

NOTE:

a Use (0) where parameter 5 is -10.

b Use (0) where parameter 10 is -8.

c Use (0) on floor with fewer than 31 patients (existing buildings only)

d Use (0) where parameter 4 is -10.

e Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200")

f Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

g Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

For SI units: 1 ft = 0.3048 m

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as 1/2 the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-2	-2		-2
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	1			1
4. Corridor Partitions/Walls	1			1
5. Doors to Corridor	0		0	0
6. Zone Dimensions			1	1
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-8	-8
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	**S_1=** 13	**S_2=** 13	**S_3=** 4	**S_4=** 11

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	11	(5)	15(12)[a]	(4)	8(5)[a]	(1)
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher	18	9	19(16)[a]	6	11(8)[a]	3

a. Use ( ) in zones that do not contain patient sleeping rooms.

b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: S_a=7, S_b=10, and S_c=7

Step 6: Determine Mandatory Safety Requirement Values - Use Table 6.

A. Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.

B. Transfer the three circled values from Table 6 to the blocks marked S_a, S_b, and S_c in Table 7.

C. For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION					Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 13 - S_a 5 = C 8	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 13 - S_b 4 = E 9	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 4 - S_c 1 = P 3	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 11 - R 5 = G 6	√	

	TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET			
	Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.	Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	√		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			√
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	√		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	√		
E.	There are no flue-fed incinerators.	√		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	√		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	√		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	√		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	√		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	√		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	√		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			√

CONCLUSIONS

1. ☒ All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the *Life Safety Code*.*

2. ☐ One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the *Life Safety Code*.*

*The equivalency covered by this worksheet includes the majority of considerations covered by the *Life Safety Code*. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0242. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

APPROVED
By Tom Linhoff at 9:06 am, May 12, 2016

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

Form Approved
OMB Exempt

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY: Grand Avenue Rest Home	BUILDING: 01-Main Building
ZONE(S) EVALUATED: Second Floor	
PROVIDER/VENDOR NO.: 24E150	DATE OF SURVEY: 04/21/2016

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.
A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factors Values					
1. Patient Mobility *(M)*	Mobility Status	Mobile		Limited Mobility	Not Mobile	Not Movable
	Risk Factor	(1.0) circled		1.6	3.2	4.5
2. Patient Density *(D)*	No. of Patients	1–5		6–10	11–30	>30
	Risk Factor	1.0		1.2	(1.5) circled	2.0
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	1.1	(1.2) circled	1.4	1.6	1.6
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0	1.1	1.2	1.5	(4.0) circled
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 year			65 Years and Over 1 Year and Younger	
	Risk Factor	1.0			(1.2) circled	

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.
A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	1.0	X	1.5	X	1.2	X	4.0	X	1.2	=	8.6

Step 3: Compute Adjusted Building Status (R) - Use Table 2.
A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

1.0 X F [ ] = R [ ]

TABLE 3B. (EXISTING BUILDINGS)

0.6 X F [8.6] = R [5.2] = 6

*** FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.**

SURVEYOR SIGNATURE: Robert S. [signature], Fire Safety Resources, LLC	TITLE: President	DATE: 04/22/2016
FIRE AUTHORITY SIGNATURE: Thomas Linhoff [signature]	TITLE: Fire Safety Supervisor	DATE: 05-12-2016

Step 4: Determine Safety Parameter Values - Use Table 4.

A. Select and circle the safety value for each safety parameter in Table 4 that best describes the conditions in the zone. Choose only one value for each of the 13 parameters. If two or more appear to apply, choose the one with the lowest point value.

TABLE 4.

Safety Parameters	Safety Parameters Values						
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II		
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433
First	-2	0	-2	0	0	2	2
Second	-7	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A				
	-5(0)[f]	0(3)[f]	3				
3. Interior Finish (Rooms)	Class C	Class B	Class A				
	-3(1)[f]	1(3)[f]	3				
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	≥½ to <1 hour	≥1 hour			
	-10(0)[a]	0	1(0)[a]	2(0)[a]			
5. Doors to Corridor	No Door	<20 min FPR	≥20 min FPR	≥20 min FPR and Auto Clos.			
	-10	0	1(0)[d]	2(0)[d]			
6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is			
	>100 ft	>50 ft to 100 ft	30 ft to 50 ft	>150 ft	100 ft to 150 ft	<100 ft	
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c]	0	1	
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.				
			<1 hr	≥1 hr to <2 hr	≥2 hr		
	-14	-10	0	2(0)[e]	3(0)[e]		
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies		
	In Zone	Outside Zone	In Zone	In Adjacent Zone			
	-11	-5	-6	-2	0		
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone				
	-5(0)[c]	0	3				
10. Emergency Movement Routes	<2 Routes	Multiple Routes					
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)		
	-8	-2	0	1	5		
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm				
			W/O F.D. Conn.	W/F.D. Conn			
	-4		1	2			
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone		
	0(3)[g]	2(3)[g]	3(3)[g]	4	5		
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building				
	0	8	10				

NOTE:
[a] Use (0) where parameter 5 is -10.
[b] Use (0) where parameter 10 is -8.
[c] Use (0) on floor with fewer than 31 patients (existing buildings only)
[d] Use (0) where parameter 4 is -10.

For SI units: 1 ft = 0.3048 m

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200")

[f] Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as ½ the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-7	-7		-7
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	0			0
5. Doors to Corridor	0		0	0
6. Zone Dimensions			0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-8	-8
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 9	S_2= 8	S_3= 3	S_4= 6

TABLE 6. MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	(9)	17(14)[a]	(6)	10(7)[a]	(3)
4th story or higher	18	9	19(16)[a]	6	11(8)[a]	3

a. Use ( ) in zones that do not contain patient sleeping rooms.

b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: S_a=7, S_b=10, and S_c=7

Step 6: Determine Mandatory Safety Requirement Values - Use Table 6.

A. Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.

B. Transfer the three circled values from Table 6 to the blocks marked S_a, S_b, and S_c in Table 7.

C. For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION					Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 9 - S_a 9 = C 0	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 8 - S_b 6 = E 2	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 3 - S_c 3 = P 0	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 6 - R 6 = G 0	√	

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET				
Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	√		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			√
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	√		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	√		
E.	There are no flue-fed incinerators.	√		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	√		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	√		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	√		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	√		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	√		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	√		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			√

CONCLUSIONS

1. ☒ All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the *Life Safety Code.**

2. ☐ One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the *Life Safety Code.**

*The equivalency covered by this worksheet includes the majority of considerations covered by the *Life Safety Code*. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

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Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
May 4, 2016

Mr. Allen Soderbeck, Administrator
Grand Avenue Rest Home
3956 Grand Avenue S0uth
Minneapolis, MN 55409

Re: Enclosed State Nursing Home Licensing Orders - Project Number SE150025 & Complaint Number HE150005

Dear Mr. Soderbeck:

The above facility was surveyed on April 11, 2016 through April 18, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number HE150005. 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 me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00208	A. BUILDING: ______ B. WING ______	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
3 000	INITIAL COMMENTS	3 000		

INITIAL COMMENTS

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

BOARDING CARE HOME
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:
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 Boarding Care Homes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00208	A. BUILDING: ______ B. WING ______	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	**3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
3 000	Continued From page 1 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. A complaint investigation was initiated to investigate case #HE150005 and correction orders are issued. Please be advised, the orders have been revised.	3 000		
3 615	MN Rule 4655.3200 Subp. 3 Patient or Resident Care Record; duration Subp. 3. Duration and placement of records. Accurate, complete, and legible records for each patient or resident from the time of admission to the time of discharge or death shall be kept current and shall be maintained in a chart holder at the nurses' or attendants' station, a central control point for the storage of records and medications.	3 615		6/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00208	A. BUILDING: ______ B. WING ______	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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3 615	Continued From page 2	3 615		

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility did not ensure retention of complete and accurate medical records for 1 of 3 (R20) residents who had been hospitalized.

Corrected. Also disputing the information that triggered this correction order.

Findings include:

R20 was admitted to the facility on 3/23/15. A Minimum Data Set (MDS) annual assessment dated 2/6/16, identified R20 as independent with activities of daily living and had intact cognition.

R20's Community Safety Assessment (CSA) dated 8/3/15, indicated R20 had a history of making poor decisions, chemical dependency issues and was currently attending treatment three times per week. The assessment further indicated R20 had a history of substance abuse and was a "former heroin addict" and that "since admission has used illegal drugs." The assessment further indicated that R20 had multiple Vulnerable Adult (VA) issues since admission related to poor choices. Staff recommendations on the assessment indicated R20 could leave the facility independently. R20's medical record lacked documentation of use of illegal drugs from the time of admission (3/23/15 through 8/3/15) as identified in the CSA.

A note dated 12/28/15, in R20's medical record signed by the administrator revealed R20 admitted to having alcohol in her room which contributed to another resident (R7) going to the emergency room. The note indicated that was not the first time that had occurred and that was a violation of the facility policy. The note further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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3 615	Continued From page 3	3 615		

stated that additional interventions were required to ensure the safety of R20 and the other residents and suggested R20 was now subject to random room checks and a room change. R20's medical record did not identify previous dates or incidents related to alcohol use.

R20's Progress Notes were reviewed from 1/16 through 4/11/16, and revealed the following:
On 2/3/16, at 7:30 a.m. resident appeared lethargic although able to respond to questions if asked. R20 was given five ounces of apple juice and stated "I'm just so thirsty." One half hour later, R20 states she could not eat breakfast and "felt sick to her stomach." R20 was checked again after the nurse was called by roommates which stated they "were worried" about R20. The nurse found resident "laying across bed with head and neck hyperextended. Res. [resident] warm and breathing, pulse approx [approximately] 80/bpm [beats per minute] and strong. Res. just not responsive-pupils dilated. 911 was called- attendants gave Narcan [a heroin reversal agent] and resident responded and was taken to ER [emergency room]." The physician and family were notified. On 2/3/16, a "Postnote" was written below the above entry that indicated "EMTS [sic] state they found a suicide note and took it with them. R20 not reported any suicidal thoughts to this nurse on duty from 7am-3pm. EMTS [sic] state resident admitted for snorting heroin." On 2/3/16, at 5:00 p.m. R20 was admitted to hospital for heroin overdose. There was no follow up documentation to the information regarding R20's suicide note in R20's medical record.

R20's Hospital Discharge Summary dated 2/8/16, indicated R20 had previously required hospitalization for altered mental status and accidental overdose.

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3 615	Continued From page 4	3 615		

R20's medical record revealed no documentation of any other recent hospitalization. However, a review of R20's MDS assessments indicated a discharge summary was completed on 1/9/16, and an entry tracking record MDS was completed on 1/13/16. When asked about the 1/9/16 discharge summary and documentation on 4/14/16, at 2:40 p.m. the social work designee (SWD) stated the hospital had not provided them with any written summary. Licensed practical nurse (LPN)-A stated they only needed the medication list, so the rest was shredded.

R20's labs were reviewed which indicated R20 tested positive for THC (marijuana) on 3/26/16. R20's medical record did not indicate any further follow up for the positive lab result.

An interview with the SWD on 4/14/16, at 2:42 p.m. revealed she was aware of R20's heroin overdose on 2/3/16. The SWD was unaware if R20 had any other hospitalizations due to overdose. The SWD stated she had followed up with the hospital on the note that the EMT's found, which she indicated was a love letter and not a suicide note. The SWD confirmed there was no documentation of follow up in R20's medical record about the note, however stated she discussed the incident with R20 who stated she "wanted to live." The SWD was aware of R20's past drug use and stated R20 had tested positive for marijuana once before and confirmed that was not indicated on R20's care plan.

Interview with the interim director of nursing (IDON) on 4/15/16, at 2:28 p.m. revealed someone at the facility followed up with the hospital on the "suicide note" and found out the note was actually a "love letter" and not a suicide

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3 615	Continued From page 5 note. The IDON stated the information should have been documented in R20's medical record. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop a system for timely and accurate documentation that reflects the resident's status. The director of nursing or designee could educate all appropriate staff on the system. The DON or designee could monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	3 615		
31130	MN Rule 4655.7830 Subp. 1 Medication Containers; Labeled containers Subpart 1. Storage in labeled containers. All medications shall be kept in their original container bearing the original label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration dates of all time-dated drugs, directions for use, resident's name, physician's name, date of original issue or in the case of a refill, the most recent date thereof, and name and address of the licensed pharmacy which issued the medications. It shall be the responsibility of the boarding care home to secure the prescription number and name of the medication if these are not on the label. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure all medications were properly labeled with resident's names,	31130	Corrected	6/9/16

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31130	Continued From page 6 directions for use and date opened for 1 of 2 residents (R17) that had diabetes. Findings include: On 4/12/16, at 12:07 p.m. during the medication storage observation a Victoza (a medication to improve blood sugars) injectable pen was in a plastic bag labeled with a first name. There was no label on the pen or bag. There was no date opened on the pen. R17's annually Minimum Data Set (MDS) dated 3/27/16, indicated R17 had a diagnosis of diabetes. The MDS indicated R17 had received insulin injections seven out of seven days. The Physician Order Sheet dated 3/24/16, indicated R17 was to receive Victoza 1.8 milligrams (mg) injection daily at noon for diabetes. During interview on 4/12/16, at 12:07 p.m. the licensed practical nurse (LPN)-A stated Victoza had been removed from the refrigerator yesterday but had not been used yet. LPN-A said, "I do not know why it does not have a name on it or a date." The Victoza manufactures package insert by Novo Nordisk dated 3/9/15, instructed users, "Use a Victoza pen for only 30 days. Throw away a used Victoza pen after 30 days, even if some medicine is left in the pen." Facility Internal Med Cart Audits policy updated 5/1/14, instructed staff, "To ensure the accuracy of the medications administered to the residents, each resident's medications and house medications will be audited internally by nursing	31130		

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31130	Continued From page 7 every two weeks." Policy instructed staff that items to audited for included: 3. All medications requiring a date opened must have a legible date. It is beginning to smear or becoming hard to read, fix it. If it is illegible, you must discard as if it is expired." Facility Proper Labeling policy updated 5/5/12, lacked instructions that medications required a label which included resident's name and directions for use. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop systems to ensure all medication areas are audited on a routine basis to ensure any medications without an appropriate label are appropriately replaced/disposed of/relabeled. The DON or designee could educate all appropriate staff members on the system. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	31130		
31145	MN Rule 4655.7830 Subp. 4 Medication Containers;Out of date medications Subp. 4. Out of date medications. Medications having a specific expiration date shall not be used after the date of expiration. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure expired medications were removed from the medication	31145	Corrected	6/9/16

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31145	Continued From page 8 cart. Findings include: On 4/12/16, at 7:04 p.m. during medication storage observation one vial of Lantus (insulin) was observed to be stored ready for use in the top drawer of the medication cart that was labeled with R1's name and dated as opened on 3/14/16, and expired on 4/12/16. That was 30 days from the opened date. LPN-B verified the Lantus expired 28 day after being opened. R1's annually Minimum Data Set (MDS) dated 2/20/16, indicated R1 had a diagnosis of diabetes. The MDS indicated R1 had received insulin injections seven out of seven days. The Physician Order Sheet dated 3/24/16, indicated R1 was to receive Lantus 15 units daily at bedtime for diabetes. Lantus manufactures insert by Sanofi-Aventis dated 7/15, indicated, "Do not use Lantus after the expiration date stamped on the label or 28 days after you first use it." During interview on 4/15/16, at 3:15 p.m. LPN-A stated, "I check every Friday for expired meds. It is the responsibility of every nurse." Facility Internal Med Cart Audits policy updated 5/1/14, instructed staff, "To ensure the accuracy of the medications administered to the residents, each resident's medications and house medications will be audited internally by nursing every two weeks." Policy instructed staff that items to audited for included: "2. Check for and remove expired medications. Dispose of expired medications using proper	31145		

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31145	Continued From page 9 procedures. 3. All medications requiring a date opened must have a legible date. It is beginning to smear or becoming hard to read, fix it. If it is illegible, you must discard as if it is expired." SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop systems to ensure all medication areas are audited on a routine basis to ensure any medications without an expiration date or beyond the expiration date are appropriately replaced/disposed of/relabeled. The DON or designee could educate all appropriate staff members on the system. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	31145		
31895	MN Rule 144.651 Subd. 23 Patients & Residents of HCF Bill of Rights Subd. 23. Services for the facility. Patients and residents shall not perform labor or services for the facility unless those activities are included for therapeutic purposes and appropriately goal-related in their individual medical record. This MN Requirement is not met as evidenced by: Based on observation interview and document review, the facility failed to ensure 2 of 2 residents (R17, R13) in the sample who performed services for the facility, did so according to an established plan, and were paid at a prevailing rate.	31895	Corrected. Also disputing the information that triggered this correction order.	5/23/16

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Findings include:

R17 was observed at 6:05 p.m. on 4/12/16, passing out trays for 15 residents in the dining room.

R17 was interviewed at 3:27 p.m. on 4/14/16. R17 stated she worked one hour a day in the kitchen passing out trays to the residents. She also stated she was upset because her pay had gone from 25 dollars a week, to 15 dollars a week, because the facility had hired a new staff person in the kitchen. When asked whether she received a paycheck from the facility, R17 said she passed out the trays Monday-Friday and was paid cash. R17 also stated R13 passed the trays out on weekends. R17 again stated she was "mad" her pay had gone down. During a follow up interview with R17 on 4/15/16, at 10:49 a.m., R17 stated she got paid every other Monday.

The dietary manager was interviewed at 10:30 a.m. on 4/15/16, and produced a calendar schedule of when R17 and R13 passed trays in the dining room. The dietary manager stated she thought the residents had volunteered and stated the job only lasted for ten minutes.

During the survey attempts were made to interview R13 however, R13 was unavailable.

R17's care plan dated 10/6/15, and R13's care plan dated 10/20/15, were void of any plan for either resident to help in the kitchen. The care plans for both residents lacked any evidence the resident was performing services for the facility, whether the resident was getting paid for the services, and whether the resident had agreed to the work arrangement.

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The facility's payroll book was reviewed from 3/14/16, going forward and it was determined neither resident was on the facility payroll.

The facility provided forms, Resident Volunteer for Meal Set Up dated 3/11, which both residents had signed. R17 had signed a form on 5/24/12, and R13 had signed on 1/8/15. The information indicated the residents agreed to volunteer for meal set-up, would be observed once a quarter, and would follow infection control guidelines. The form lacked any indication as to whether either resident was being paid to perform the service, or any plan for their help having been added to their individualized plans of care.

On 4/15/16, at 4:15 p.m. the social worker designee (SWD) and administrator were interviewed. The SWD acknowledged the residents had come to her to ask for jobs and that both were either paid cash, or with gift cards, for the services rendered in the kitchen. The SWD verified R17's and R13's desire to work, work arrangement, and the assigned kitchen duties were not documented on their plans of care.

Suggested Method of Correction: The director of nursing (DON) or designee could ensure there was a system in place to ensure no resident's work for the facility without appropriate assessment, care planning and pay/volunteer status. The DON or designee could ensure all staff are aware of the facility policies and procedures. The DON or designee could develop monitoring systems to ensure ongoiong compliance.

TIME PERIOD FOR CORRECTION: Twenty One (21) days

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31990	MN Rule 626.557 Subd. 4 Reporting Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to report allegations of verbal abuse, injuries of unknown origin, elopement, substance abuse within the facility, and/or falls with significant injury for 5 of 17 residents (R20, R7, R16, R14, R6). Findings include: R20 was admitted to the facility on 3/23/15. A minimum data set (MDS) annual assessment dated 2/6/16 identified R20 as independent with activities of daily living and intact cognition. R20's Community Safety Assessment dated	31990	Corrected. Also disputing some of the information that triggered this correction order.	6/9/16

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31990	Continued From page 13	31990		

8/3/15 indicated that R20 had an extensive history of substance abuse, poor decision making, and was currently attending treatment three times per week. The assessment further indicated "since admission has used illegal drugs". The assessment further identified R20 had multiple vulnerable adult (VA) issues since admission related to poor choices. Staff recommendations on the assessment indicated R20 could leave the facility independently.

A note dated 12/28/15 in R20's medical record signed by the administrator revealed that R20 admitted to having alcohol in her room which contributed to another resident (R7) going to the emergency room. The note indicated that this was not the first time this has occurred.

R20's progress notes were reviewed from 1/16-4/11/16 and revealed on 2/3/16 at 7:30 a.m. R20 was found to be lethargic and unresponsive. Emergency Medical Services (EMS) were activated, the resident was provided Narcan (medication which reverses some overdoses such as Heroin) and transported to the emergency room. R20 was admitted. R20's Hospital Discharge Summary dated 2/8/16 indicated that R20 was admitted to the hospital for altered mental status and accidental heroin overdose.

R20's Mental Health Summary dated 3/5/16-4/5/16 indicated that R20 had a "lengthy history of heroin abuse and methamphetamine abuse" and staff had an order for Narcan if overdose was suspected. The mental health summary further indicated that R20 had a verbal altercation with another resident and resident's family member and "needs to be closely monitored by staff". R20's careplan dated 3/3/16

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31990	Continued From page 14	31990		

identified a history of heroin addiction-recent heroin overdose and indicated that the facility now had and order for Narcan.

Interview with the Social Worker Designee (SWD) on 4/14/16 at 2:42 p.m. revealed that she was aware of R20's heroin overdose on 2/3/16. The SWD was unaware if R20 had any other hospitalizations due to overdose. The SWD was asked if R20's heroin overdose with hospitalization was reported to the state agency. The SWD replied the incidents were "not required to be reported , even if hospitalized. We follow a flow chart".

Interview with the Interim Director of Nursing (IDON) on 4/15/16 at 2:28 p.m. revealed that she was the nurse working on 2/3/16 and stated she was aware of R20's previous drug use but was unaware why R20 was unresponsive that morning. The IDON stated she was not familiar with R20 having any similar incidents related to drug use prior to 2/3/16 was not aware of any drugs in the facility. When asked if this incident should be reported to the state agency the DON replied "I don't know".

R7 was admitted to the facility on 9/30/14 with diagnoses that included but not limited to mood disorder, schizophrenia, and alcohol dependency. R7's Minimum Data Set (MDS) quarterly review assessment dated 1/5/16 indicated R7's cognition was intact and was independent with activities of daily living.

R7's careplan dated 10/19/15 included vulnerable adult (VA) issues of history of promiscuous behavior and chemical use making poor decisions. The care plan identified 12-28-16 (sic-facility dated the care plan as the year 2016) R7

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consumed alcohol that resulted in hospitalization.

R7's progress notes were reviewed from 10/21/15-4/11/16 and revealed on 12/27/15 at 9:11 p.m. R7 was found with a "blank stare unable to sit up in bed" and slurred speech. 911 was called and R7 was transported to the hospital. She returned 12/28/15. R7 reportedly got the alcohol from her roommates R20 and R17. An emergency department hospital admission sheet dated 12/17/15 which indicated that R7 was hospitalized for alcohol intoxication.

R7's social service progress notes were also reviewed and indicated on 1/4/16 the social worker designee (SWD) spoke with R7 regarding the drinking incident and resulting hospitalization. R7 got angry and screamed "that was not me".

R7's medical record included a psych appointment referral dated 1/11/16 which included the note that R7 was hospitalized for alcohol intoxication. Roommate gave her alcohol that was hidden in the room.

An interview with the SWD and administrator on 4/14/16, at 4:03 p.m. indicated the SWD was familiar with R7's chemical dependency issues. The SWD stated the alcohol use was "not a problem, just because something happens once, if it was an ongoing issue I would have put it as a problem on the careplan". The SWD and administrator confirmed the alcohol use and resulting hospitalization were not reported to the state agency. The administrator stated the incident was "not required to be reported, even if hospitalized" and that the facility followed a flow chart for reporting of incidents to the state agency.

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31990	Continued From page 16 An interview with the Interim Director of Nursing (IDON) on 4/15/16 at 2:28 p.m. revealed she thought the facility reported the incident to "where it should be reported to". R16 was accepted and admitted to the facility 11/9/15, under commitment for chemical dependency. The Minimum Data Set (MDS) dated 12/7/15, indicated R16 was cognitively intact, mildly depressed, had verbal behavioral symptoms directed towards others, and rejected care daily. The Care Area Assessment (CAA) dated 12/7/15, indicated R16 was receiving anti-psychotic medications for anxiety and verbal aggression. The undated care plan identified R16 had one missing person report for failure to return to facility at specified time. R16 was able to have leaves of absence (LOA's) and self administer medications. Nursing progress notes on 11/17/15, at 6:00 p.m. R16 was found to be lethargic and confused. The resident was taken to the emergency room via ambulance. The hospital reported an alcohol level of 0.37. On 11/18/15, it was documented that R16 had been admitted to the hospital. On 11/24/15, R16 returned to the facility. On 12/8/15, at 10:00 R16 left via taxi to the doctor and spend the day with her boyfriend. She had medications through bedtime. She stated she will be back at 10:00 p.m. Although contacted through her boyfriend, R16 did not return to the facility until 12/15/15 at 5:30 p.m. When asked why she didn't return for a week, R16 replied "I had some things I had to take care of." Mental Health Summary dated 12/9/15, indicated: R16 was noncompliant with medications, had a long history of alcohol use and multiple chemical dependencies, treatment programs and long history of unstable housing. R16 was currently	31990		

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31990	Continued From page 17 getting alcohol from her boyfriend in exchange for favors. On 12/25/15, R16 went on LOA with her boyfriend and medications. R16 stated she would be back that evening. On 12/26/15, at 6:45 p.m. R16 called the facility to inform them she was at the emergency room and was being admitted for pneumonia. The facility verified this with the ER staff. The interim director of nursing (IDON) ' s hand written, undated Discharge/Summary Information identified "Consumption of alcohol, left premises for extended time without notice. Broke court order for no overnights outside of facility." On 4/14/16, at 2:42 p.m. the social work designee (SWD) and administrator were asked for policies for resident LOA's. The SWD stated the residents "Sign LOA form and ask for meds." The SWD stated they complete one community assessment and one self administration of medication assessment. If a resident did not return from the outing, she would utilize the missing person protocol. When asked if the overdoses were reported to the state agency, the SWD stated they were "Not required to be reported, even if hospitalized. We follow a flow chart." The IDON was not available in the facility, a scheduled phone conversation occurred with IDON at 2:00 on 4/15/16. The IDON had not considered R16 an elopement, but she was a vulnerable adult (VA), "I thought it was reported." The facility failed to report R16's alcohol intoxication to the SA. The facility also failed to report the elopement from 12/8-12/15/15 to the SA even though the facility reported it to the police on 12/10/15 as a missing person. Policy	31990		

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31990	Continued From page 18	31990		

The facility's policy entitled "Vulnerable Adult Maltreatment Prevention Plan" dated 3/6/15, indicated that the facility "does not tolerate any form of maltreatment" which included "any form of physical, verbal, mental or sexual abuse; any form of neglect, involuntary seclusion, corporal punishment or mishandling of resident property". The policy also included the following:
-" An assessment will be made of a prospective resident prior to admission for a known history of potentially dangerous behavior patterns"
-"Individual susceptibility will be assessed and included in the overall resident careplan along with goals and approaches for prevention and safety".
-"If maltreatment is suspected or observed the administrator must be notified immediately".
-"The administrator or representative will use the flowchart to determine the reporting requirements.
-"Nursing completes the internal reporting forms whish [sic] is a collection of information that needs to be submitted to MDH online. The Administrator submits the online report to the Minnesota Department of Health immediately as available"
-"You must make your report directly to the facility Administrator immediately after ensuring resident safety. The facility is responsible to report all reportable incidents and suspected crimes to MDH".

R14 quarterly Minimum Data Set (MDS) indicated she was cognitively intact and was independent with all activities of daily living. R14's care plan dated 2/23/16 identified her as a vulnerable adult and indicated no vulnerable adult issues.

A review of facility progress notes indicated in 3/20/16, R14 had been called a derogatory name

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by another resident in the facility three times that day. The noted indicated "this incident was very upsetting" to R14. A progress note dated 4/12/16 indicated R14 had complained of being called derogatory names by another resident "qday" (every day). R14 stated it had happened as recently as the previous day.

During an interview on 4/12/16, at 4:26 p.m., R14 further stated a resident in the house is "nasty" to other residents and stated another resident beat that resident up. R14 stated the staff is aware of the situation, but no one did anything about it.

During a subsequent interview on 4/14/16, at 10:22 a.m., R14 stated another resident in the house yells all the time and is "bossy" and "hard to deal with."

During an interview on 4/15/16, at 2:15 p.m. the social work designee (SWD) stated she was responsible for handling and reporting potential abuse and abuse allegations. She stated when a resident had concerns she would talk to the other person. She stated "you have to separate whether it's happening, or if it is their perception of what's happening." The SWD further stated, "reporting to the state agency isn't always the answer." She stated verbal aggression between resident's is not reportable to the state agency and takes place "frequently" but are not an actual threat to a resident.

R6's quarterly Minimum Data Set (MDS) dated 2/5/16, indicated R6 was cognitively intact with delusions (fixed false beliefs) and was independent with all activities of daily living except dressing and personal hygiene. The MDS also indicated R6 was unsteady when going from sitting to standing or turning around, did not use

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any mobility devices and that R6 became short of breath with walking. R6's MDS indicated R6 had diagnoses of anemia, diabetes, hypertension, and schizophrenia. Diagnosis of mild mental retardation noted on office visit note dated 4/14/15.

R6's care plan dated 8/26/15, identified R6 as a vulnerable adult and comments dated 11/16/15, and 2/16/16, indicated no vulnerable adult issues. 12/23/15, temporary care plan problem "Fx [fracture]. of proximal phalanx of L [left] 5th finger (etiology unknown-res does not know how it happened)"

Observation on 4/13/16, at 11:40 a.m. identified R6 walking without a cane, limping and stumbling into the smoking room. R6 fell into a chair in the smoking room. At 12:41 p.m. R6 was again observed to stumble and fall into chair in the smoking room.

Review of Incident/Accident Report dated 4/21/15, at 11:29 a.m. indicated "Pt woke up-few hours p[after] being up we noticed her R [right] eye all puffy and 2 sm [small] lacerations around R [right] eye. She does not remember how it happened." Type of injury listed as "hematoma, abrasion, and swelling." Incident form indicated staff did not know when injury happened and resident did not remember falling. Incident /Accident report did not indicate the administrator or state agency were informed of the injury.

Nurses Record and Progress Notes dated 4/21/15, at 12:00 p.m. indicated: "Appears pt [patient] fell against something during the noc [night], has a swollen right eye under each eye and two small lacerations are 3 mm [millimeters] long around eye." "Does not remember what she

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fell against."

Note dated 4/21/15, at 3:00 p.m. ..."is now c/o [complaining of] (unreadable) w c/o headache. States hit head on door going to BR-has flashlight to help guide her." Review of progress notes 4/21/15 through 4/27/15, did not indicate the administrator or SA were notified of the injury of unknown origin.

Nurses Record and Progress Notes dated 12/23/15 at 1:30 p.m. indicated R6 came into office and showed nurse her left hand. Nurse noted bruising on the front and back of hand with minor swelling. R6 was sent to urgent care.

Physician's Progress Notes dated 12/23/15, indicated R6 is in clinic for assessment of bruising and swelling of left hand and that R6 did not remember hitting hand or banging it. Progress note indicated X-ray showed fracture of proximal phalanx of left fifth finger splint placed and orthopedic follow up with in next week recommended.

The Serious Injury Report dated 12/23/15, sent to the Office of the Ombudsman for Mental Health and Mental Retardation, indicated R6 had sustained an fracture of the fifth finger of the left hand. Description of how the injury happened indicated "resident does not know what happened. Nurse observed swelling and bruising of left hand." The section triggering others to be notified including medical, OHFC [Office of Health Facility Complaints - state agency] and adult protection were blank.

At time of the injury R6 was unable to state what happened. While the Office of the Ombudsman was notified there was no evidence that the state

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agency was notified of the significant injury of unknown origin.

During interview on 4/14/16, at 10:25 a.m. the social worker designee (SWD) stated the injury for R6 was reported to the ombudsman's office but not to the state agency because they were not vulnerable adult issues.

During interview on 4/15/16, at 9:25 a.m. Licensed practical nurse (LPN)-A said "We do not document notifying the administrator. If there is a fracture we do not notify administrator on the weekend or nights because we have dealt with it. If the resident were admitted to the hospital we would let them know."

During interview on 4/15/16, at 9:27 a.m. the SWD said "I don't think they would bother calling the administrator because it was not a vulnerable adult issue, it was a serious injury. [Administrator] would need to know about fractures if it were a vulnerable adult issue like the fracture was due to being beaten. Do not need to know if it is due to a fall."

During interview on 4/15/16, at 2:15 p.m. the administrator said, "I ask them to chart notifying me. I expect them to notify me about fractures."

During interview on 4/15/16, at 2:19 p.m. the interim director of nurses (IDON) stated, the facility reported injuries of unknown origin. Reporting fractures depended on whether or not we know where the resident had been. The IDON said, "If there have not been any incidents then it is not reportable. We report to where ever we are supposed to." When asked about reporting injuries of unknown origin to the state agency versus the office of the ombudsman the IDON

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31990	Continued From page 23 said, "I have always reported to the same place." SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop systems to ensure potential abuse/neglect/misappropriation of funds allegations are reported immediately to the administrator and state agency. The administrator or designee could educate all staff om this system. The administrator could monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	31990		
32000	MN Rule 626.557 Subd. 14 Reporting Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person ' s susceptibility to abuse by other	32000		6/9/16

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32000	Continued From page 24 individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility ' s ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to operationalize their policy for reporting of allegations of verbal abuse, injuries of unknown origin, elopement, substance abuse within the facility, and/or falls with significant injury for 5 of 17 residents (R20, R7, R16, R14, R6). Findings include: The facility's policy entitled "Vulnerable Adult	32000	Corrected.	

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Maltreatment Prevention Plan" dated 3/6/15, indicated that the facility "does not tolerate any form of maltreatment" which included "any form of physical, verbal, mental or sexual abuse; any form of neglect, involuntary seclusion, corporal punishment or mishandling of resident property". The policy also included the following:
-" An assessment will be made of a prospective resident prior to admission for a known history of potentially dangerous behavior patterns"
-"Individual susceptibility will be assessed and included in the overall resident careplan along with goals and approaches for prevention and safety".
-"If maltreatment is suspected or observed the administrator must be notified immediately".
-"The administrator or representative will use the flowchart to determine the reporting requirements.
-"Nursing completes the internal reporting forms whish [sic] is a collection of information that needs to be submitted to MDH online. The Administrator submits the online report to the Minnesota Department of Health immediately as available"
-"You must make your report directly to the facility Administrator immediately after ensuring resident safety. The facility is responsible to report all reportable incidents and suspected crimes to MDH".
Based on observation, interview and document review, the facility failed to report allegations of verbal abuse, injuries of unknown origin, elopement, substance abuse within the facility, and/or falls with significant injury for 6 of 17 residents (R20, R7, R16, R14, R6, R8).

R20 was admitted to the facility on 3/23/15. A minimum data set (MDS) annual assessment dated 2/6/16 identified R20 as independent with

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activities of daily living and intact cognition.

R20's Community Safety Assessment dated 8/3/15 indicated that R20 had an extensive history of substance abuse, poor decision making, and was currently attending treatment three times per week. The assessment further indicated "since admission has used illegal drugs". The assessment further identified R20 had multiple vulnerable adult (VA) issues since admission related to poor choices. Staff recommendations on the assessment indicated R20 could leave the facility independently.

A note dated 12/28/15 in R20's medical record signed by the administrator revealed that R20 admitted to having alcohol in her room which contributed to another resident (R7) going to the emergency room. The note indicated that this was not the first time this has occurred.

R20's progress notes were reviewed from 1/16-4/11/16 and revealed on 2/3/16 at 7:30 a.m. R20 was found to be lethargic and unresponsive. Emergency Medical Services (EMS) were activated, the resident was provided Narcan (medication which reverses some overdoses such as Heroin) and transported to the emergency room. R20 was admitted. R20's Hospital Discharge Summary dated 2/8/16 indicated that R20 was admitted to the hospital for altered mental status and accidental heroin overdose.

R20's Mental Health Summary dated 3/5/16-4/5/16 indicated that R20 had a "lengthy history of heroin abuse and methamphetamine abuse" and staff had an order for Narcan if overdose was suspected. The mental health summary further indicated that R20 had a verbal

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32000	Continued From page 27 altercation with another resident and resident's family member and "needs to be closely monitored by staff". R20's careplan dated 3/3/16 identified a history of heroin addiction-recent heroin overdose and indicated that the facility now had and order for Narcan. Interview with the Social Worker Designee (SWD) on 4/14/16 at 2:42 p.m. revealed that she was aware of R20's heroin overdose on 2/3/16. The SWD was unaware if R20 had any other hospitalizations due to overdose. The SWD was asked if R20's heroin overdose with hospitalization was reported to the state agency. The SWD replied the incidents were "not required to be reported, even if hospitalized. We follow a flow chart." Interview with the Interim Director of Nursing (IDON) on 4/15/16, at 2:28 p.m. revealed that she was the nurse working on 2/3/16 and stated she was aware of R20's previous drug use but was unaware why R20 was unresponsive that morning. The IDON stated she was not familiar with R20 having any similar incidents related to drug use prior to 2/3/16 was not aware of any drugs in the facility. When asked if this incident should be reported to the state agency the DON replied "I don't know". R7 was admitted to the facility on 9/30/14 with diagnoses that included but not limited to mood disorder, schizophrenia, and alcohol dependency. R7's Minimum Data Set (MDS) quarterly review assessment dated 1/5/16 indicated R7's cognition was intact and was independent with activities of daily living. R7's careplan dated 10/19/15 included vulnerable adult (VA) issues of history of promiscuous	32000		

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32000	Continued From page 28 behavior and chemical use making poor decisions. The care plan identified 12-28-16 (sic- facility dated the care plan as the year 2016) R7 consumed alcohol that resulted in hospitalization. R7's progress notes were reviewed from 10/21/15-4/11/16 and revealed on 12/27/15 at 9:11 p.m. R7 was found with a "blank stare unable to sit up in bed" and slurred speech. 911 was called and R7 was transported to the hospital. She returned 12/28/15. R7 reportedly got the alcohol from her roommates R20 and R17. An emergency department hospital admission sheet dated 12/17/15 which indicated that R7 was hospitalized for alcohol intoxication. R7's social service progress notes were also reviewed and indicated on 1/4/16 the social worker designee (SWD) spoke with R7 regarding the drinking incident and resulting hospitalization. R7 got angry and screamed "that was not me". R7's medical record included a psych appointment referral dated 1/11/16 which included the note that R7 was hospitalized for alcohol intoxication. Roommate gave her alcohol that was hidden in the room. An interview with the SWD and administrator on 4/14/16, at 4:03 p.m. indicated the SWD was familiar with R7's chemical dependency issues. The SWD stated the alcohol use was "not a problem, just because something happens once, if it was an ongoing issue I would have put it as a problem on the careplan". The SWD and administrator confirmed the alcohol use and resulting hospitalization were not reported to the state agency. The administrator stated the incident was "not required to be reported, even if hospitalized" and that the facility followed a flow	32000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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chart for reporting of incidents to the state agency.

An interview with the Interim Director of Nursing (IDON) on 4/15/16 at 2:28 p.m. revealed she thought the facility reported the incident to "where it should be reported to".

R16 was accepted and admitted to the facility 11/9/15, under commitment for chemical dependency. The Minimum Data Set (MDS) dated 12/7/15, indicated R16 was cognitively intact, mildly depressed, had verbal behavioral symptoms directed towards others, and rejected care daily.
The Care Area Assessment (CAA) dated 12/7/15, indicated R16 was receiving anti-psychotic medications for anxiety and verbal aggression.
The undated care plan identified R16 had one missing person report for failure to return to facility at specified time. R16 was able to have leaves of absence (LOA's) and self administer medications.
Nursing progress notes on 11/17/15, at 6:00 p.m. R16 was found to be lethargic and confused. The resident was taken to the emergency room via ambulance. The hospital reported an alcohol level of 0.37. On 11/18/15, it was documented that R16 had been admitted to the hospital. On 11/24/15, R16 returned to the facility.
On 12/8/15, at 10:00 R16 left via taxi to the doctor and spend the day with her boyfriend. She had medications through bedtime. She stated she will be back at 10:00 p.m. Although contacted through her boyfriend, R16 did not return to the facility until 12/15/15 at 5:30 p.m. When asked why she didn't return for a week, R16 replied "I had some things I had to take care of."
Mental Health Summary dated 12/9/15, indicated: R16 was noncompliant with medications, had a

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	00208	A. BUILDING: ______ B. WING ______	04/18/2016

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32000	Continued From page 30 long history of alcohol use and multiple chemical dependencies, treatment programs and long history of unstable housing. R16 was currently getting alcohol from her boyfriend in exchange for favors. On 12/25/15, R16 went on LOA with her boyfriend and medications. R16 stated she would be back that evening. On 12/26/15, at 6:45 p.m. R16 called the facility to inform them she was at the emergency room and was being admitted for pneumonia. The facility verified this with the ER staff. The interim director of nursing (IDON) ' s hand written, undated Discharge/Summary Information identified "Consumption of alcohol, left premises for extended time without notice. Broke court order for no overnights outside of facility." On 4/14/16, at 2:42 p.m. the social work designee (SWD) and administrator were asked for policies for resident LOA's. The SWD stated the residents "Sign LOA form and ask for meds." The SWD stated they complete one community assessment and one self administration of medication assessment. If a resident did not return from the outing, she would utilize the missing person protocol. When asked if the overdoses were reported to the state agency, the SWD stated they were "Not required to be reported, even if hospitalized. We follow a flow chart." The IDON was not available in the facility, a scheduled phone conversation occurred with IDON at 2:00 on 4/15/16. The IDON had not considered R16 an elopement, but she was a vulnerable adult (VA), "I thought it was reported." The facility failed to report R16's alcohol intoxication to the SA. The facility also failed to report the elopement from 12/8-12/15/15 to the SA even though the facility reported it to the police on 12/10/15 as a missing person.	32000		

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R14 quarterly Minimum Data Set (MDS) indicated she was cognitively intact and was independent with all activities of daily living. R14's care plan dated 2/23/16 identified her as a vulnerable adult and indicated no vulnerable adult issues.

A review of facility progress notes indicated in 3/20/16, R14 had been called a derogatory name by another resident in the facility three times that day. The noted indicated "this incident was very upsetting" to R14. A progress note dated 4/12/16 indicated R14 had complained of being called derogatory names by another resident "qday" (every day). R14 stated it had happened as recently as the previous day.

During an interview on 4/12/16, at 4:26 p.m., R14 further stated a resident in the house is "nasty" to other residents and stated another resident beat that resident up. R14 stated the staff is aware of the situation, but no one did anything about it.

During a subsequent interview on 4/14/16, at 10:22 a.m., R14 stated another resident in the house yells all the time and is "bossy" and "hard to deal with."

During an interview on 4/15/16, at 2:15 p.m. the social work designee (SWD) stated she was responsible for handling and reporting potential abuse and abuse allegations. She stated when a resident had concerns she would talk to the other person. She stated "you have to separate whether it's happening, or if it is their perception of what's happening." The SWD further stated, "reporting to the state agency isn't always the answer." She stated verbal aggression between resident's is not reportable to the state agency and takes place "frequently" but are not an actual threat to a resident.

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32000	Continued From page 32 R6's quarterly Minimum Data Set (MDS) dated 2/5/16, indicated R6 was cognitively intact with delusions (fixed false beliefs) and was independent with all activities of daily living except dressing and personal hygiene. The MDS also indicated R6 was unsteady when going from sitting to standing or turning around, did not use any mobility devices and that R6 became short of breath with walking. R6's MDS indicated R6 had diagnoses of anemia, diabetes, hypertension, and schizophrenia. Diagnosis of mild mental retardation noted on office visit note dated 4/14/15. R6's care plan dated 8/26/15, identified R6 as a vulnerable adult and comments dated 11/16/15, and 2/16/16, indicated no vulnerable adult issues. 12/23/15, temporary care plan problem "Fx [fracture]. of proximal phalanx of L [left] 5th finger (etiology unknown-res does not know how it happened)" Observation on 4/13/16, at 11:40 a.m. identified R6 walking without a cane, limping and stumbling into the smoking room. R6 fell into a chair in the smoking room. At 12:41 p.m. R6 was again observed to stumble and fall into chair in the smoking room. Review of Incident/Accident Report dated 4/21/15, at 11:29 a.m. indicated "Pt woke up-few hours p[after] being up we noticed her R [right] eye all puffy and 2 sm [small] lacerations around R [right] eye. She does not remember how it happened." Type of injury listed as "hematoma, abrasion, and swelling." Incident form indicated staff did not know when injury happened and resident did not remember falling. Incident /Accident report did not indicate the administrator	32000		

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32000	Continued From page 33 or state agency were informed of the injury. Nurses Record and Progress Notes dated 4/21/15, at 12:00 p.m. indicated: "Appears pt [patient] fell against something during the noc [night], has a swollen right eye under each eye and two small lacerations are 3 mm [millimeters] long around eye." "Does not remember what she fell against." Note dated 4/21/15, at 3:00 p.m. ..."is now c/o [complaining of] (unreadable) w c/o headache. States hit head on door going to BR-has flashlight to help guide her." Review of progress notes 4/21/15 through 4/27/15, did not indicate the administrator or SA were notified of the injury of unknown origin. Nurses Record and Progress Notes dated 12/23/15 at 1:30 p.m. indicated R6 came into office and showed nurse her left hand. Nurse noted bruising on the front and back of hand with minor swelling. R6 was sent to urgent care. Physician 's Progress Notes dated 12/23/15, indicated R6 is in clinic for assessment of bruising and swelling of left hand and that R6 did not remember hitting hand or banging it. Progress note indicated X-ray showed fracture of proximal phalanx of left fifth finger splint placed and orthopedic follow up with in next week recommended. The Serious Injury Report dated 12/23/15, sent to the Office of the Ombudsman for Mental Health and Mental Retardation, indicated R6 had sustained an fracture of the fifth finger of the left hand. Description of how the injury happened indicated "resident does not know what happened. Nurse observed swelling and bruising	32000		

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32000	Continued From page 34 of left hand" The section triggering others to be notified including medical, OHFC [Office of Health Facility Complaints - state agency] and adult protection were blank. At time of the injury R6 was unable to state what happened. While the Office of the Ombudsman was notified there was no evidence that the state agency was notified of the significant injury of unknown origin. During interview on 4/14/16, at 10:25 a.m. the social worker designee (SWD) stated the injury for R6 was reported to the ombudsman's office but not to the state agency because they were not vulnerable adult issues. During interview on 4/15/16, at 9:25 a.m. Licensed practical nurse (LPN)-A said "We do not document notifying the administrator. If there is a fracture we do not notify administrator on the weekend or nights because we have dealt with it. If the resident were admitted to the hospital we would let them know." During interview on 4/15/16, at 9:27 a.m. the SWD said "I don't think they would bother calling the administrator because it was not a vulnerable adult issue, it was a serious injury. [Administrator] would need to know about fractures if it were a vulnerable adult issue like the fracture was due to being beaten. Do not need to know if it is due to a fall." During interview on 4/15/16, at 2:15 p.m. the administrator said, "I ask them to chart notifying me. I expect them to notify me about fractures." During interview on 4/15/16, at 2:19 p.m. the interim director of nurses (IDON) stated, the	32000		

Minnesota Department of Health

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facility reported injuries of unknown origin. Reporting fractures depended on whether or not we know where the resident had been. The IDON said, "If there have not been any incidents then it is not reportable. We report to where ever we are supposed to." When asked about reporting injuries of unknown origin to the state agency versus the office of the ombudsman the IDON said, "I have always reported to the same place."

SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop systems to ensure the abuse/neglact plan/policy is operationalized. The administrator or designee could educate all staff om this system. The administrator could monitor to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty One (21) days